

## Abuse in older persons: why physicians need to be aware

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Elder abuse is not just a trendy medical topic that every medical journal has to tackle every once in a while. Studies from several countries in America, Europe, Asia, and even Africa, have observed overall prevalence rates of abuse that averaged about 10% in the general older population, but amounted to as high as 40 to 60% when studying specifically older persons suffering from dementia [1]. Such high prevalence rates essentially imply that every physician who cares for elderly persons is “at-risk” to face a situation of abuse.

Elder abuse includes psychological, physical, financial and sexual abuse, and neglect. Whatever its type, elder abuse not only generates physical and psychological pain and suffering, but has also been repeatedly associated with negative health outcomes such as increased risk of death, emergency department and hospital use, as well as nursing home placement [1].

Despite this evidence, elder abuse remains a largely underreported problem. One aspect of its disturbing reality is currently exposed in the *Swiss Medical Weekly* journal. In a retrospective study, Lacher S. et al. investigated the types of elder abuse most frequently reported in an official complaints database in the Canton of Zurich, Switzerland [2]. Their study also aimed at describing victims’ and perpetrators’ characteristics and at identifying potential risk factors for abuse and neglect. Results showed that, among 903 complaints, 150 cases of abuse and neglect were identified. Psychological abuse was the most frequent type of abuse, representing about half (47%) of the cases, followed by financial exploitation and physical abuse (35 and 30%, respectively). The authors also confirmed that the most common risk factors related to the victims were the need of support and care in activities of daily living (i.e., functional dependency), and dementia. Another important observation is the relatively long time elapsed (a median of 3 months in this study) before these situations were brought to the attention of the complaints office.

Overall, the authors have to be commended for their important contribution to a field of public health concern that remains largely neglected and understudied, especially in Switzerland. Even though data presented are issued from a

selected database that lacks representativeness, this study has the tremendous merit of showing that elder abuse is a reality that happens everywhere, even in one of the wealthiest regions in the world...

The study by Lacher et al. emphasises that physicians need to become familiar with the issue of elder abuse as the older population grows. The US preventive service task force recently concluded that evidence was insufficient to recommend for or against systematic screening for abuse in older persons. However, we strongly believe that any physician caring for older patients needs to become aware of the “red flags” – some of which were also observed in Lacher’s study – that have been associated with a greater risk of abuse in older persons [3]. These red flags relate to the abused persons (e.g., cognitive impairment and dementia, behavioural and psychological symptoms of dementia such as aggressive or oppositional behaviours, functional impairment, lower income, social isolation, etc.), to the perpetrator (e.g., history of substance abuse, mental and/or physical health problems, unemployment and financial difficulties, etc.), and to the dynamic of the situation (e.g., financial dependency of the perpetrator on the victim, shared living arrangement, etc.) [4].

The presence of two or more of these red flags should alert physicians, as well as all other health professionals, to the potential risk of abuse, and arouse their suspicion. In Lacher’s study, only 13% of the cases of elder abuse did not have any risk factors identified, whereas 81% had two or more. Because abused older patients are frequently socially isolated, any encounter with a physician (be it an outpatient or an emergency department consultation, a home visit, or a hospital encounter) should be an opportunity to identify these red flags. However, physicians’ duty is not limited to the detection of situations of potential abuse, but also includes triggering preventative interventions such as the early management of behavioural problems that generate stress in the caregiver, optimising home care assistance, or organising adult day care. In other words: good geriatric care!

In this regard, the study by Lacher et al. also highlights the diversity of the type of abuse and, therefore, the diversity

of skills needed to address adequately these situations. Although physicians should play a critical role in detecting potential elder abuse, they are unlikely to be able to manage these situations on their own. Instead, they need to become familiar with the health, social and legal resources available in their environment, and endorse the role of coordinator between professionals of these different fields. Associations such as Alter Ego (<http://www.alter-ego.ch/>) or Pro Senectute could provide useful social as well as legal advice and support.

Finally, the study by Lacher et al. is also a reminder that more research is needed, as large gaps remain in our understanding of the pathway leading to elder abuse, as well as in how best to organise an evidence-based and comprehensive approach to preventing and managing these not-so-rare situations.

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