

Elder abuse

Mark S Lachs, Karl Pillemer

Elder abuse has received increasing attention over the past decade as a common problem with serious consequences for the health and wellbeing of old people. Our aim is to assist clinicians by summarising recent international research and clinical findings about elder abuse, and to assess their quality, relevance, and feasibility for health-care providers in clinical practice. This seminar includes issues of definition and frequency of elder abuse and a summary of major known risk factors. The advantages and disadvantages of screening for elder abuse are discussed. We review clinical manifestations and diagnosis of elder abuse, and propose a protocol for medical assessment of a patient with confirmed or suspected abuse. Suggestions for treatment are offered on the basis that elder abuse is multifactorial and needs individual medical and social intervention strategies, preferably in the context of a multidisciplinary team.

Elder abuse is now recognised internationally as a pervasive and growing problem, meriting the attention of clinicians who provide medical care for old people, as well as the general public. For example, a recent WHO report about violence and health¹ prominently featured elder abuse and highlighted the range of harmful activities covered by this term throughout the world. Examples ranged from outright physical assault of old people in modernised cultures that have been sadly acculturated to so-called traditional forms of family violence, to the systematic ostracisation of tribal elders by the community in some less developed countries as a form of scapegoating (eg, old Tanzanian women accused of witchcraft and abandoned in retribution for natural events such as drought or famine). The establishment in 1997 of the International Network for the Prevention of Elder Abuse, with representation from more and less developed countries throughout the world, indicates increasing international concern about elder abuse.

At the same time as this rising public interest, a slowly improving body of scientific work on the subject has been published. Although most research has been criticised as being subject to bias and methodologically flawed, recent years have seen more rigorous approaches and gains in knowledge. Although much of the published research comes from the USA, Canada, the UK, and other European countries, this situation is beginning to change. For example, in 2001, WHO and the International Network for the Prevention of Elder Abuse held focus groups in several countries—including Kenya, Lebanon, Argentina, India, and Brazil—as a prelude to international collaborative research on the topic.²

Several incidence and prevalence studies have been done throughout the world with standard case definitions and in some studies, scientifically acceptable research methods. More rigorously designed risk-factor and natural-history studies have been done, and there are calls for intervention studies that involve rigorous randomised designs, observer masking, and attempts to standardise the interventions that are offered. In the USA, a National Academy of Sciences panel was

convened to assess the state of research on abuse of elderly people.³ Elder abuse is being recognised as a specialty worthy of interest by clinicians, epidemiologists, and health-service researchers.

However, these research advances create a quandary for the busy clinician. The published work on elder abuse is complex and sometimes contradictory, and a gap exists between basic research and clinical application. Much of the epidemiological and risk-factor research has been done by social scientists who have no first-hand familiarity with the practice of medicine, whereas clinical guidelines come mainly from the specialties of medicine and nursing. Elder abuse is also one of a mounting list of family and social problems that are now seen as within the scope of medical practice, yet the time and resources needed to address such issues are increasingly constrained in health systems in virtually all countries. The aim of this seminar is to assist clinicians by summarising international research and clinical findings about elder abuse, and assessing their quality, relevance, and feasibility for health-care providers in clinical practice.

Search strategy and selection criteria

Because elder abuse is both a medical and social problem, relevant publications appear in both medical and social-science publications. Therefore, we searched the following databases: Ageline, PubMed, and Sociological Abstracts to 1980. Keywords were “elder abuse”, “elder mistreatment”, “elder neglect”, and “domestic violence in the elderly”. Many publications on this topic are case studies, policy analyses or essays, clinical reviews, or small studies of non-representative samples; we therefore focused on empirical articles that met the standards for a scientific review (eg, large epidemiological surveys, case-control studies). However, we also included classic articles, important policy publications, or case series when we judged these to be relevant for an international audience.

Lancet 2004; 364: 1263–72

Division of Geriatric Medicine and Gerontology, Weill Medical College (Prof M Lachs MD), and Department of Human Development and Cornell Gerontology Research Institute (Prof K Pillemer PhD), Cornell University, Ithaca, NY, USA

Correspondence to: Dr Mark Lachs, Division of Geriatric Medicine and Gerontology, Weill Medical College of Cornell University, 1300 York Avenue, Box 39, New York, NY 10021, USA
mnlachs@mail.med.cornell.edu

Definition and occurrence

The frequency of any clinical event depends on a case definition that ideally meets the criteria of inter-rater reliability and clinical applicability. A major impediment to the understanding of elder abuse has been the use of widely varying (and sometimes poorly constructed) definitions. Fortunately, some consensus is now emerging in the previously controversial area of definitions and classification of elder abuse. From both clinical and research standpoints, two questions arise: what is the general definition of elder abuse, and what are the major types of mistreatment encompassed by the term?

A recent panel convened by the US National Academy of Sciences has proposed a useful scientific vocabulary for elder abuse, which we follow in this seminar. Elder abuse is defined as: “(a) intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended), to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder, or (b) failure by a caregiver to satisfy the elder’s basic needs or to protect the elder from harm”.³ This definition encompasses two key ideas: that the old person has suffered injury, deprivation, or unnecessary danger, and that a specific other individual (or individuals) is responsible for causing or failing to prevent it. It is also quite consistent with consensus definitions developed by international groups. For example, the definition in the WHO Toronto Declaration on Elder Abuse⁴ was “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.”

Within the general framework of elder abuse, there is now general agreement on the scope of actions that are covered by the term. Both clinical reports and most legal international statutes recognise the following types of abuse: (1) physical abuse, which includes acts done with the intention of causing physical pain or injury; (2) psychological abuse, defined as acts done with the intention of causing emotional pain or injury; (3) sexual assault; (4) material exploitation, involving the misappropriation of the old person’s money or property; and (5) neglect, or the failure of a designated carer to meet the needs of a dependent old person. Clinicians must be prepared to recognise the signs and symptoms of these types of elder abuse, and to create effective treatment plans for victims. We provide clinical manifestations and treatment guidelines later.

Abuse of elderly people can take place in various environments, including their homes, hospitals, assisted living arrangements, and nursing homes. Here, however, we concentrate on elder abuse in domestic settings (that is, by family members and trusted others in non-institutional settings). We made this decision partly for practical reasons: there is almost no scientifically credible empirical research about abuse in

institutions. Moreover, domestic and institutional abuse are likely to have different dynamics, causes, and outcomes, and are best addressed separately.³ This paper cannot specifically detail issues of institutional abuse; however, information provided here about detection of abuse will probably be relevant for such cases. This review may apply generally to paid in-home carers, who are often in a trust relationship with the old person.

Estimates of the frequency of elder abuse are now available from several international sources. Various sampling and survey methods and case definitions have been summarised by Thomas;⁵ the range of estimates from these studies is between 2% and 10%. Random-sample, community-based epidemiological studies have generally reported rates at the lower end of this range. Four large-scale population surveys have been completed so far. In a probability sample of elderly people not in institutions in the metropolitan area of Boston, MA, USA, the overall rate was 3.2%.⁶ A national random sample survey of elderly people in Canada used similar methods, and measured that 4% reported having experienced maltreatment since having reached the age of 65.⁷ The difference might be explained by the fact that the USA survey assessed physical abuse, psychological abuse, and neglect, whereas the Canadian survey included material abuse as well. A Dutch study,⁸ which included these four types of abuse, measured a 1-year rate of 5.8%. A telephone survey of national samples from Denmark and Sweden used more inclusive definitions of elder abuse. This study recorded a rate of 8%, but the higher rate is driven by the inclusion of theft as a type of abuse.⁹

Detailing of additional reasons for these varying results is beyond the scope of this article. Researchers have advocated more refined methods so that the frequency of such abuse can be more precisely measured, but this is an academic exercise for the clinician who needs only the following message: elder abuse is common enough to be encountered regularly in daily clinical practice. With the range of frequency mentioned, a busy clinician seeing between 20 and 40 old people per day could encounter at least one clinical or subclinical victim of elder abuse daily. Further, as our discussion of risk factors below indicates, certain subpopulations that are over-represented in medical practices have higher risks of abuse (such as people with dementia). There is no question that the extent of elder abuse is sufficiently large that physicians and other health professionals who serve elderly adults are likely to encounter it routinely.

Pathophysiology and risk factors

Progress has been made over the past decade in the empirical identification of risk factors for elder abuse. Various epidemiological designs have been used to elucidate such risk factors ranging from case-control studies to longitudinal designs. Care should be taken

because research on risk factors for elder abuse is at an early stage of development, and much further study is needed. We limit ourselves in this review to studies with acceptable designs; specifically, those that involve a comparison group design of some kind, and in which information was obtained directly from victims or perpetrators (rather than review of medical or service agency records).

Substantial evidence exists for the following risk factors: first, both empirical studies and clinical accounts indicate that a shared living situation is a major risk factor for elder abuse and that people living alone are at lowest risk.^{6,10-12} The mechanism for this effect is increased opportunities for contact—and thus conflict and tension—in a shared living arrangement. An exception to this pattern appears to be financial abuse, for which victims disproportionately live alone.¹³ Indeed, the Canadian survey⁷ recorded that the category of victims most likely to live alone was financially abused people.

Second, several studies have reported higher rates of physical abuse in patients with dementia than in people without this disorder.^{11,12,14-17} A likely mechanism is the high rate of disruptive and aggressive behaviours of patients, which are a major cause of stress and distress to carers, and which can provoke them to retaliate. Carers, who might be old and frail themselves, can also be victims of assault by demented patients.

Third, social isolation has been identified as characteristic of families in which abuse of children and wives occurs. Elder abuse shows a similar pattern, with victims more likely to be isolated from friends and relatives (besides the person with whom they may be living) than non-victims.¹⁷⁻²⁰ Social isolation can increase family stress, heightening the potential for abuse. Furthermore, behaviours that are illegitimate tend to be hidden; the presence of other people can lead to intervention and sanctions.

Fourth, there is surprising agreement that pathological characteristics of perpetrators, particularly mental illness and alcohol misuse, contribute to elder abuse. Several studies have established that a history of mental illness is more common among those who commit elder abuse than in the general population.^{18,19,21} Depression seems to be a common characteristic of elder abusers.^{11,15,16,21-23} Alcohol misuse by perpetrators also seems to be a significant risk factor for elder abuse.^{16,21,22,24,25}

Finally, people who commit elder abuse tend to be heavily dependent on the person they are mistreating.^{26,27} Abuse results in some cases from attempts by the relatives (and especially adult offspring) to obtain resources from the victim. Moreover, situations have been identified in which a tense and hostile family relationship is maintained because a financially dependent son or daughter is unwilling to leave and thus lose parental support.²⁰

Clinical experience has pointed to several other plausible potential risk factors, but data are either lacking or inconsistent at present. Physical impairment of the old person could be predisposing factor for abuse, in that it diminishes the individual's ability to defend himself or herself or to escape the abusive situation. However, the role of the victim's health and functional status as a risk factor is unclear. Reis and Nahmiash²⁸ did not find that impairment of activities of daily living predicted elder abuse, and several other case-comparison studies did not find other forms of functional impairment to be a risk factor for abuse by carers.^{11,18,20,25,29} One study¹⁰ showed that impairment of activities of daily living predicted identification as an abuse victim, but the researchers acknowledged that the dependent variable—protective services intervention for elder abuse—could have led to these results, and that findings might differ for elder abuse that is not detected by an agency.¹⁰

Furthermore, an old person's dependency on the carer and resulting stress has not been found to predict the occurrence of elder abuse in most studies to date. Case-comparison studies have generally failed to find either higher rates of dependency of the old person or greater carer stress in elder abuse situations.^{12,16,18,20,21,25,29} Intergenerational transmission of violent behaviour (the cycle of violence) is a plausible risk factor, given the important role that childhood experience of violence has in child abuse and other forms of aggressive behaviour. However, research has not yet been done to confirm this relation with elder abuse.

In light of the aim of this Seminar, comment on the role of cultural and ethnic factors in elder abuse would be appropriate, because cultural context influences every part of elder abuse, from definitions to societal response. For example, different ethnic groups, when presented with progressively more outrageous scenarios, will have different opinions on what constitutes elder abuse.³⁰ However, there are as yet no reliable empirical field data about differences in either rates of abuse or risk factors between groups defined by ethnic origin, nationality, or culture. This is an important area for future research and clinical accounts. Additionally, customary patterns of medical and social care in different societies might be judged to be abusive in some countries but not in others. Examples include the extent to which physical restraints are tolerated, the degree to which health-care proxies can direct care decisions without direct consent from the patient, and the propensity to allow patients with various degrees of cognitive impairment to live independently.

The clinician should be aware that abuse can take place with or without any of these factors being apparent, and many families with extensive risk factors (eg, interdependency of carer and old person, high burden of dementia) do not manifest abuse. However, this review provides a profile of patients who might be at greatest risk of maltreatment and therefore worthy of

Area	Assessment	Comments and findings
Situations that might lead clinician to suspect elder abuse	Comprehensive geriatric assessment. Direct inquiries about physical, emotional, and financial abuse as well as neglect, ideally in collaboration with a multidisciplinary team (see table 2). Functional status (independence with activities of daily living). Who is designated carer if such activities are impaired? With whom is the suspected victim living? Is the suspected abuser the provider or recipient of care?	Absence of risk factors should not dissuade the clinician from considering the diagnosis. Clinicians should maintain an index of suspicion for all clinical encounters.
History from elder	Interview patient alone. Direct inquiries about physical violence, restraints, or neglect. Precise details about nature, frequency, and severity of events. Questions about theft or improper control of money or property.	Delays between injury or illness and seeking medical attention. Disparate histories from patient and abuser. Implausible or vague explanations provided by either party.
History from abuser	Abuser should also be interviewed alone (best left to professionals with appropriate experience). Avoid confrontation in information-gathering phase. Interview other sources if possible. Recent psychosocial factors (bereavement, financial stresses). Carer's understanding of patient's illness (care needs, prognosis, and so on). Carer's explanations for injuries or physical findings.	Repeated chronic disease exacerbations when carer has been monitoring patient. Different mechanisms of injury offered. Different chronology of injuries. Frequent visits to emergency department for chronic disease exacerbations despite care plan and available resources.
History from others	Use as many sources of information as practically possible. These could include other health and home care providers, other family members, neighbours, or other reliable sources.	Other individuals might provide information that corroborates or refutes primary accounts of abuse. Could also provide insight into other forms of abuse such as financial abuse.
Behavioural observation	Withdrawal. Infantilising of patient by carer. Carer who insists on providing history.	Functionally impaired patient who presents without designated caregiver, absence of eye contact with interviewer.
General appearance	Hygiene, cleanliness, and appropriateness of dress.	Patient with advanced dementia presents for medical care alone. General condition of clothing and hygiene, oral health.
Skin and mucous membranes	Skin turgor, other signs of dehydration. Multiple skin lesions in various stages of evolution. Bruises, decubitus ulcers; how established skin lesions have been cared for.	Bruising most common in abuse; patterns (eg, tramlines) might suggest stick or other implement. ¹⁵
Head and neck	Traumatic alopecia (distinguishable from male pattern alopecia on basis of distribution). Scalp haematomas, lacerations, abrasions.	In a small forensic autopsy study of elder-abuse victims in Japan, ⁴⁴ subdural haematoma was most common cause of death in victims of physical abuse.
Trunk	Bruises, welts. Shape may suggest implement (eg, iron or belt).	Cham and Seow ⁴⁵ showed most common presentation of abuse presenting to an emergency department in Singapore was blunt musculoskeletal trauma.
Genitourinary	Rectal or vaginal bleeding. Decubitus ulcers, infestations.	Could indicate sexual abuse.
Extremities	Wrist or ankle lesions suggest restraint use or emersion burn (stocking/glove distribution).	Palms and soles usually not injured accidentally; bruising may suggest abuse. ¹⁵
Musculoskeletal	Examination for occult fracture, pain. Observe gait.	Fractures that are not explained by mechanisms of injury.
Neurological psychiatric	Thorough examination to assess focality. Symptoms of depression, anxiety.	Dyer and colleagues ⁴⁴ noted extremely high rate of both depression and dementia in patients referred to a geriatric assessment centre for abuse.
Mental status	Formal mental status testing (eg, Mini-Mental State Examination). Psychiatric symptoms, including delusions and hallucinations.	Cognitive impairment suggests delirium or dementia and plays a part in assessing decision-making capacity as well as assessing truth of history.
Imaging	As indicated from clinical assessment.	Lacerations healing by secondary intention.
Laboratory	As indicated from clinical assessment. Albumin, blood urea nitrogen, and creatinine measurements. Toxicology.	Laboratory findings inconsistent with history provided. Subtherapeutic drug concentrations (eg, digoxin) despite compliance reported by carer. Toxicology reveals psychotropic agents not prescribed.
Social and financial resources	Other members of social network available to assist the elderly person, financial resources. History might also suggest financial abuse.	Crucial in considering interventions that include alternative living arrangements and home services.

Modified from Lachs and Pillemer.⁴⁶

Table 1: Medical assessment of elder abuse

special investigation in the clinical setting. To give a concrete example, a patient who is cognitively impaired, fairly isolated socially, and living with a relative with mental-health problems should attract the attention of the clinician and motivate further investigation.

Screening

Should apparently asymptomatic patients be tested for elder abuse? There have been no randomised trials of elder abuse screening in asymptomatic populations, although the 1992 American Medical Association guidelines on elder abuse suggested that all outpatients be screened for family violence.³¹ By contrast, the US Preventive Medicine Task Force concluded that there was insufficient evidence for or against screening for family violence in outpatients of any age,³² and a Canadian Task force had a similar opinion.³³ How should the clinician

reconcile these two competing stances? Arguments against screening for family violence essentially are based on two major themes: (1) no effective screening techniques have been developed for elder abuse, and (2) even if there were an effective screening strategy, no study has shown that intervention in those identified actually improves clinical outcomes (and might, paradoxically, worsen matters in a contentious family violence situation in which the abuser of a vulnerable victim is brought to the attention of the health-care system or official agencies). The first criticism is addressed in this section; the second is addressed in the subsequent section about intervention.

Screening techniques for elder abuse have been developed; these have been reviewed by Fulmer and colleagues.³⁴ In general, they suffer from methodological problems in their construction and validation that derive

	Role(s)
Physician	In a position to screen and diagnose elder abuse during customary care. Undertakes medical component of multidisciplinary assessment, including physical examination, cognition, and mood. Makes referrals to other team members on the basis of these findings. Could be called on to testify in guardianship and other legal proceedings. Once care plan is started, follows course, aware of the tendency for all forms of family violence to rise and fall like other chronic diseases. Is a crucial team member in that he or she may be the only individual in contact with the old person other than the abuser.
Nurse	Also in a position to raise possibility of abuse given the more extensive nature and duration of contact (ie, during customary skin or continence care). Especially true in the home-care setting where the nurse might be the only external observer of abuser-victim interaction. Can also make referrals to other team members, including physicians. When the abuser is the carer, nurse is in unique position to provide support and tactfully show the carer that behaviours are aberrant, which can stop abuse in some situations.
Social worker	Critical team member for marshalling and coordinating the medical and community response to abuse. Assists with situation-specific interventions (eg, adult day care, respite services). Identifies family and new resources with which to offer plan of care.
Elder care attorneys/lawyers	Can assist in guardianship proceedings, advanced care planning, and identification of surrogate decision makers. Can assist in identification of resources to provide care and share the carer's burden.
Adult protection (or equivalent)	Reporting to official agencies is required in certain jurisdictions, but involvement of government agencies and employees should not be viewed as simply an administrative activity. Rather, they are well positioned to identify resources that can be integrated into a comprehensive plan of care.
Law enforcement personnel/police	Rarely do cases of elder abuse become a matter of criminal law since most abused victims do not pursue charges. However, in such cases (most of which are extreme), law enforcement personnel (eg, district attorneys, local police) play an important part in gathering and presenting evidence.

Table 2: Potential members of an interdisciplinary team for elder abuse and their roles

largely from the nature of family violence in medical practice. In the traditional medical model of screening, an individual actively interested in his or her own health presents without symptoms for a negligibly invasive test (eg, a cervical smear), seeking early detection of a common disease (eg, cervical carcinoma), for which a definitive test exists to confirm or refute the findings of a positive screening test (eg, colposcopy with biopsy and histopathological examination).

This clinical metaphor has limited applicability to elder abuse.³⁵ Many victims are frail and socially isolated, cognitively impaired, and not particularly involved with their care. They might be brought to the doctor by the abuser. Unlike the primary care patient, who seeks early detection of any disease, the victim of elder abuse might be fully away of its presence, but actively wants to hide its existence from the clinician. Even more compellingly, there is no universally agreed test as to what constitutes definitive elder abuse, and limited accessibility to a suspected victim who is cloistered might very well preclude definitive testing. Thus, the subsequent creation of 2×2 tables and calculation of sensitivity, specificity, and predictive value—fundamental properties of the screening test that govern its usefulness, dissemination, and fate in medical practice—would not be feasible.

However, methods of screening for elder abuse have been validated in other ways. Performance and psychometric properties such as construct validity and inter-rater and intrarater reliability have been examined. For example, Schofield and Mishra³⁶ developed a postal screening technique for elder abuse as part of the Women's Health Australia Study and established its reliability and construct validity. These are important characteristics, but not the most essential feature of a test that clinicians might adopt. Rather, the goal of screening is to detect clinical disease when it is present and exclude its presence when it is absent. That two observers can

agree on the size and colour of a bruise is important, but not sufficient to endorse a method to detect hidden abuse.

Another concern is testing of putative methods in non-representative settings or with populations that were enriched with cases of elder abuse for the purposes of the study. For example, Shugarman and colleagues³⁷ used data from the Minimum Data Set for Home Care assessment (a clinical and administrative data collection tool used in home-care programmes in the USA) in an attempt to identify old people enrolled in community long-term care programmes in Michigan who are at risk of abuse. Poor social network and poor social function were the factors most strongly associated with abuse, but no specific screening strategy was suggested on the basis of these findings. This population is very different from those expected in outpatient practice. Similarly, Reis and Nahmiah²⁸ created and validated the Indicators of Abuse screen, a method intended for use by practitioners, and showed that it could discriminate abuse from non-abuse in most cases. In general, attempts to develop new screening tests and methods in elder abuse are laudable and should continue.

In view of the limits of current techniques, should screening for elder abuse be abandoned? Without evidence either way at an early stage, we believe that related published work—on self-reported practice by clinicians and educational interventions in elder abuse—supports reliance on clinical judgment and raising of awareness in physicians. McCreadie and colleagues³⁸ reported that less than half of British general practitioners have diagnosed elder abuse in the previous year in two geographical samples of physicians in England; the most compelling predictor of identification was personal knowledge of five or more high-risk situations. A study that surveyed US geriatricians' case-finding strategies³⁹ showed that formal methods, screening techniques, or so-called typical patients'

profiles were less commonly used than reliance on clinical judgment and a “high index of suspicions in all patient interactions”. A study from Sweden indicated that 25% of surveyed general practitioners were generally aware of patients in their practices who were at risk of elder abuse or had actually been abused.⁴⁰

Thus the best policy at this time, rather than over-reliance on a specific screening strategy or clinical algorithm, seems to be education to raise awareness of elder abuse in clinicians. In 2000, a US National Academy of Science Panel on the Training Needs of Health Care Professionals in the area of family violence proposed that domestic violence training be formally integrated into all medical-school teaching.⁴¹ Although paediatricians have made great progress in incorporating education on child abuse into all training levels, the extent to which education on elder abuse is being so incorporated is essentially unknown, especially at an international level. Whatever the state of education, incorporation of training on elder abuse into medical education would seem high priority; several traditional and non-traditional methods have been suggested,^{42,43} such as training in elder abuse as a requirement for licensure or simulated teaching cases of elder abuse in clinical presentations to appeal to physicians.

Clinical manifestations and diagnosis

Patients for whom elder abuse is suspected (from either a positive screening test or outright clinical findings that might or might not be due to abuse) need further examination for the diagnosis. Attempts to identify diagnostic findings or arrays of findings (akin to so-called shaken baby syndrome in child abuse, for example) have not been successful. A patient with symptoms of elder abuse might or might not have findings clearly attributable to elder abuse, and those not subject to abuse could have symptoms that mimic abuse, since the signs and symptoms of many illnesses of late life can be erroneously ascribed to abuse.

For example, injuries are a common cause of death in old people, but injuries related to falls (fractures, bruises, contusions, head injuries, and lacerations) can also be sustained through elder abuse. Weight loss from cancer or other chronic diseases could result from those illnesses, or from intentional withholding of food, medicines, or care. Apparently innocent non-adherence to medication regimens is common in patients of all ages, but could be ascribed, correctly or incorrectly, to malevolence and withholding of prescribed medicines by the carer. Alternatively, patients can be given psychotropic medications to assist with activities of daily living or might be overmedicated to make them more docile. Thus, potential exists for both false positives and false negatives, and overzealous pursuit of elder abuse can have devastating effects on individuals and families.

Dyer and colleagues¹⁵ have systematically summarised the published work on forensic markers of elder abuse

with respect to physical findings, and point to the paucity of primary data. This is an important area, in that most cases of abuse are not directly witnessed by health-care professionals or other family. Unfortunately, most research on clinical findings purported to be common in elder abuse derives from anecdotes or, at best, case reports and small case series. Table 1 integrates these findings with our own experience of what constitutes a reasonable medical assessment of the patients with confirmed or suspected abuse. As in all geriatric care, special attention should be given to assessment of cognitive status, an important component in the assessment of decision-making capacity, which has serious implications for proffering of subsequent interventions.

Once the possibility of elder abuse has been raised, a comprehensive assessment is necessary, which needs substantial clinical and psychosocial expertise. The hectic pace of clinical practice makes this type of assessment difficult, and could explain why elder abuse is frequently missed in outpatient settings, as are other geriatric syndromes. The patient should be examined away from the suspected abuser and, ideally, other health-care staff; many patients find the admission that they are victims of elder abuse shameful. The clinician should be a supportive advocate of the patient in this context. Direct queries about abuse are encouraged, but the interviewer can begin with general questions about safety and the home environment. Details should be elicited about the nature, frequency, and provoking factors of abuse. A comprehensive elder-abuse assessment is time consuming, but may take place in hurried contexts such as the emergency department or during brief, routine, outpatient visits. In a retrospective emergency-department study of old people known to be victims of physical elder abuse through protective service records, physicians rarely asked patients about abuse or made the diagnosis, even when the clinical presentation suggested a substantial possibility of mistreatment.⁴⁷

Great care should be taken in interacting with the alleged abuser; if at all possible, contact should be left to individuals with appropriate expertise. The danger in confronting an alleged perpetrator is that access to the vulnerable old person will be lost. Additionally, physicians will often find themselves working with abusers when they are also the carers of their patients. If a physician has to interview a suspected abuser, an empathetic approach can be helpful (“caring for your mother must be very difficult, how do you cope?”) and the physician should try to remain non-judgmental if abuse history is confirmed. In addition to the screening methods described previously, standard methods have been developed to identify signs and symptoms of elder abuse in various settings such as emergency departments.⁴⁸ These too have advantages and pitfalls. On the one hand, a systematic assessment of the abused

old person ensures comprehensiveness for both clinical care and subsequent legal proceedings that require documentation. On the other hand, their introduction has also confused the intellectual background because they can be used for reasons other than assessment, including screening, for which they were not intended. Even when they are applied to the purposes for which they were created, their performance characteristics have not been assessed or validated across an array of clinical settings, populations, and health-care providers.

Application of the traditional medical framework—screening, diagnosis, and treatment—to elder abuse is also complicated by the fact that diagnosis and treatment are simultaneous, which in many cases violates the linear reasoning underlying much of medical practice. Chemotherapy would not be given without histological evidence of disease, cholecystectomy would not be done without radiographical evidence of cholecystitis; yet every day clinicians encounter old people—for whom they are considering the possibility of elder abuse—while treating root causes of uncorroborated abuse through interventions such as pharmacotherapy for depression, home-care services to relieve the carer's burden, or neuroleptic medication to treat assaultive behaviours related to dementia. This approach is pragmatic in that interventions directed at these symptoms are desirable in and of themselves, whether or not they are ultimately deemed to be part of a corroborated case of elder abuse.

Course and treatment

In a large longitudinal study of old people,⁴⁹ those who were mistreated were 3·1 times more likely to die during a 3-year period than those who did not experience abuse, even after adjustment for comorbidity and other factors associated with mortality. At the end of 13 years of follow-up, 9% of those who were mistreated were alive, compared with 41% who had not experienced abuse.⁴⁹ Elder abuse is also associated with various other adverse life course and health outcomes ranging from depression to placement in a nursing home.⁵⁰ Thus, the development of effective interventions for abuse is a high priority. Unfortunately, the US National Academy of Sciences Panel on Elder Abuse concluded that “no efforts have been made to develop, implement, and evaluate interventions based on scientifically grounded hypotheses about the causes of elder abuse, and no systematic research has been conducted to measure and evaluate the effects of existing interventions.”³

Why the paucity of intervention studies on which to base clinical practice? We have argued that elder abuse has many of the features of so-called traditional geriatric syndromes such as falling and incontinence:⁴⁶ there are multifactorial causes with both host and environmental components, the disorder is common but undiagnosed in outpatient practice, and it is associated with other geriatric syndromes, mortality, and reductions in

quality of life and functional status. Research into geriatric syndromes is difficult for many reasons: profound comorbidity makes comparability of baseline states difficult, multifactorial interventions (because of multifactorial causes) can be difficult to standardise, and access to frail populations is poor. Thus, a patient in a fall-intervention study could be receiving a polypharmacy review by a physician, strength training from a physical therapist, refraction or cataract removal from an ophthalmologist, and treatment for depression from a psychotherapist—all intended to decrease the frequency of a relatively discrete and measurable clinical outcome, falling. In the case of elder abuse, this already complex area can be compounded by restricted access to the patient, the patient's reluctance to make public an embarrassing family situation, the heterogeneity of activities that fall under the term elder abuse, and difficulty in discretely measuring when abuse occurs because it could be a daily, continuous exposure (unlike a fall).

How then, does a clinician proceed with a patient confirmed to have a diagnosis of elder abuse, but who cannot wait for evidence-based intervention studies that might be a decade or more away? Paradoxically, the example of geriatric syndromes can provide some guidance here. By recognising elder abuse as multifactorial rather than as a homogeneous disease, the clinician can offer interventions likely to be effective in treating it or mitigating its impact on the vulnerable old person. The case of an adult with schizophrenia who is abusing his or her parent will need different treatment strategies from the case of a patient with dementia who physically assaults his or

Context of elder abuse	Potential interventions
Abuse potentially related to stress from caring for impaired family member	Respite services Adult day care Carer education programmes (eg, on what constitutes abuse) Recruitment of other family, informal, or paid carers to share burden of care Psychotherapy for carer Treatment for depression Social integration of carer to reduce isolation
Violence related to substance or alcohol misuse	Referral to alcohol or drug alcohol misuse rehabilitation programmes as appropriate
Violence related to behavioural problems associated with mental health	Treatment referral
Longstanding spousal violence	Marital counselling Support groups Shelter Orders of protection Victim advocacy
Abuse by aggressive dementia patient	Geriatric medical assessment of causes of underlying behaviour (eg, new or established medical conditions)
Financial exploitation by family members	Guardianship proceeding, power of attorney (transfer of legal authority) Protective services
Financial exploitation by paid carer	Referral to legal services Involvement of law enforcement Protective services

Table 3: Context-specific interventions for components of elder abuse

her caring spouse; longstanding spousal violence that has aged will not respond to interventions to stop financial exploitation. And although there is little published on global intervention studies for elder abuse, there is research to lend support to at least some of the component interventions that are part of a coordinated treatment programme (eg, alcohol treatment programmes).

Table 3 describes some of the interventions that should be contemplated for various types of abuse. Theoretically and empirically, social support should benefit the wellbeing of victims of elder abuse. For example, in a Dutch study of elder-abuse victims,⁸ high social support had a favourable effect on psychological distress. Clinicians might need to be resourceful in identifying such programmes; in a nationwide search in both Canada and the USA,⁵¹ only 30 support groups were identified for elderly victims of domestic violence. Unwillingness of elderly people to participate in such groups was noted by programme directors, and interventions designed to improve acceptability to these clients were suggested (eg, geographical accessibility, elderly group leaders). Though it was not a randomised trial, Anetzberger and colleagues⁵² described an intervention model for elder abuse of patients with dementia by carers; fairly regimented materials were

developed for many constituencies and stakeholders.⁵² The goal of providing reproducible interventions is highly laudable.

The figure provides a context in which to deliver these situation-specific interventions; two major decisions define how these interventions should be offered.⁵³ First, does the abused person accept interventions? If so, then the strategies for various types of mistreatment can be offered, ideally with the physician as part of a multidisciplinary team. The importance of a team approach cannot be overemphasised. This approach has served geriatricians well in the multidimensional assessment of other complex geriatric syndromes, provides discipline-specific expertise not accessible in any other way, and insulates the clinician against the mental exhaustion likely if he or she attempts to take on cases of elder abuse in isolation. Table 2 lists members of a multidisciplinary team that could diagnose and treat elder abuse and their typical roles; it is not intended to be exhaustive. Many such teams function in existing geriatric practices and gerontological programmes that encounter elder abuse in their daily work (eg, as part of a university geriatric assessment programme or a programme of home visits by a social service agency). Physician input in these situations is generally highly

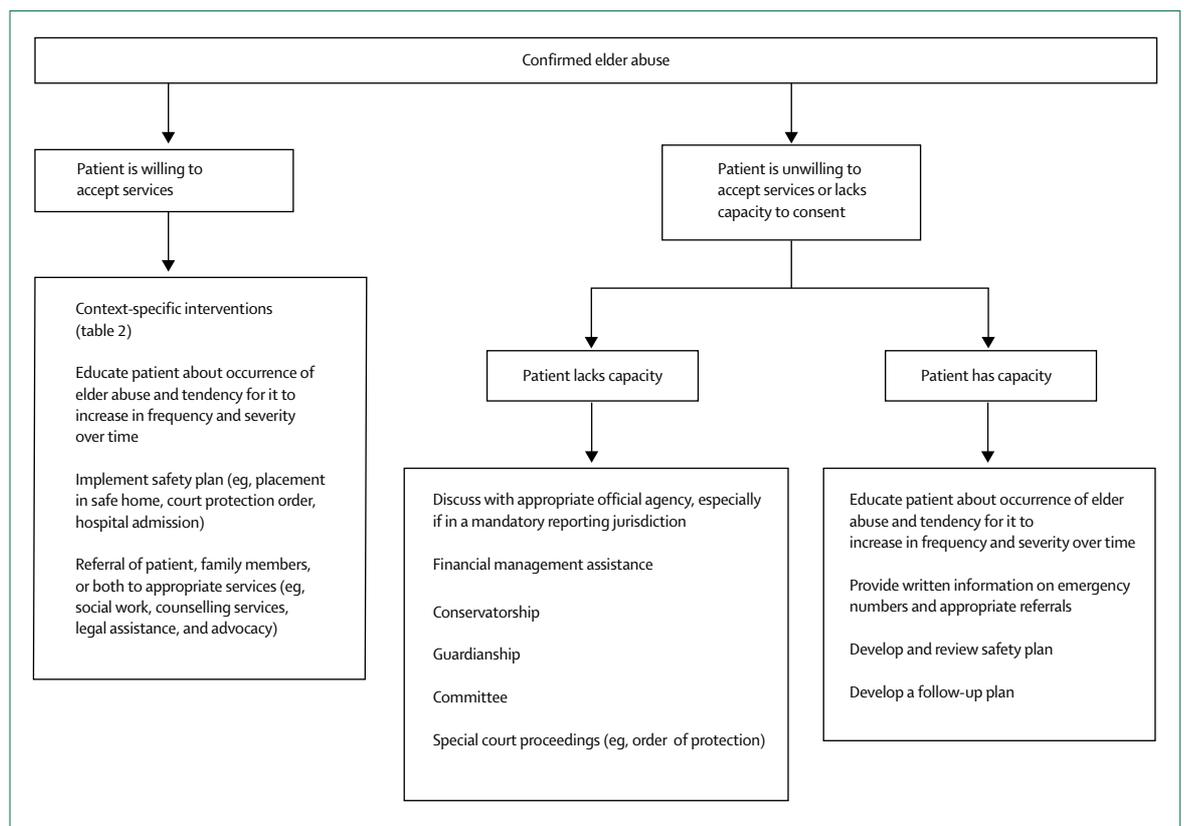


Figure: Decision support for management of cases of elder abuse Modified from Lachs and Pillemer⁶ 1996.

welcome. The second decision is whether the patient who refuses intervention has the capacity to make that decision; thus assessment of cognitive function and decision-making capacity is an important part of elder-abuse assessment and intervention.

We recognise that many clinicians will have neither time for nor access to such a multidisciplinary group. In these cases, we urge clinicians to form informal alliances with providers in their environment who have an interest in elder abuse. How to make such links depends on the specific country and environment. In large cities, specialised elder-abuse programmes might be available; government agencies that respond to elder abuse are good sources of information on their whereabouts in any local community. In smaller jurisdictions, senior citizens centres or other elder service agencies could be a means of contacting appropriate individuals. We would be remiss if we did not acknowledge the important (and in many countries, legally required) role of state bodies charged with the detection and management of elder abuse. Mandatory reporting is itself thought to be an abuse intervention with potentially ameliorating influences on an abusive situation;³ however, there is debate about its effectiveness, and many countries have chosen for reporting of elder abuse not to be mandatory. Nonetheless, this question is academic when the clinician is confronted with an abused old person in a jurisdiction where reporting is required. In this case, the clinician should not only comply with the law, but also consider how such state agencies might be meaningfully integrated into a plan of care that stops abuse or keeps its consequences to a minimum.

Conclusion

Although there are gaps in knowledge with respect to the clinical manifestations and treatment of elder abuse, they should not prevent clinicians from taking an active role in identification and management. Family violence directly affects quality of life, and removal of a patient from an abusive situation is one of the most gratifying experiences for physicians and other health-care professionals. Despite the need for more data on interventions, a reasonable approach is a multidisciplinary one, specifically tailored to the situation, ideally involving multiple team members with varied expertise (the model used in other geriatric syndromes). Future research should focus on the creation of clinically useful screening techniques and evidence-based assessments of replicable interventions.

Acknowledgments

Our work is partly supported by an National Institute on Aging Mentoring Award in Patient Oriented Research in Aging (K24AG022399) to MSL and an Edward R Roybal Center Grant from the National Institute on Aging (P30AG022845-01) to KP. These funding sources had no role in the preparation of this Seminar. This Seminar is dedicated to the memory of our friend and colleague, Dr Gerry Bennett.

References

- 1 WHO. Abuse of the Elderly. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World Report on Violence and Health. Geneva: WHO Press, 2002.
- 2 WHO. Missing voices: views of older person on elder abuse. Geneva: WHO Press, 2002.
- 3 National Academies of Sciences. Bonnie R, Wallace R, eds. Elder abuse: abuse, neglect, and exploitation in an aging America. Washington DC: National Academy Press, 2002.
- 4 WHO. The Toronto declaration on the global prevention of elder abuse. Geneva: WHO, 2002.
- 5 Thomas C. First National Study of Elder Abuse and Neglect: contrast with results from other studies. *J Elder Abuse Neglect* 2002; 12: 1–14.
- 6 Pillemer K, Finkelhor D. The prevalence of elder abuse: a random sample survey. *Gerontologist* 1988; 28: 51–57.
- 7 Podnieks E. National survey on abuse of the elderly in Canada. *J Elder Abuse Neglect* 1992; 41: 5–58.
- 8 Comijs HC, Penninx BW, Knipscheer KP, van Tilberg W. Psychological distress in victims of elder abuse: the effects of social support and coping. *J Gerontol Psychol Sci Soc Sci* 1999; 54: 240–45.
- 9 Tornstam L. Abuse of the elderly in Denmark and Sweden: results from a population study. *J Elder Abuse Neglect* 1989; 1: 35–44.
- 10 Lachs MS, Williams C, O'Brien S, Hurst L, Horowitz R. Risk factors for reported elder abuse and neglect: a nine-year observational cohort study. *Gerontologist* 1997; 37: 469–74.
- 11 Paveza GJ, Cohen D, Eisdorfer C, et al. Severe family violence and Alzheimer's disease: prevalence and risk factors. *Gerontologist* 1992; 32: 493–97.
- 12 Pillemer K, Suito JJ. Violence and violent feelings: what causes them among family givers? *J Gerontol* 1992; 47: S165–72.
- 13 Choi NG, Kulick DB, Mayer J. Financial exploitation of elders: analysis of risk factors based on county adult protective services data. *J Elder Abuse Neglect* 1999; 10: 369–62.
- 14 Dyer CB, Pavlik VN, Murphy KP, Hyman DJ. The high prevalence of depression and dementia in elder abuse or neglect. *J Am Geriatr Soc* 2002; 48: 205–58.
- 15 Dyer C, Connolly M, McFeeley P. The clinical and medical forensics of elder abuse and neglect. In: Bonnie R, Wallace R, eds. Elder Abuse: abuse, neglect, and exploitation in an aging America. Washington DC: National Academy Press, 2002.
- 16 Homer AC, Gilleard C. Abuse of elderly people by their careers. *BMJ* 1990; 301: 1359–62.
- 17 Lachs M S, Berkman L, Fulmer T, Horwitz RI. A prospective community-based pilot study of risk factors for the investigation of elder abuse. *J Am Geriatr Soc* 1994; 42: 169–73.
- 18 Compton SA, Flanagan P, Gregg W. Elder abuse in people with dementia in Northern Ireland: prevalence and predictors in cases referred to a psychiatry of old age service. *Int J Geriatr Psychiatry*, 1997; 12: 632–35.
- 19 Grafstrom M, Nordberg A, Winblad B. Abuse is in the eye of the beholder. *Scand J Soc Med* 1993; 21: 247–55.
- 20 Pillemer K, Finkelhor D. Causes of elder abuse: caregiver stress versus problem relatives. *Am J Orthopsychiatry* 1989; 59: 179–87.
- 21 Wolf RS, Pillemer K. Helping elderly victims: the reality of elder abuse. New York: Columbia University Press, 1989.
- 22 Reay AM, Browne KD. Risk factor characteristics in carers who physically abuse or neglect their elderly dependents. *Aging Ment Health* 2001; 5: 56–62.
- 23 Williamson GM, Shaffer DR. Relationship quality and potentially harmful behaviors by spousal caregivers: how we were then, how we are now. *Psychol Aging* 2001; 16: 217–26.
- 24 Anetzberger GJ, Korbin JE, Austin C. Alcoholism and elder abuse. *J Interpers Viol* 1994; 9: 184–93.
- 25 Bristowe E, Collins J. Family mediated abuse of noninstitutionalized frail elderly men and women in British Columbia. *J Elder Abuse Neglect* 1989; 1: 45–64.
- 26 Pillemer, K. Elder abuse is caused by the deviance and dependence of abusive caregivers. In: Loseke D, Gelles R, Cavanaugh M, eds. Current Controversies on Family Violence. Newbury Park, CA: Sage, 2004.

- 27 Greenberg JR, McKibben M, Raymond JA. Dependent adult children and elder abuse. *J Elder Abuse Neglect* 1990; **2**: 73–86.
- 28 Reis M, Nahmiash D. Validation of the Indicators of Abuse (IoA) screen. *Gerontologist* 1998; **38**: 471–80.
- 29 Cooney C, Mortimer A. Elder abuse and dementia: a pilot study. *Int J Soc Psychiatry* 1995; **41**: 276–83.
- 30 Moon A, Williams O. Perceptions of elder abuse and help-seeking patterns among African American, caucasian American, and Korean-American elderly women. *Gerontologist* 1993; **3**: 386–95.
- 31 American Medical Association Diagnostic and Treatment Guidelines on Elder Abuse and Neglect. Chicago: American Medical Association, 1992.
- 32 US Preventative Services Task Force. Guide to Clinical Preventive Services. 1996.
- 33 Patterson C. Secondary prevention of elder abuse. In: Canadian Task Force on the Periodic Health Examination. Canadian Guide to Clinical Preventative Health Care. Ottawa: Health Canada, 1993: 922–29.
- 34 Fulmer T, Guadano L, Dyer C, Connolly MT. Progress in elder abuse assessment instruments. *J Am Geriatr Soc* 2004; **52**: 297–304.
- 35 Lachs MS. Screening for family violence: What's an evidence-based doctor to do? *Ann Intern Med* 2004; **140**: 399–400
- 36 Schofield MJ, Mishra GD. Validity of self-report screening scale for elder abuse: Woman's Health Australia study. *Gerontologist* 2003; **43**: 110–20.
- 37 Shugarman LR, Fries BE, Wolf RS, Morris JN. Identifying older people at risk of abuse during routine screening practices. *J Am Geriatr Soc* 2003; **51**: 24–31.
- 38 McCreadie C, Bennett G, Gilthorpe MS, et al. Elder abuse: do general practitioners know or care? *J R Soc Med*. 2000; **93**: 67–71.
- 39 Harrell R, Tornjo CH, McLaughlan J, Pavlik VN, Hyman DJ, Dyer C. How geriatricians identify elder abuse and neglect. *Am J Med Sci* 2002; **323**: 34–38.
- 40 Saveman B, Sandvide A. Swedish general practitioners awareness of elderly patients at risk of or actually suffering from elder abuse. *Scand J Caring Sci* 2001; **16**: 79–85.
- 41 Cohn F, Salmon M, Stobo J, eds. Confronting chronic neglect: the education and training of health professionals on family violence. Washington DC: The National Academies Press, 2002.
- 42 Lachs MS. Preaching to the unconverted: educating physicians about elder abuse and neglect. *J Elder Abuse Neglect* 1995; **7**: 1–12.
- 43 Heath JM, Dyer CB, Kerzner LJ, Mosqueda L, Murphy C. Four models of medical education about elder abuse. *Acad Med* 2002; **77**: 1106–66.
- 44 Akaza K, Bunia Y, Tsujinaka M, et al. Elder abuse and neglect: social problems revealed from 15 autopsy cases. *Leg Med (Tokyo)* 2003; **5**: 7–14.
- 45 Cham GW, Seow E. The pattern of elderly abuse presenting to an emergency department. *Singapore Med* 2000; **41**: 567–70.
- 46 Lachs MS, Pillemer K. Abuse and neglect of elderly persons. *N Engl J Med* 1995; **333**: 437.
- 47 Lachs MS, Williams CS, O'Brien S, et al. Emergency department utilization by older victims of family violence. *Ann Emerg Med* 1997; **30**: 448–54.
- 48 Jones J, Dougherty J, Schelble D, Cunningham W. Emergency department protocol for the diagnosis and evaluation of geriatric abuse. *Ann Emerg Med* 1988; **17**: 1006–15.
- 49 Lachs MS, Williams CS, O'Brien S, Pillemer KA, Charlson ME. The mortality of elder abuse. *JAMA* 1998; **280**: 428–43.
- 50 Lachs MS, Williams CS, O'Brien S, Pillemer KA. Adult protective service home use and nursing home placement. *Gerontologist* 2002; **42**: 734–39.
- 51 Wolfe RS. Support groups for older victims of domestic violence. *J Women Aging* 2001; **13**: 71–83.
- 52 Anetzberger GJ, Palmisano BR, Sanders M, et al. A model intervention for elder abuse and dementia. *Gerontologist* 2000; **40**: 492–97.
- 53 Elder mistreatment guidelines for health care professional. New York: Mount Sinai Victim Services Agency Elder Abuse Project, 1988.