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Interconnections in Violence Over the Life Course:

From Cradle to Grave

Karestan C. Koenen, PhD, Bizu Gelaye, PhD, MPH, Christy A. Denckla, PhD

Department of Epidemiology, Harvard T.H. Chan School of Public Health, Boston, Massachusetts.

Elder abuse is defined by the Centers for Disease Control and Prevention as “an intentional act, or failure to act, by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult.”¹ Elder abuse has striking similarities to child abuse in that it occurs in the context of a fiduciary relationship, where there is an expectation of care, and includes a range of adverse experiences such as physical abuse, sexual abuse, emotional abuse, neglect, and financial abuse or exploitation. According to the Centers for Disease Control and Prevention, 1 in 10 adults older than 60 years who lives at home experiences elder abuse.² The prevalence is much higher for older adults who live in institutional settings. This means that an estimated 5 million adults are currently experiencing elder abuse. Given changing population demographics, this number is expected to double by 2060,³ assuming the prevalence of elder abuse remains stable. However, emerging evidence suggests that elder abuse is on the rise; a recent World Health Organization study found that 16% of adults older than 60 years reported experiencing at least one form of elder abuse.⁴ In contrast to child maltreatment, which has received much needed focused attention from both researchers and policymakers in the past decade, elder abuse is a neglected area of investigation. Thus, little is known about what puts some persons at risk for elder abuse and, therefore, there is little to inform prevention.

New research by Dong and Wang⁵ in this issue of *JAMA Internal Medicine* directly addresses this gap in knowledge. The authors use data from the Population Study of Chinese Elderly in Chicago project to document the associations of childhood maltreatment and intimate partner violence with the risk of elder abuse. The association of childhood maltreatment with increased risk of intimate partner violence and other forms of repeated abuse has been well established. Dong and Wang provide some of the first evidence that the adverse experiences of childhood maltreatment extend into older age by increasing the risk of elder abuse.

Strikingly, the authors find the prevalence of elder abuse to be 15.2%, which is similar to the World Health Organization estimates,⁶ although higher than previous estimates among community-dwelling older people (range, 7.6%–10%).⁷ In contrast, child maltreatment and intimate partner violence were less prevalent at 11.4% and 6.5%, respectively,⁵ than the US national average or than has been reported in China.⁸ Child maltreatment was associated

Corresponding Author: Karestan C. Koenen, Department of Epidemiology, Harvard T.H. Chan School of Public Health, Boston, MA 02115 (kkoenen@hsph.harvard.edu).

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with a 2-fold increased risk of elder abuse (adjusted odds ratio, 2.08; 95% CI, 1.57–2.75).⁵ Most strikingly, intimate partner violence was associated with a more than 5-fold increased risk (adjusted odds ratio, 5.53; 95% CI, 4.01–7.64). The strengths of this study include a large sample (3157 community-dwelling US Chinese older adults 60 years or older in Chicago) from a relatively understudied population, as well as clear hypotheses and analytic approaches.

The findings of Dong and Wang⁵ set an agenda for future research aimed at identifying risk factors to inform elder abuse prevention. Specifically, to move the field forward, there are at least 4 areas of research to be pursued. First, future work should include more comprehensive assessments of child maltreatment and intimate partner violence. The lower prevalences of child maltreatment and intimate partner violence found in this study may be because the scale used, although a good instrument in terms of reliability, does not measure severe forms of physical and sexual abuse, such as rape, nor does it assess neglect, which is the most common form of child maltreatment. Second, more detailed information is needed on the timing of intimate partner violence. The strong association between intimate partner violence and elder abuse could be because of, in part, the large age range for which intimate partner violence was assessed (ages 18–59 years). That is, the association may be explained by participants who remained involved with the perpetrator of intimate partner violence through family or partner status. As the authors note, research that focuses on the abused-abuser dyad might help bring important information into the mechanism of the cycle of violence. Third, given sex differences in exposure to specific types of maltreatment and intimate partner violence, it would be informative to see whether the relationships observed are consistent across sex. Fourth, identifying the mechanisms driving the associations among child maltreatment, intimate partner violence, and elder abuse could help inform interventions. For example, does intimate partner violence mediate the association between child maltreatment and elder abuse? Do some of the same mechanisms that drive the association between child maltreatment and subsequent abuse drive the association with elder abuse?

Future research, while important, will not produce results in time to relieve the estimated 5 million people currently experiencing elder abuse. The devastating reality is that some persons both begin and end their lives experiencing maltreatment and abuse. Until progress is made in prevention, the burden of ameliorating elder abuse will be borne by the health care professionals who interact with and treat elderly patients. Such health care professionals need to be trained to identify the signs of elder abuse and how to screen for it, as well as to be informed on the resources available if such abuse occurs. Unfortunately, little actual evidence is available to guide such health care professionals. A recent systematic review found no studies that assessed the effectiveness of screening or treatment for elder abuse.⁹ Clearly, much more work needs to be completed by researchers, clinicians, and policymakers together to address the public health problem of elder abuse that will only continue to grow with the aging of the US population.

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