Editorial

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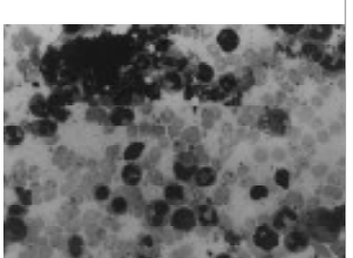

Cover Picture:
A repeat bone marrow aspirate showing marked granulopoiesis with full maturation which is characteristic of chronic phase of CML. May-Grunweld-Giemsa, x 40.
(Refer to page 595-598)

Elder Abuse: Under-Recognised and Under-Reported

W S Pang

The subject of elder abuse has gained prominence in the past two decades. A literature search using PubMed yielded over 600 publications, many of which were in nursing and allied health journals. Local information on this subject has been scarce. Elder abuse is seldom reported, and perhaps even less so in an Asian society where filial piety and respect for the elderly is traditionally highly regarded. Abused elderly are unlikely to report on their own families for fear of embarassment and fear of losing care support. Lack of awareness of support services may also be a contributory factor. In the study by Cham and Seow, the relatively low figure of 17 cases of elder abuse out of 62,826 elderly attendances at the Emergency Dept is likely to be the tip of the iceberg[1].

In 1996, the Administration for Children and Families (ACF) and Administration on Aging (AoA) in the US Department of Health and Human Services jointly funded the National Elder Abuse Incidence Study (NEAIS) to determine the incidence of domestic elder abuse and neglect in the US[2]. They estimated that 449,924 elderly persons aged 60 and above experienced abuse and/or neglect in domestic settings in 1996. Of this, 16% were reported to and substantiated by Adult Protective Service agencies. If self-neglect was included, the total estimate increased to 551,000.

One of the difficulties has been the definition of elder abuse. Hazzard described elder abuse as cruel and inhumane treatment of the elderly and further classified them into four types: (1) infliction of physical pain or injury (2) debilitating mental anguish (3) unreasonable confinement and (4) wilful deprivation by a caretaker of services necessary to maintain mental and physical health[3]. The National Center for Elder Abuse defines seven types of elder abuse: physical, sexual, emotional or psychological, financial or material exploitation, neglect, abandonment and self-neglect[4]. Neglect is perhaps the most difficult to define, and may be intentional or unintentional. Intentional neglect would include refusal of a caregiver to provide for basic needs such as nutrition, hygiene and medical care. Unintentional neglect often arises as a result of ignorance on the part of the caregiver. Self-neglect as a form of elder abuse is debatable, as there is absence of a perpetrator and the individuals may have dementia or depression.

Recognition of physical abuse may not be straightforward, as injuries may be secondary to falls to which the frail elderly are more prone. Diagnosis may be difficult even at autopsy as findings may be subtle and invariably some chronic or debilitating disease would be present[5]. Connolly reported the case of an elderly lady from a nursing home referred to the police for suspected physical abuse[6]. Investigations showed that osteomalacia and spontaneous fractures could have accounted for her injuries.

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Sexual abuse usually implies a physical sexual relationship with an elderly person without that person's informed consent, though this is not restricted to sexual intercourse but includes other forms of intimate sexual contact[7]. It is often difficult to establish whether sexual abuse has occurred, particularly if the individual has cognitive impairment.

Various studies have looked at factors associated with elder abuse. In the NEAIS report, females and those aged 80 and above were more likely to suffer abuse, family members were the most likely perpetrators and victims of self-neglect were usually depressed, confused or extremely frail[1]. Other studies have similarly reported vulnerable elderly as those with physical and mental weaknesses, advanced age, women, those with previous abusive relationships in the family, financial strain and caregiver stress and burnt out. Elder abuse was also associated with alcohol abuse by caregivers and long term relationships of poor quality[8]. A study in Iowa looking at community characteristics found that rates of reported or substantiated elder abuse were positively associated with population density, children in poverty and reported child abuse[9]. The strong association between child abuse and elder abuse is likely related to similar social factors.

Dyer et al in a case controlled study of elderly patients referred for neglect to a geriatric assessment clinic found a higher prevalence of depression and dementia in victims of self-neglect compared to patients referred for other reasons[10]. Coyne et al, using anonymous questionnaires, had 11.9% of caregivers admitting to direct physical abusive behaviour towards dementia patients in their care[11]. Higher burden scores and depression scores were noted amongst these caregivers. Of interest is that 33.1% of the caregivers reported that patients had directed abuse towards them in the course of providing care. The authors suggested that the relatively high psychological and physical demands placed on caregivers contributed to elder abuse of dementia patients.

With an ageing population, it is imperative that all health care professionals be aware of the problem of elder abuse. In particular, geriatricians, family physicians, nurses and community health care providers, particularly those in respite services and nursing homes need to be proactive in identifying potential cases of elder abuse. Doctors have an ethical responsibility to report and address abuse of residents in nursing homes whether by staff, visitors or other residents[12]. Elderly individuals may for various reasons not report abuse. The emergency department is a key point of contact as elders who are mistreated are often isolated and an unexpected visit to the emergency department may be the only opportunity for detection of abuse. Emergency physicians have a responsibility to recognise, manage and when appropriate, report suspected cases of elder abuse. The American College of Emergency Physicians recommended in their policy statement the use of written protocols on recognition and treatment of elder abuse in emergency departments and for hospitals to have the necessary staff and resources to assess and assist individuals identified to be abused or neglected[13].

Other health care professionals should also have an awareness of the issues. There are published reports of elder abuse incidentally identified by dental surgeons, radiologic technologists, physiotherapists and other health care professionals in the course of working with the elderly. Family violence including elder abuse should be incorporated into and given eminence in the training of doctors and all health care professionals. This should include an awareness of the support services available. In managing cases of elder abuse, Bradley recommended a sequence of identification of warning signs,

The National Center for Elder Abuse defines seven types of elder abuse: physical, sexual, emotional or psychological, financial or material exploitation, neglect, abandonment and self-neglect.

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assessment by a interdisciplinary team which should assess both caregiver and patient, followed by action in the form of a care package designed to deal specifically with the situation[14]. The latter is particularly important as managing elder abuse is not just about identifying and prosecuting perpetrators but assisting patients and caregivers deal with the factors precipitating abuse.

Certainly elder abuse will increase with an ageing population worldwide, especially if adequate caregiver support programmes and services are not developed in tandem. A most appropriate comment was published in a letter to the BMJ: "an initiative for the millennium that centred on the health and social care of elderly people and helped them to remain free of abuse and neglect would be a major advance towards truly healthy ageing[15]." SMJ

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ERRATUM

In the article "A Case Series of Acanthamoeba Keratitis in Singapore" published in Vol 41 issue 11 November 2000, the photos for Fig. 3 and Fig. 4 should be switched.

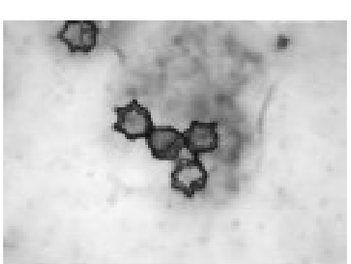

Fig. 3 Giemsa Stain of acanthamoeba cyst.

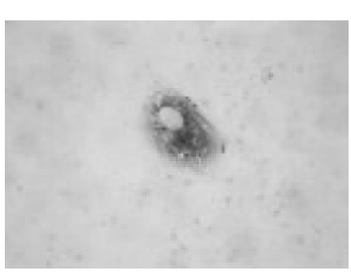

Fig. 4 Giemsa Stain of acanthamoeba trophozoite.