LETTERS TO THE EDITOR

Elder abuse – the tip of the iceberg

Sir – Interest in, and concern about, the abuse of elderly people is developing rapidly. A study of the literature reveals little research in the UK. Bennett described it as 'another iceberg phenomenon'.[1] 'Granny battering' was first described in Britain in 1975.[2] A social services survey in 1988 found that 5% of elderly clients were being abused.[3] Homer and Gilleard[4] interviewed consecutive patients referred to geriatric wards for respite care and their carers. Some 45% of the carers admitted to having carried out some form of physical abuse on their dependent relatives.

Ogg and Bennett[5] reported the results of structured interviews, using the Office of Population Censuses and Surveys. Almost 600 people over 65 years of age and their 1,366 adult carers and/or relatives were interviewed. While 5% of the old people reported a form of abuse, only 2% reported physical abuse *per se*. While 10% of the adult carers admitted to some form of abuse, only 1% actually acknowledged physical abuse.

It is difficult to reach a consensus on definitions in this area. Wolf and Pillemer,[6] provide a helpfully systematic classification of abuse and neglect as follows. Firstly, physical abuse represents the infliction of physical harm or injury, including physical coercion, sexual molestation and physical restraint. Secondly, psychological abuse is the infliction of mental anguish. Thirdly, material abuse denotes the illegal or improper exploitation and/or use of funds or resources. Fourthly, active neglect defines the refusal or failure to undertake a care giving obligation, including a conscious and intentional attempt to inflict physical or emotional distress on the elder. Finally, passive neglect represents a refusal or failure to fulfil a caretaking obligation which excludes a conscious and intentional attempt to inflict physical or emotional distress on the elder.

We report three examples of elder abuse that highlight some of its different forms and perpetrators.

Case 1: Mrs A is a 79 year old married woman with severe cognitive impairment due to mixed Alzheimer's and multi-infarct dementia (MID). Her sons had discovered Mrs A's husband had been locking her in a bedroom, giving her 60 units of whisky per week as a sedative. Physical examination revealed weight loss and erythema ab igne.

On admission she gained weight rapidly, showing failure to thrive in the home environment. The husband found it difficult to accept he could no longer care for her. He was often inebriated and attempted repeatedly to make her leave the ward; her sons from her previous marriage persuaded her otherwise. He finally cooperated with her placement in a nursing home.

'Failure to thrive', with rapid recovery in the hospital setting and overt denigration, shouting and tension in the care-giver are helpful indicators of abuse in this case.[7] It was vital to engage the whole family, particularly when the spouse was presenting an impasse. Indeed there is encouraging evidence that family therapy is of benefit to carers showing significant levels of stress,[8] although it is time consuming and therefore expensive to provide. Efforts were directed toward increasing the coping skills of the care-giver. Physical abuse is associated strongly with excess alcohol consumption by the carer.[4] Studies have shown that spouses are more likely to engage in violence than any other relatives.[9]

Case 2: Mrs B, an 85 year old widow, had a multi-infarct dementia resulting in an inability to manage her finances. She was transferred from a geriatric ward following an episode of toxic confusion. The lodger spent her pension on alcohol and was often absent from the flat for days, whilst her main carer. He encouraged Mrs B to drink whisky to the extent her MCV was elevated. This showed material abuse and both passive and active neglect as defined by Wolf and Pillemer[6] by a pathological carer.

The social worker involved arranged for her niece to be designated appointee under the Social Security Regulations 1987, Regulation

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33; the lodger was moved to alternate accommodation, whilst an intensive care package was set up for Mrs B's return to her flat. Mrs B remained stubbornly independent in the face of mounting difficulties. However, a trial of the care package rapidly broke down and Mrs B agreed to placement in a residential home.

The lodger refused to undertake a care-giving obligation and encouraged Mrs B's alcohol misuse. The social worker gained his co-operation in the care plan by taking a neutral stance and helping a housing move, the well-being of the perpetrator should not be forgotten in the management process. It was essential that the lodger be rehoused appropriately before a trial of the care package, otherwise he may have jeopardised the plan of care by returning.

Case 3: Mrs C, an 84 year old blind widow with moderately severe Alzheimer's dementia, was assessed at a day hospital for possible material abuse by Mr D. Mr D, a door-to-door salesman, had befriended Mrs C. He subsequently estranged her from her usual support network and arranged for her to appoint him as her attorney under the Enduring Power of Attorney Act 1985. She was mentally incapable of acting for herself. Mr D had been removing furniture, had received at least £500 from Mrs C and was attempting to gain the title deeds to her house. The police believed he was involved with three other elderly persons in a similar way. An application to manage this lady's finances through the court of protection was made. She has been maintained at home with intensive support and monitoring. Mr D eventually withdrew.

The third case shows that measures designed to protect the elderly may be used against them. Mrs C's friends contacted the police with their concerns, but they were unable to take action as Mrs C was unwilling to press charges.

The above cases illustrate some difficulties in the management of elder abuse and certain of its important features. Firstly, the identification of elder abuse has to be proportional to the extent to which the agencies in contact with the elderly are alert to the possibility of abuse. There is much debate about the reliability and validity of detection criteria. In all of the cases, concerned relatives, friends or voluntary sector agencies initiated professional concern, highlighting the importance of full corroborative history-taking in the detection of elder abuse. Seymour[10] has defined five features of a pathological carer: an excessively dependent personality; inability of the carer to set limits when the cared-for person behaves unreasonably; inability of the carer to leave the cared-for person, even when adequate arrangements are made; difficulties for the carer in engaging with outside agencies when help is offered and a marked discrepancy in the cared-for person's level of functioning between home and other care settings.

It has been suggested that cases of material and physical abuse may be more successfully resolved if abuse is treated as a criminal act rather than a social problem.[4] Abuse, it can be argued, is a crime rather than a diagnosis. It is more difficult to treat it as such in countries such as the USA where mandatory reporting operates in 48 of the states.[11] If patients are reluctant or unable to admit to abuse, which was the case in all three, they are unlikely to press charges.

Once abuse is confirmed, action must follow. The priorities are: the safety of the victim; the physical and psychological health of the victim; the physical and psychological health of the abuser and a plan for the future to prevent the abuse from recurring. Here a full multidisciplinary approach and close cooperation with social services is essential.

Fisk[12] outlines several sensible avenues to prevent abuse. Firstly, information packs on how to provide care to the elderly should be made widely and freely available; self-help groups, such as Alzheimer's Disease Support Groups, should provide psychological support for more carers; benefits should be made more easily available, for example, attendance allowance. Extra benefits are needed to compensate for loss of wages, career and recreational opportunities. There may also be a role for specialist teams to detect, intervene and prevent elder abuse co-ordinated by health authorities and social services. Finally, preventive legislation such as mandatory reporting of abuse and specific protective acts for the vulnerable elderly should not be forgotten.

The needs of carers include: the recognition of their work by professionals, planned respite care, information about dementia, services and benefits, physical help and continuity of support. When these issues are not addressed, carer stress may follow, as in the first case. As well as the measures outlined by Fisk above, the importance of psychological interventions should be emphasised. These include education, group psychotherapy, family therapy and telephone helplines. The latter has been used successfully in South Wales and is a cost-effective way of channelling help to stressed carers.[13]

This important area should be highlighted in Ireland and the UK because, although it is well researched in North America and perhaps less so in Australia and Sweden, it is receiving sadly little prominence here. Awareness of the issues needs to be raised amongst health care professionals and as the third case illustrates, solicitors as well. All the cases stress the need for effective inter-agency cooperation, particularly between hospital and social services.

With an increasingly aged population and the rationing of resources at local level the authors hope that these cases will keep the spotlight on the vital area of enquiry and stimulate research into incidence and prevalence so that the 'iceberg' may be fully uncovered.

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The Celts and Macha's curse

Sir – In their review of the medical aspects of Celtic literature Drs Carney and Sheffield[1] refer to the 'Ulster Sickness', more often known as the 'Pangs of Ulster' – a strange, periodic, hereditary disease characterised by a triad of weakness, lethargy and abdominal pain. We coined the term 'Macha's curse' because similar symptoms occurred in a modern Irish pedigree in which depressive illness was combined with Idiopathic Intestinal Pseudo-Obstruction (IIPO).[2]

Macha found herself coerced into participating in a race because her husband Crunniuc had boasted that his wife could run faster than Conor's chariot. Despite being heavily pregnant and despite her protestations Macha made the heroic effort against the unequal struggle in order to extricate her foolhardy husband from his fate. After the race, while giving birth she screamed aloud that all the men present that day would at their times of greatest difficulty suffer from the pangs for five days and four nights and would have no more strength than a woman on the bed of labour. This affliction ever after