# MWIA CASE STUDIES

## ELDER ABUSE

## Case 25: Three Cases in Germany

### Narrative Cases

** At the end of the case study you can find "Learning points" related to information presented in the narrative case, denoted by numbers in square brackets.*

**1) Domestic violence not recognised due to lack of knowledge**

During a home visit as a general health practitioner, I saw a family at an isolated rural location (edge of Wuppertal in Germany). A lady of around 80-years of age presented in a weak state with various pains in different places caused by several falls. [1] The patient herself was silent and her home, clothing and family seemed rather neglected. [2]

After writing an admission note for the hospital, I had the vague feeling that something was being withheld from me. I had asked the family to call an ambulance but should have waited for the ambulance to arrive. I realized this much later when I learnt more about violence against elderly people within the family. [3]

**2) Successful intervention of the GP**

An 85-year-old woman's family said she was unable to pass urine and suffering from severe abdominal pains. This history was given in an excited and wordy account. The patient was very restless, anxious and her bladder clearly full. While writing down the results of my examination, I hear the patient ask her family: "Can I now go to the toilet?" and hear a hissing whispering: "No"!

I wrote a hospital admission note and called the ambulance myself. [4] I had the suspicion that the family had forced the patient not to go to the toilet. I think they did not know how to care for the grandmother and feigned illness in a very clumsy way to bring help from outside. [5] Soon after the visit, I informed my colleague on duty at the hospital about my suspicion. [6] After admission, the patient had been able to pass urine without any problems. Social/familiar background problems could be solved at the hospital by a special care service for needy and lonely patients. [7]

**3) Unclear Situation – case of domestic violence of not?**

A patient on my list for over 10 years, [8] aged 87 years, lived after her daughter's death with her son-in-law in a detached family house. [9] The patient was suffering from cardiac insufficiency and repeatedly she came with injuries and excoriations on her legs to my private practice. "She is always running down the stairs too quickly!" said the son-in-law who accompanied her. His behaviour was then rather uncooperative and disturbed. The patient insisted that she was kindly nursed by him and a niece with a nurse living nearby looked after her. [10, 11]

Until now I have not known what to think about the situation. [12]

## Learning Points

[1] The WHO state there are several risk factors concerning elderly abuse such as illnesses and shared living situations. In addition, strong dependence on caregivers can make such abuse more likely.

[2] Elderly abuse can have many different forms and involves more than physical components. The neglect of an elderly person, whether intentional or not, is also considered as abuse. At times, it is difficult to determine whether it is already abuse or still unkemptness.

[3] Here the main problem is described; the general lack of knowledge regarding this topic. The physician did not even think about it! Not only are there few studies on this topic but there are also no reports on this issue worldwide. The topic itself is also regarded as taboo (should stay within the family) and no-one wants to talk about it, which makes recognition even more difficult.

[4] In comparison to the first story, the physician recognized the abuse and decided to intervene. She stayed and made sure that the patient went to hospital.

[5] In this example, the family is clearly overburden with the care of the old lady. They wanted to get help from outside but didn´t know how to do this. The physician was sensitive to the issue but as the awareness is not very high many cases can go undetected. The WHO started preventative programmes for people who are caring for their older relatives. These provided assistance and teaching on how to deal with the situation.

[6] Here we see the positive impact of an intact chain of information between physicians. The physician at the hospital is informed about the suspicion and can further intervene.

[7] This is a best practice example. In most hospitals such a special service is not available. It will assist families that want to get help.

[8] The physician knows the patient for a very long time and the family situation as well. If a relationship like this exists, a physician can recognize changes faster and usually some kind of trust exists between doctor and patient.

[9] Another risk factor is social isolation. It goes together with dependency as the abused person might have only the abuser as their sole contact person.

[10] The physician suspects abuse but does not get a sufficiently detailed answer. Here a standardized sample of questions might help which can be answered with yes or no. Questions like this do already exist such as the H-S/East (Hwalek-Sengstock Elder Abuse) screening test. Recently the WHO has tried to develop a more simple approach using 12 easy to understand questions, EASI - The Elder Abuse Suspicion Index. These questions can be found on the internet (see below). It might also help to question the patient in private. There are many reasons why potential victims do not want to talk about abuse including feeling afraid to be alone or feeling ashamed.

[11] Once again the importance of a network is seen. The physician could contact this nurse and talk with her about the situation in the patient´s home. In addition, the physician could visit the patient to check the situation for herself.

[12] As already described in [2] it can be rather difficult without screening tools to determine abuse. This underlines the importance of raising awareness and proper training for physicians

## Background information

According to the WHO elder abuse is "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person" [1] It can have many different forms "such as physical, psychological or emotional, sexual and financial."[1]

The importance of this topic has long been underestimated but it has gained growing attention. Still elder abuse is believed to be underreported by up to 80% with a prevalence ranging from 1% to 35% according to various questionnaires. There exists a remarkably lack of studies concerning it. The biggest study regarding this topic was in 2002 the "*Missing voices: views of older persons on older abuse"* study conducted by the WHO. It was conducted in eight different countries: Argentina, Austria, Brazil, Canada, India, Kenya, Lebanon and Sweden.

This study demonstrated the necessity of addressing this topic. The WHO has started to develop screening tools to make it easier to raise physicians' awareness and help to detect more cases. Different methods and questionnaires previously used such as the *H-S/East* but were regarded as taking too much time to ask, were difficult to understand and non specific. Taking these issues into account, *EASI the "Elder Abuse Suspicion Index"* was drawn up which consists of only six questions of which five are answered by the patient and the last one by the doctor.

The WHO identified five fields of **risk factors**:

- Individual: illnesses (mental disorders, alcohol abuse), gender (in countries where woman have a lower society status than men, they are more likely to experience elder abuse)
- Relationship: shared living situation, dependence, financial dependence of the caregiver on the elderly person, history of poor relationships within the family, overburden of the caregiver
- Community: social isolation of the elderly person
- Socio-cultural: financial problems, general depiction of old people as weak and helpless, erosion of bonds between the generations, migration of young couples
- Institutional: low standards, poorly trained and overworked staff, economic reasons (the economic situation of a home for the elderly is more important than the well-being of its residents).[2]

As with any type of abuse, elder abuse can cause not only physical injuries but may lead to long-lasting psychological problems such as anxiety and depression.[2]

After raising awareness, the WHO proposes various measures to tackle this form of abuse such as a general screening for abuse and better caregiver support and training. They are demanding mandatory reporting on each case, building safe houses and shelters for victims and the foundation of self-help groups.

All these measures show great similarity to the measures against domestic violence.

## Useful Resources


- WHO. (2008). *A Global Response to elder abuse and neglect: Building primary health care capacity.* Retrieved from: http://www.who.int/ageing/publications/elder_abuse2008/en/
- WHO. (2008). *Discussing screening for elder abuse at primary health care level.* Retrieved from: http://www.who.int/ageing/publications/discussing_screening/en/
- WHO. (2002). *Missing voices: views of older persons on elder abuse.* Retrieved from: http://www.who.int/ageing/publications/missing_voices/en/
- WHO. (2014). *Fact sheet on elder abuse.* Retrieved from: http://www.who.int/en/news-room/fact-sheets/detail/elder-abuse

## HWALEK-SENGSTOCK ELDER ABUSE SCREENING TEST (H-S/EAST)[3]

Purpose: Screening device for service providers interested in identifying people at high risk of needing protective services.

Instructions: Read the questions and write in the answers. A response of “no” to items 1, 6, 12, and 14; a response of “someone else” to item 4; and a response of “yes” to all others is scored in the “abused” direction.

1. Do you have anyone who spends time with you, taking you shopping or to the doctor?
2. Are you helping to support someone?
3. Are you sad or lonely often?
4. Who makes decisions about your life—like how you should live or where you should live?
5. Do you feel uncomfortable with anyone in your family?
6. Can you take your own medication and get around by yourself?
7. Do you feel that nobody wants you around?
8. Does anyone in your family drink a lot?
9. Does someone in your family make you stay in bed or tell you you’re sick when you know you’re not?
10. Has anyone forced you to do things you didn’t want to do?
11. Has anyone taken things that belong to you without your O.K.?
12. Do you trust most of the people in your family?
13. Does anyone tell you that you give them too much trouble?
14. Do you have enough privacy at home?
15. Has anyone close to you tried to hurt you or harm you recently?

## EASI QUESTIONS[4]

Instruction: Q.1-Q.5 asked of patient; Q.6 answered by doctor

Within the last 12 months:

1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with?
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?
4) Has anyone tried to force you to sign papers or to use your money against your will?
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?
6) Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?

## References


1. Retrieved from: http://www.who.int/ageing/projects/elder_abuse/en/
2. Retrieved from: http://www.who.int/mediacentre/factsheets/fs357/en/
3. Retreived from: http://www.medicine.uiowa.edu/uploadedFiles/Departments/FamilyMedicine/Content/Research/Research_Projects/hwalek.pdf
4. Retrieved from: https://www.mcgill.ca/files/familymed/EASI_Web.pdf