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INVITED COMMENTARY

Promoting Good Clinical Care to Prevent Elder Abuse

Elder abuse has received increasing attention over the last 2 decades, and its prevalence will likely increase as the aged population increases. Elder abuse is commonly defined as "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] Different types of elder abuse have been defined: (1) physical abuse (infliction of pain or injury); (2) psychological abuse (infliction of mental anguish); (3) sexual assault (nonconsensual contact of any kind); (4) financial exploitation (illegal or improper use of funds or resources), and (5) neglect (failure of a caregiver to meet the needs of a dependant person). Elder abuse may occur in the community, as well as in institutions like nursing homes or hospitals.

A recent systematic review found that 6.3% of community-dwelling elderly persons reported significant abuse during the last month, and 5.6% of older couples reported physical violence in their relationship over the last year.[2] Prevalence was even higher in disabled older adults (25% reported psychological abuse; 1%, physical abuse, and 6% to 18%, financial abuse). These high figures contrast with those of referral to adult protective services that concerned only 1% to 2% of abuse cases.[2]

Numerous factors have been associated with elder abuse.[3] Some relate to the victim's characteristics, such as the presence of dementia (particularly when behavioral problems are present), social isolation, lower household income, and need for assistance in activities of daily living. Other factors relate to the abuser, such as the presence of mental illness (including depression), substance abuse, and social dependency on the victim (eg, for finances, housing, or food). Finally, situational factors, such as sharing a living situation (except for financial abuse that tends to occur in persons who live alone), have also been associated with an increased likelihood of elder abuse. Theoretical models have been drawn to explain the phenomena of elder abuse, but no single theory may explain all abuse situations.

Abuse has been linked with poorer health and quality of life in the abused elderly person.[3] For instance, significant associations have been shown between elder abuse and depression, as well as mortality. Some observations also suggest an increased risk for nursing home placement. The study by Dong and Simon[4] published in this issue adds knowledge to this field of research. Using data from the Chicago Health and Aging Project (CHAP) prospective study of community-dwelling elderly persons (N=6674), the authors highlight significant relationships between elder abuse reported to social services agencies (106 participants) and increased rates of hospitalization, even after adjustment for numerous potential confounders. Although this observational study could not establish causality, the observation that hospitalization rates gradually increased among persons reporting 1 vs 2 or more types of abuse strongly suggest a dose-response relationship that supports this hypothesis. Another notable finding of this study is the differential relationship observed between selected types of elder abuse and hospitalization rates. In fully adjusted models, psychological abuse, financial exploitation, and caregiver neglect each remained independently associated with increased rates of hospitalization. The stronger effect was observed for caregiver neglect. The lack of association between physical abuse and rate of hospitalization in this study should be interpreted with caution because the small number of cases likely reduced substantially the statistical power of this analysis.

Overall, the findings of the study by Dong and Simon[4] are consistent with previous findings that described an association between elder abuse and higher

elder vulnerability. Yet, the direction of this association remains unclear. Despite the thorough methodology used, residual confounding cannot be excluded. Are these elderly persons at higher risk for health care services utilization because of being abused? Or are they mostly vulnerable elderly persons with poor health status that triggers higher health care services utilization and makes them susceptible of being abused? The answer is probably both.

In some way, elder abuse may come close to a geriatric condition such as falls, urinary incontinence, or delirium, with its own risk factors, adverse outcomes, and screening strategies to prevent its occurrence, recurrence, and consequences. However, addressing elder abuse with a too univocal logic might prove too simplistic for several reasons.

First, "diagnosing" elder abuse is difficult. While some situations are evident (eg, physical abuse in institutions), others can be very difficult to diagnose. Diagnosis criteria are essentially lacking to define, in a trust relationship between 2 intimate persons living at home, the limit between "normal" conflict and abuse. Abuse may also appear in frail couples with no history of intimate violence, and identifying the direction of abuse is sometimes difficult when dependencies are shared. Designing one as a victim might possibly cause mistreatment to the other. In all these situations, the clinician might struggle to pronounce the term *abuse*.

Second, when abuse is suspected, the clinician must investigate risk factors associated with abuse. Reasons for elder abuse include victims' factors but also their social environment, in a large sense (eg, caregivers, family members, health professionals, community, and financial resources). Addressing elder abuse implies that these multiple factors are investigated, and clinicians may have to seek help from interdisciplinary teams and social services. However, patients are often reluctant to allow their physician or other professionals to intervene in handling intimate family problems. This may jeopardize the trusting relationship between the physician and his or her vulnerable patient.

Third, evidence regarding the effectiveness of specific interventions is limited.[5] Indeed, the US Preventive Services Task Force concluded that there is insufficient evidence to recommend for or against systematic screening of elder abuse in health care setting.[6] Overall, interventions are complex to implement and, although an intervention may successfully reduce abuse, it could also sometimes result in an outcome (eg, moving from home to nursing home or being imposed a guardianship) viewed as undesirable by the concerned elderly person. Therefore, clinicians have to assess the right balance between respect for autonomy and principle of beneficence in order to build the most meaningful plan of care with their vulnerable patient.

Overall, these difficulties highlight the complexity of addressing elder abuse issues. Elder abuse is most often intertwined with medical, psychological, social, or existential issues. Addressing abuse, without considering these other dimensions, may conduct clinicians in an impasse, not knowing how to best manage these situations. Caring for polymorbid frail elderly patients is already complex, and addressing each medical problem separately is problematic and sometimes nonsense.[7] Geriatricians recently called for new ways to care for these patients,[8] in going toward a truly patient-centered medicine that focuses on patient's values, needs, and health goals.[9] A similar approach must be delineated to address abuse appropriately.

In conclusion, elder abuse is a shocking and unacceptable problem that requires great attention. Increased awareness of elder abuse is important, but promoting good routine care that encompasses preventative measures is also of paramount importance to protect these patients from becoming abused. Identifying dementia at an early stage, being aware of a patient's functional decline, implementing home care services to support caregivers, and meeting regularly older patients with their relatives to assess relationships problems all contribute to prevent occurrence of elder abuse. In other words, preventing incidence of elderly persons' vulnerability should be a priority for clinicians, long before abuse occurs.

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