International Journal of Gerontology 15 (2021) 278–280
https://doi.org/10.6890/IJGE.202107_15(3).0017

International Journal of Gerontology

journal homepage: http://www.sgecm.org.tw/ijge/

Case Report

Investigation of an Elder Abuse Case in a Convalescent Rehabilitation Ward

Hiromasa Inoue [a *], Nobuko Kawabe [b], Yoshiro Tsuji [a], Shinsuke Ishino [a], Yasukazu Katsumi [c]

[a] *Department of Rehabilitation Medicine, Jyujyo Takeda Rehabilitation Hospital, Japan,* [b] *Support Center for Patients, Jyujyo Takeda Rehabilitation Hospital, Japan,* [c] *President, Jyujyo Takeda Rehabilitation Hospital, Japan*

ARTICLE INFO

Accepted 5 October 2020

Keywords:
dementia,
physical abuse,
subcutaneous hemorrhage,
Japan

SUMMARY

A woman in her early 90s was transferred to our convalescent rehabilitation ward (CRW) because of the development of disuse syndrome after surgery for the treatment of proctocele a year before. The woman had a subcutaneous hemorrhage around the left eye orbit, in addition to many hemorrhages in the bilateral upper arms and bilateral femurs, which were the characteristics of injury inflicted by another person. We reported the case to the authorities as physical abuse, which was certified as "Level B" (immediately protected when manifestation of abuse is recognized). The authorities decided to monitor her son (perpetrator) to prevent further elder abuse. Her activity of daily living was improved by intensive rehabilitation in our CRW. She was discharged from our hospital and lived at home with her son again while being observed by the authorities. CRWs would have to play a prominent role in undetected elder abuse cases.

1. Introduction

Elder abuse is a growing concern worldwide, and has devastating effects on the victims; its prevalence has been estimated to be between 2% and 36%.[1–4] In Japan, the current number of older people aged over 65 years is approximately 35 million. Meanwhile, the number of reported elder abuse cases was 17,588 in 2017, indicating a prevalence of about 0.05%.[5] According to a recent study, the prevalence of elder abuse was 11.1% in men and 13.3% in women.[6] Elder abuse is generally overlooked because the victim cannot recognize it and/or report it to the authorities for various reasons, such as dementia and embarrassment.[7] Thus, its prevalence in Japan is likely underestimated.

Elder abuse includes physical abuse, psychological abuse, sexual assault, material exploitation, and neglect.[1] Whereas physical abuse tends to be demonstrably recognizable, psychological abuse is the most prevalent among these types.[2] For elder abuse to be prevented effectively, it should be detected early and then robustly intercepted in consideration of the abusive behaviors, victims, perpetrators, and contexts.[1]

We encountered a woman who developed disuse syndrome after surgery for the treatment of proctocele in our convalescent rehabilitation ward (CRW). She was suspected of being physically abused by her son. Indeed, the purposes of her admission were to rehabilitate impaired physical activity and explore her care strategy after discharge from our ward. Herein, we present the various methods that we used, such as gathering evidence of abuse, and intervention on victim and perpetrator.

2. Case report

A woman in her early 90s was transferred to our CRW because of the development of disuse syndrome after surgery for the treatment of proctocele a year before. At admission to our hospital, she had a brownish purple subcutaneous hemorrhage around her left eye orbit (Figure 1A), in addition to many subcutaneous hemorrhages in the bilateral upper arms (Figure 1B) and bilateral femurs. Imaging inspection revealed old fractures of many ribs and many compression fractures in the thoracic and lumbar vertebrae. We found neither intracranial hemorrhage nor skull fracture.

She could not follow our instructions. We performed cognitive impairment screening using the revised Hasegawa's dementia scale (HDS-R), and her score was 9/30 (lower than 21/30 of HDS-R would indicate dementia).[8] Her general muscle strength was reduced; however, she could perform antigravity action and walk with a walker by herself. Moreover, she was capable of eating and clothing alone and was repeatedly trained for these actions for two months to enable walking with the wall support. In addition, she was occasionally prompted to urinate and/or evacuate at the toilet when she had the urge to do so.

Her psychological abuse by her son had been certified as "Level C" (Table 1), and as such, it was difficult to intervene actively in the abuse case. The responsible authorities had visited them to investigate her, but her son did not allow investigators to enter their house. Given that she had no caregiver except for him, we proposed her admission to a nursing home after discharge from our hospital, but he objected because of financial reasons. Although we discussed the management of care with him and the authorities several times before her discharge, he had obstinately denied violence toward her and refused to receive home care services. However, he was later persuaded to accept, at the suggestion of the medical social worker

* Corresponding author. Department of Rehabilitation Medicine, Jyujyo Takeda Rehabilitation Hospital, Kisshoin-Hattanda cho 32, Minami-ku, Kyoto 601-8325, Japan.
E-mail address: h-inoue@takedahp.or.jp (H. Inoue)

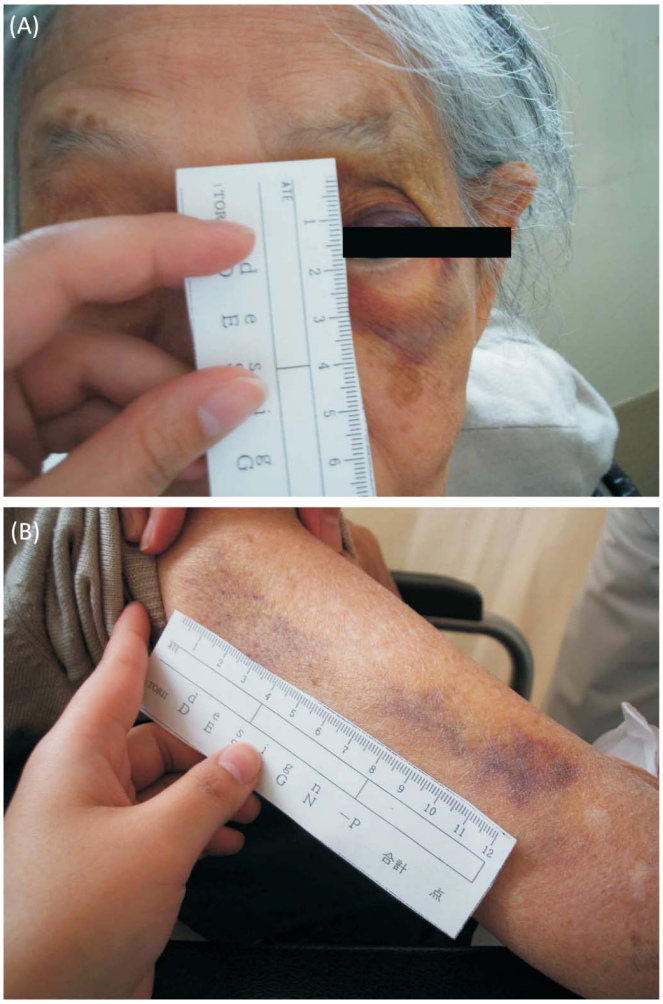

Figure 1. (A) Brownish purple subcutaneous hemorrhage around the left orbit, and (B) yellowish and brownish purple subcutaneous hemorrhages on the right upper arm, were observed on admission to our convalescent rehabilitation ward.

of our hospital and care manager in charge. Large subcutaneous hemorrhages observed at admission in our hospital completely disappeared after hospitalization for two months. We reported to the authorities that she was physically abused based on these findings. Her physical abuse was certified as "Level B" (Table 1).

For a safe stay at home, thrice-weekly day care, home help service, and home-visit nursing were set up by our medical social worker and care manager in charge, using the care insurance system. The authorities decided to schedule regular visits to them to observe their life situation. Eventually, she was discharged from our hospital and lived at home with her son again. One month after discharge, she was committed to a senior care home in accordance with her "Level B" status, because some caregivers reported to the authorities observing an increasing number of subcutaneous hemorrhages throughout her body. She spent six months and died naturally at the facility.

This case report was presented with the approval of the ethical committee of our hospital under the condition of anonymity because it was difficult to obtain agreement from the people involved.

3. Discussion

Because of the presence of multiple injuries (both old and new) all over the entire body, and the location of the injuries (mostly in the upper extremity and maxillofacial region), we suspect that these would be deliberately caused by another person.[10] The subcutaneous hemorrhages in the left eye orbit and extremities, and the many old rib fractures, were sufficient indications of elder abuse in the woman victim. She was hospitalized for more than one month before being admitted to our hospital. Nevertheless, many subcutaneous hemorrhages remained on the face and extremities, which also indicated that she might have been abused during previous hospitalization. Thus, she was hospitalized in a room near the staff room in our ward to ensure closer monitoring. Accordingly, few injuries developed during hospitalization at our CRW, which indicated that most of the subcutaneous hemorrhages could have been inflicted by her son for the following reasons: 1) the prevalent types of abuse in nursing homes are neglect and psychological abuse perpetrated by nursing staff, because physical abuse is conspicuous; 2) another type of abuse in nursing homes is the psychological abuse inflicted by other patients using verbal aggression; and 3) abuse in nursing homes obviously has a lower incidence compared with domiciliary abuse.[11]

In elder abuse cases, a generally accepted fact is that not only the perpetrator but also the victim are responsible for the causes leading to the abuse.[1–4] Cognitive impairment (dementia) of the victim would be consistently associated with greater risk for elder abuse, and older patients with Alzheimer's disease (AD) are reported to be abused 4.8 times greater than those without AD.[4] Additionally, the poor physical and mental health of older persons are also linked with elder abuse.[3] These conditions are attributed to the degradation of older adults' activities of daily living (ADL). Degradation of ADL in older persons would result in increased caregiver burden. Meanwhile, elder abuse perpetrators also have some risk factors associated with elder abuse, such as mental illness, substance misuse, and abuser dependency.[3,8] In this case, the ADL of the victim was

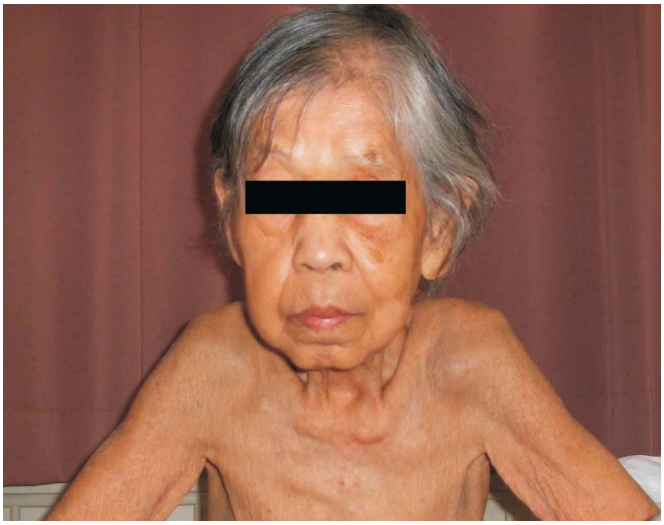

Figure 2. Upper body immediately before discharge from our hospital. The subcutaneous hemorrhage around the left orbit had disappeared after two months of hospitalization.

Table 1
Decision criteria for abuse in Japan.

Level	Provision for victim
A (Emergency)	Protected at once
B (Intervention)	Immediately protected when manifestation of abuse is recognized
C (Observation)	Routinely observed and possibly protected

This table was translated into English.[9]

obviously deteriorated because of dementia and disuse syndrome, which could be improved by convalescent rehabilitation. Her son, who was suspected as the perpetrator of elder abuse, had developmental impairment (not diagnosed) based on the results of our repeated interviews with him. Moreover, he had frequently changed jobs, probably due to his developmental impairment, which presumably led to financial poverty. Indeed, both mental illness and low income of the perpetrator are the causes of elder abuse.[3] In this case, the victim often resisted nursing care at our CRW with violence and ranting. It is possible that he could have lost control of his temper when she would curse him. The authorities decided to monitor both the woman (victim) and her son (perpetrator) to prevent elder abuse at home after discharge from our hospital, which would result in her safely spending the rest of her life. Meanwhile, the perpetrator may have not recognized his behavior toward her as abuse from the first because he made no effort to hide her subcutaneous hemorrhages after her discharge.

This case was categorized as "physical abuse by children", but the incidence of elder physical abuse has not been large among elder abuses.[1] CRWs provide intensive rehabilitation to improve ADL and to facilitate discharge to home, which may be appropriate and effective action against elder abuse. The duration of hospitalization in CRWs tends to be longer than that in acute hospitals. Moreover, medical social workers at CRWs evaluate the family situation, such as relationship and economics status, before discharge to home. Therefore, CRWs may play a prominent role in undetected elder abuse cases in the future.

We presented a case in our CRW of physical elder abuse by the patient's son. When patients who had been abused are required to be discharged to home, care practitioners should create an individualized support mechanism with the maximum utilization of the social system for safe living at home.

Conflict of interest

The authors declare no conflict of interest or any financial relationship to disclose.

References

1. Santos AJ, Nunes B, Kislaya I, et al. Elder abuse victimization patterns: latent class analysis using perpetrators and abusive behaviours. *BMC Geriatr.* 2019;19:117.
2. Yon Y, Mikton CR, Gassoumis ZD, et al. Elder abuse prevalence in community settings: a systematic review and meta-analysis. *Lancet Glob Health*. 2017;5(2):e147–e156.
3. Abolfathi Momtaz Y, Hamid TA, Ibrahim R. Theories and measures of elder abuse. *Psychogeriatrics*. 2013;13(3):182–188.
4. Dong XQ. Elder abuse: systematic review and implications for practice. *J Am Geriatr Soc*. 2015;63(6):1214–1238.
5. The Ministry of Health, Labour and Welfare. *The fiscal 2018 survey on the application of "Act on the Prevention of Elder Abuse, Support for Caregivers of Elder Persons and Other Related Matters"*. Tokyo, Japan: Ministry of Health, Labour and Welfare. Available at https://www.mhlw.go.jp/content/12304250/000491671.pdf. Accessed September 20, 2019. [In Japanese]
6. Koga C, Hanazato M, Tsuji T, et al. Elder abuse and social capital in older adults: The Japan Gerontological Evaluation Study. *Gerontology*. 2020;66(2):149–159.
7. Mosqueda L, Burnight K, Gironda MW, et al. The abuse intervention model: a pragmatic approach to intervention for elder mistreatment. *J Am Geriatr Soc*. 2016;64(9):1879–1883.
8. Imai Y, Hasegawa K. The revised Hasegawa's dementia scale (HDS-R) — Evaluation of its usefulness as a screening test for dementia. *J Hong Kong Coll Psychiatr.* 1994;4(SP2):20–24.
9. Bureau of Social Welfare and Public Health, Tokyo Metropolitan Government. *The manual to deal with elder abuse cases*. Tokyo, Japan: Bureau of Social Welfare and Public Health, Tokyo Metropolitan Government. 2006. Available at https://www.fukushihoken.metro.tokyo.lg.jp/zaishien/gyakutai/torikumi/doc/gyakutai_manual.pdf. Accessed August 24, 2020. [In Japanese]
10. Saukko P, Knight B. *Knight's Forensic Pathology*. 3rd ed. London, UK: CRC Press; 2004.
11. Phelan A. Protecting care home residents from mistreatment and abuse: on the need for policy. *Risk Manag Healthc Policy*. 2015;8:215–223.