The Pattern of Elderly Abuse Presenting to an Emergency Department

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ABSTRACT

Aim: To determine the pattern and frequency of elder abuse presenting to an urban Emergency unit in Singapore.

Method: The survey was conducted from May 1994 to December 1997. The patients consisted of adults who were 65 years or older who presented to the Emergency Department with non-accidental trauma or complained of other acts of cruelty.

Result: 17 cases of elder abuse were found, out of a total of 62,826 elderly patients. The frequency of elder abuse presenting to the Emergency Department was 0.03%. Elder abuse makes up 2.9% of all cases of family violence involving adults in this period. The average age was 74.6 years old. There was a predominance of Chinese females. In 58.8% the assailants were the daughter-in-law or son. 70.5% were ambulatory. Most (76.4%) had a chronic medical illness, commonly hypertension, diabetes mellitus, or both. Blunt musculoskeletal trauma, head or maxillofacial injuries were the commonest injuries encountered.

Conclusion: Elder abuse is a significant subset of Family Violence. It may be more widespread than thought. Awareness of its occurrence is a first step in halting its progression.

Keywords: elder abuse, domestic violence, family violence, profile, emergency

Singapore Med J 2000 Vol 41(12):571-574

INTRODUCTION

Family violence is metaphorically considered a chronic disease with periods of quiescence and exacerbation[1]. The victims often find their way to the Emergency departments and pose a significant challenge to the Emergency Physician. Abuse involving the elderly can take many forms. Physical or sexual abuse is readily recognisable; but material exploitation and mental harassment or verbal abuse does not present with anything tangible during an examination. Neglect is a form of abuse by omission, with the caregiver failing to meet the needs of a dependent elderly person. It is generally accepted as a form of maltreatment[1]. Many victims may choose to remain reticent for fear of being cut off from their sole means of survival. A medline search from 1966 to 1999 for local data revealed six articles dealing with child abuse, four on spousal abuse and two on family violence in general, but none had any data on elderly abuse. Ironically the problem of elderly abuse has not received the local attention it deserves although it may be associated with other forms of Family Violence[2].

SUBJECTS & METHODS

Consecutive cases of non-accidental injuries and other acts of cruelty involving those 65 years old and above were accrued from the patient population who presented to the Emergency Department in Tan Tock Seng Hospital in Singapore. We reviewed their injuries during this period spanning the 44 months from May 1994 to Dec 1997.

RESULTS

17 cases of elder abuse were collected from a total attendance of 62,826 elderly patients. The frequency of physical abuse in the elderly who presented to the Emergency Department during this period was 0.03% (Table I). It made up 2.9% of the 573 cases of Family Violence involving adults seen in that period. This averages about 4.6 cases, of 156 cases of domestic trauma per year.

Age

The age for elderly abuse is arbitrarily taken as 65 years and older. The age range of the patients in this study was 65 to 86 years old. The average age was 74.6 years. The average male was 74.3 years old, while the average female was 74.7 years old. Six (35.3%) were 75 years or older.

Sex

Only three were males (17.6%). The majority (82.3%) of the patients were females.

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Table I

	1994	1995	1996	1997
Total Emergency Department patients aged 65 years old and above	9,910 (from May)	15,679	17,522	19,715
Percentage of elderly patients in the Emergency Dept	14.3%	15%	15.8%	16.6%
Percentage of elderly female patients	38%	37.7%	37.5%	35.8%
Percentage of Chinese	67.5%	66.9%	65.9%	63.9%
Number of elderly abuse	6	5	3	3
Frequency of elderly abuse	0.06%	0.03%	0.02%	0.02%

Race

There was a predominance of Chinese (88.2%) victims. Two were Indians. No Malays or other races were seen during the period of study.

Medical History

Two were suffering from mental disease and dementia. Eight (47%) had hypertension and five patients had diabetes mellitus (29.4%). Diabetic patients in this group were seldom isolated, and had at least one other disease in their medical history. Six patients had more than a single chronic disease, five (83.3%) had hypertension and five (83.3%) had diabetes mellitus. Four patients (23.5%) did not have any chronic illness and all were mobile in this group who were medically well.

Mobility

Three (17.6%) were feeble on their feet or wheelchair bound and needed help getting around. The majority (14) or 82.4% were independently mobile. Two were mobile despite having suffered a stroke and the other a hip fracture previously.

Injury

Eight patients had blunt musculoskeletal trauma, mostly contusions. There was one case of fractured radius and ulna. Seven had maxillofacial or head injury, but only one was admitted for loss of consciousness due to the assault. Three patients suffered bruises on the chest. One had abdominal contusion and one had cold water poured over her by her granddaughter while she was asleep. None were sexually abused.

Severity of Injury

Seven (41.2%) were admitted to the hospital and in only three (17.6%) was it due to their injuries, including one who had been dehydrated from neglect.

Neglect

Two of these patients were obviously neglected. One was unkempt and the other was dehydrated after she was not fed for three days. They were also among those who were less mobile.

Assailants

Eight patients were assaulted by a female relative. The daughter-in-law was the assailant in five cases (29.4%) and a similar proportion was by their children, mostly sons, whether singly or with others. In four of the incidents, there was more than one assailant. In one case it was due to the helpers in a nursing home. Three of these cases were victims of spousal abuse.

Employment

Two patients were actively employed at the time of the incident. They were 70 and 74 years old. The former was assaulted by her son who was a drug addict. The latter was assaulted by her daughter and grandchildren. These two cases were also documented to have suffered more than one episode of domestic violence.

Mode of Arrival and Delays in Presentation

10 were brought to the Emergency department by ambulance; nine of them were assaulted on the same day. The Police referred four patients, where three were assaulted on the same day. A total of 12 of the cases presented on the same day after a dramatic event that involved the Police and Ambulance service. Three were brought by a relative or friend. Only two came to the Emergency Department on their own. Six cases were delayed for one to eight days prior to consulting a doctor; of these, two of them were impeded by their lack of mobility.

Police Involvement

The police were involved in 14 of the cases (82.4%) eventually. Four had the immediate intervention of the police at the time of assault.

Involvement of the Medical Social Worker

Ten patients (58.8%) were referred to the Medical Social Worker (MSW). Two defaulted. In seven others (41%), no referrals were made. Three were admitted into the

ward but no subsequent referral was made. Two were referred for follow up at a clinic without a referral to a MSW. Two were sent home without an MSW referral.

Disposition

41.2% required admission, mostly to clarify their social situation. Only three (17.6%) needed admission for their injuries. Ten patients (58.8%) were allowed to go home, but two were discharged without any clear follow up.

DISCUSSION

Ogg estimated a 1.1% prevalence rate of physical abuse in those 65 years and older in a random survey in Britain in 1992[3]. A 0.4% prevalence rate of physical abuse was found among those using the Protective Services for the elderly in New Haven, Connecticut in 1982[4]. Clearly the group that presented to the Emergency Department was self-selected, hence seeing a frequency of 0.03% for physical abuse represents the proverbial tip of the iceberg. 28.6% of the mobile patients were delayed in their presentation, and may be a reflection of their hesitation to involve others in a family matter. Other cases of elderly abuse that did not need immediate medical care were probably dealt by other agencies and the conclusions of this study cannot be generalised. The true incidence of elder abuse will probably be never known.

In the same Connecticut study[4], patients 75 years or older were 1.9 times likelier to use Protective Services for abuse. It also found that women were 1.3 times likelier to be abused. Locally, the majority (82.4%) of the victims were women and 88.2% were Chinese. These figures are vastly different from the overall patient composition of the Emergency Department of 37.3% women and 66.05% Chinese in those 65 years and older. The low frequency of abuse involving local men may be a reflection of their reluctance to seek help or may indeed be truly low. It is unknown if a similar reluctance exists amongst other races to use the Emergency Department when abuse occurs. A similar preponderance of Chinese women was not seen in spousal abuse[5].

Fong identified the main caregiver of a stroke sufferer to be commonly a female relative[6], which may explain the preponderance of female assailants in this survey. However the similar numbers of male assailants is unexplained. One of the male assailants had been a drug addict but other addictions among the abusers were not studied. Alcohol consumption has been associated with Family Violence[7,8]. Violent drinkers tend to be more severely dependent on alcohol than non-violent drinkers[9].

Dehydration and malnutrition are the commonest manifestations of neglect[1]. 11.8% in this study were neglected, but we believe the figure for this is higher than it appears, due to the predominantly ambulant elderly seen in this study; the bed bound were self excluded. It is indeed possible that the aetiology of some injuries may be discounted and abuse was never suspected.

CONCLUSION

The doctor is faced with the challenge to recognise, manage and report these cases to stem the cycle of violence. The Emergency Department is but one avenue for recourse for victims. The community nurse, neighbours and family members may help these patients by reporting them to the Family Welfare Services. Protection from persons causing hurt, continual harassment, threats, wrongful confinement is spelt out in the Women's Charter. Under this charter, the victim can apply for a Protection Order, or a relative can do so if the victim is incapacitated.

Elderly abuse is not a problem seen in isolation; it is an integral part of Family Violence. Successful intervention may indirectly help other victims caught in the same cycle of violence.

We advocate that the elderly person who present with suspicious or unexplained injuries be interviewed alone for any history of abuse. The victim should be asked if they had ever been abused and the type of abuse they suffered. Homer alluded to the reticence some of these patients may have[7]. The carer should also be asked if they ever lose control. Homer noted that carers are willing to talk about their difficulties under the right circumstances (in privacy, non-judgemental listener) and may even express relief at sharing their problems with someone else.

Who cares for the carers? Many carers of stroke patients found themselves ill prepared to face the task ahead[6]. Providing information leaflets, information on day care centres and adequate nursing training prior to leaving hospital may help alleviate some of the anxieties of the carer. Carers may get temporary respite by admitting the patient into an institution in the interim. The carer seeking temporary respite should no longer be thought of in a negative light. Alcoholism has a close association with Family Violence and by helping the alcoholic, the beneficiaries are often more than is apparent.

In some cases the abusive relationship may be a manifestation of a long-term relationship of poor quality[7]. Abuse goes both ways, as the elderly person may be abusive to start with. 17.6% of the patients had neither a Police report nor a referral to the Medical Social Worker. With indifference on the part of the doctor or Health Care Worker, the patient is left without a choice

but to return to the abusive relationship to fend for themselves. A report to the relevant authorities is perhaps a last resort to address the injustices suffered by the elderly. Equipping the carer with ways of coping and treating the alcoholic are avenues worth pursuing first. Future questions should seek to answer the risk factors for abuse to prevent its occurrence and ensuring that the elderly thrives in this community.

ACKNOWLEDGEMENTS

We thank the staff of the Medical Records Office and Mrs Hwang Mei Woon (MSW) for their help in collecting the data presented above. We also thank Ms Ayliana Phe of the Office of Quality Management, Tan Tock Seng Hospital, for some of the statistics.

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