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Literature Review

Elder Abuse: Global Situation, Risk Factors, and Prevention Strategies

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Abstract

Purpose: Elder mistreatment is now recognized internationally as a pervasive and growing problem, urgently requiring the attention of health care systems, social welfare agencies, policymakers, and the general public. In this article, we provide an overview of global issues in the field of elder abuse, with a focus on prevention.

Design and Methods: This article provides a scoping review of key issues in the field from an international perspective.

Results: By drawing primarily on population-based studies, this scoping review provided a more valid and reliable synthesis of current knowledge about prevalence and risk factors than has been available. Despite the lack of scientifically rigorous intervention research on elder abuse, the review also identified 5 promising strategies for prevention.

Implications: The findings highlight a growing consensus across studies regarding the extent and causes of elder mistreatment, as well as the urgent need for efforts to make elder mistreatment prevention programs more effective and evidence based.

Key Words: Elder abuse, Epidemiology, Risk factor models, Prevention

Elder abuse is now recognized internationally as an extensive and serious problem, urgently requiring the attention of health care systems, social welfare agencies, policymakers, and the general public. Reports from the World Health Organization, United Nations, and other international bodies have prominently featured elder abuse and highlighted the range of harmful activities subsumed under this rubric throughout the world (World Health Organization, 2011, 2014; OHCHR, 2010; Podnieks, Anetzberger, Wilson, Teaster, & Wangmo, 2010). With a global explosion in the older adult population, elder abuse is expected to become an even more pressing problem, affecting millions of individuals worldwide. Elder abuse is associated with devastating individual consequences and societal costs, meriting attention as a serious public health issue.

In this article, we provide an overview of global issues in the field of elder abuse, with a focus on prevention. This emphasis is appropriate because elder abuse is likely the most widespread problem of older people that is largely preventable (unlike many disease conditions of old age). Therefore, a better understanding of causes and prevention of elder abuse should be a major international priority. Fortunately, an improving international scientific literature has accompanied this growing concern, including prevalence studies in a number of countries and international comparative projects. In addition, prevention strategies have been increasingly documented in some countries.

Methods of the Review

Scoping reviews are used to provide a broad overview of a subject and to help map commonalities, themes, and gaps in the literature (Armstrong, Hall, Doyle, & Waters,

2011). We conducted a scoping review to gain an overview of the literature on elder abuse prevalence and risk factors. We restricted the review to high-quality elder abuse prevalence studies in order to synthesize and advance the most valid and reliable knowledge available. To this end, we only included population-based elder abuse prevalence studies using random or exhaustive sampling and that collected data directly from older adults. We excluded studies based on convenience, clinical, or social service agency samples, as well as studies that collected data from caregivers, professionals, or agency records to identify cases of elder abuse. We focused on regional or national-level studies unless this scale of research was unavailable in a given country (e.g., in some cases, the only surveys were conducted in an individual city). Our scoping review initially drew from existing systematic and comprehensive literature reviews on elder abuse (Cooper, Manela, Katona, & Livingston, 2008; De Donder et al., 2011; Johannesen & LoGiudice, 2013; Sethi et al., 2011; Sooryanarayana, Choo, & Hairi, 2013). These prior reviews covered elder abuse studies until 2011 and identified 12 records satisfying our inclusion/exclusion criteria. To retrieve records from 2011 onwards, we conducted title/abstract searches in four major databases (PubMed, MEDLINE, PsycINFO, and Social Work Abstracts) between 2011 and 2014 with the following search terms: [(elder abuse OR elder neglect OR elder mistreatment OR elder maltreatment) AND (incidence OR prevalence)]. This database search resulted in 211 records overall, which was reduced to eight studies after omitting duplications and records that did not satisfy inclusion/exclusion criteria. The 20 studies informing our scoping review of elder abuse prevalence and risk factors are described in Supplementary Table. In addition, we consulted international comparative documents regarding the state of elder abuse programing in different countries. Special characteristics of the review of prevention programs are described in that section.

Definitions

Research and intervention strategies regarding any form of interpersonal abuse depend on a case definition that withstands the criteria of research operationalization, clinical applicability, and policy formulation. A major barrier to improving our understanding elder abuse has been the use of widely varying, and sometimes poorly constructed, definitions of the phenomenon. Fortunately, consensus is now emerging regarding both the general definition of elder abuse as well as the major types of mistreatment encompassed by the term.

The U.S. National Academy of Sciences (Wallace & Bonnie, 2003) proposed a widely accepted scientific definition of elder abuse that we employ in this article. 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, or (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm." This definition includes two major points: that an older person has suffered injury, deprivation, or unnecessary danger, and that another person (or persons) in a relationship of trust was responsible for causing or failing to prevent the harm.

Within the overarching framework of elder abuse, there is general agreement on the scope of actions that fall under this rubric (Council, 2003; Lachs, Williams, O'Brien, Hurst, & Horwitz, 1997; Laumann, Leitsch, & Waite, 2008; Phelan, 2013). Researchers, practitioners, and most legal statutes recognize the following types of abuse: (a) *physical abuse*, which includes acts carried out with the intention to cause physical pain or injury; (b) *psychological abuse*, defined as acts carried out with the intention of causing emotional pain or injury; (c) *sexual assault*; (d) *material exploitation*, involving the misappropriation of the elder's money or property; and (e) *neglect*, or the failure of a designated caregiver to meet the needs of a dependent older person.

Although elder abuse generally falls into one or more of these five types, reports have documented extensive cultural variation in the circumstances and context of elder abuse. For example, widows in some traditional societies risk having their property seized and being abandoned by their families. In some regions of India and Africa, mourning activities expected of widows would elsewhere be considered abusive, such as being forced into marriage or being expelled from their homes (Kumari, 2014; McFerson, 2013). Reports have also identified devastating effects of accusations of witchcraft in some cultures, typically directed at older women (Kabole & Kioli, 2013; Krug, Mercy, Dahlberg, & Zwi, 2002; Schnoebelen, 2009). Thus, significant cultural variation exists in these five forms in which elder abuse appears.

Prevalence

Data from a number of countries about the extent of elder abuse justify urgent attempts to address the problem. Although some population surveys suffer from unclear or overly broad definitions or questionable methods, evidence is now available from a number of well-conducted, large-scale population surveys of community-dwelling individuals in a number of countries. Elder abuse research tends to be subdivided into typologies based on community or institutional living older adult populations (Acierno et al., 2010). In the following review of elder abuse prevalence, we focus on community-based surveys. Elder abuse prevalence in institutional settings is not covered because of the lack of research in this area; no reliable prevalence studies have been conducted of such mistreatment in nursing homes or other long-term care facilities.

Elder abuse prevalence rates for separate and aggregate forms of mistreatment described in this section are based on a synthesis of results from 18 studies in Supplementary Table that reported prevalence rates using a 1-year period.

More specifically, two studies (Brozowski & Hall, 2004, 2010) from Supplementary Table were excluded from prevalence calculations because these two studies measured prevalence over a different, 5-year period. Among the remaining 18 studies using a 1-year prevalence period, not all studies collected data on every form of elder abuse. Therefore, the synthesized elder abuse subtype prevalence rates were based on the subsets of studies with relevant data.

Physical Abuse

Elder physical abuse was the most consistently measured mistreatment type. Screening was commonly based on the Conflict Tactic Scale (CTS) or a modified version of the CTS as developed in Pillemer and Finkelhor's (1988) prevalence study. In nearly all studies, physical abuse caseness was defined as one or more events within a designated prevalence period. Figure 1 shows the distribution of 1-year physical abuse prevalence rates across studies, which ranged from 0.2% to 4.9% (outlier 14.6%) with a mean of 2.8% (95% CI: 1.0%–4.6%). Worldwide, Canada (0.5%) and the United States (1.4%) reported the lowest prevalence rates of elder physical abuse, followed by Europe (1.67%). Two studies from Asia reported somewhat higher physical abuse rates (India: 4.3%, China: 4.9%), whereas a single study from Nigeria found by far the highest rate (14.6%).

Sexual Abuse

Although one study incorporated the Revised CTS (Soares et al., 2010), researchers have generally developed their own set of questions to screen for elder sexual abuse. Studies consistently operationalized sexual abuse caseness as one or more events occurring in a given time period. Across studies, 1-year elder sexual abuse prevalence ranged from 0.04% to 0.8% (outlier 3.3%), with a mean of 0.7% (95% CI: 0%–1.5%; see Figure 1). Unlike physical abuse, Nigeria reported the lowest prevalence of sexual abuse (0.04%), followed by the United States (0.5%), Mexico (0.8%), and Europe (1.0%).

Financial Abuse

Standardized tools have been unavailable to screen for elder financial abuse. Therefore, a wide range of measurement approaches were employed across prevalence studies to assess this mistreatment type. However, studies consistently defined elder financial abuse caseness as one or more mistreatment events within a given prevalence period. Across studies, 1-year prevalence of financial abuse ranged from 1.0% to 9.2% (outlier 13.1%; Figure 1) with a mean of 4.7% (95% CI: 2.8%–6.5%). Studies from Nigeria and Israel reported the highest prevalence of financial abuse at 13.1% and 6.4%, respectively. Mexico had the lowest prevalence of financial abuse (2.6%), whereas mean rates across Europe (3.8%) and the United States (4.5%) fell in the middle.

Emotional/Psychological Abuse

The CTS (or a modified version) was the most common tool used to measure elder emotional/psychological abuse, although several studies also developed their own screening questions. Overall, studies reported a very wide range in 1-year emotional/psychological abuse prevalence rates (0.7%–27.3%), with a mean of 8.8% (95% CI: 4.4%–13.1%). However, studies should be subdivided by those that defined emotional/psychological abuse caseness according to substantive threshold criteria and those that defined caseness simply as one or more events. This definitional/operational distinction appears

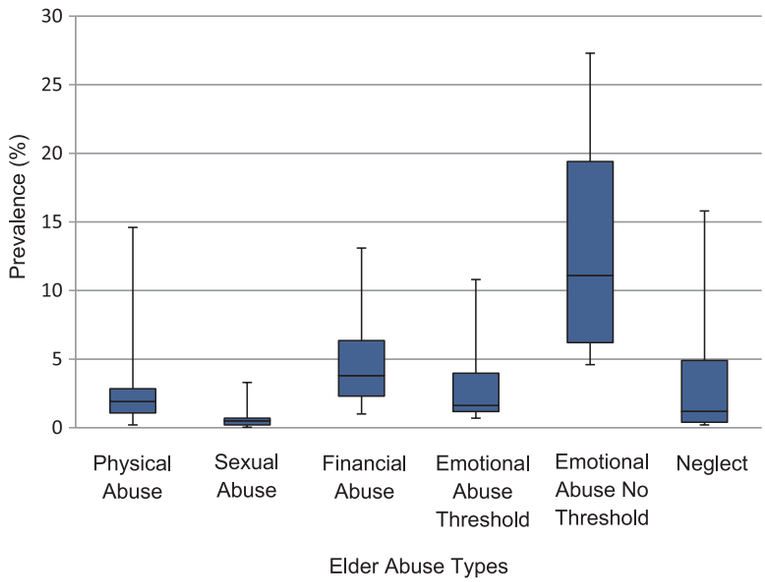

Figure 1. International prevalence rates according to elder abuse type.

to account for much of the variation in emotional/psychological abuse prevalence rates, as depicted in Figure 1.

Studies using substantive threshold criteria typically defined emotional/psychological abuse caseness as 10 or more events in the past year, and some studies added a criterion that the mistreatment be perceived as somewhat or very serious by the older adult. Among studies that used substantive threshold criteria, 1-year emotional/psychological abuse prevalence ranged from 0.7% to 6.3% (outlier 10.8%), with a mean of 3.3% (95% CI: 0.4%–6.3%). Studies that did not use substantive threshold criteria reported 1-year emotional abuse prevalence ranging from 4.6% to 27.3%, with a mean of 13.6% (95% CI: 7.0%–20.2%). Defining emotional abuse caseness as one or more events (without thresholds) is likely oversensitive because it captures one-time scenarios that ought not to be characterized as elder abuse (e.g., a single insult between 60-year-old spouses in the last year). Among studies that used threshold criteria, India reported relatively high emotional abuse prevalence (10.8%), whereas Canada, United States, and Europe had lower mean rates of 1.4%, 1.5%, and 2.9%, respectively.

Neglect

The majority of researchers generated their own set of questions to screen for elder neglect, although a few studies used standardized tools (Duke OARS, Katz ADL Index). Studies either defined neglect caseness as one or more events within a given time period or according to substantive threshold criteria based on event frequency and elder self-perceived seriousness. Studies using substantive thresholds typically defined positive neglect as 10 or more events in the past year, whereas some studies added the criterion that the events be perceived as somewhat or very serious by the elder. Across all studies, 1-year neglect prevalence ranged from 0.2% to 5.5% (outlier 15.8%), with a mean of 3.1% (95% CI: 0.6%–5.5%; see Figure 1). The difference in 1-year neglect prevalence between studies that used threshold criteria (mean = 1.1% [95% CI: 0%–2.3%]) and those that did not (mean = 5.7% [95% CI: 0.01%–11.3%]) was not significant (although this is based on a low sample of studies). However, it is worth noting that neglect caseness defined as one or more events is likely oversensitive because it captures onetime scenarios that most experts would agree should not be characterized as elder abuse (e.g., a child forgetting to clean the older adult's house once in the last year). Among studies that incorporated threshold criteria, Canada reported the lowest rate of elder neglect (0.4%), followed by Europe (0.5%) and the United States (1.1%), whereas India reported the highest neglect prevalence (4.3%).

Aggregate

Several studies reported an aggregated elder abuse prevalence that incorporated all forms of mistreatment. Overall, studies reported an aggregated elder abuse prevalence ranging from 2.2% to 36.2%, with a mean of 14.3% (95% CI: 7.6%–21.1%). Across all studies, the highest aggregated prevalence was reported in China (36.2%) and Nigeria (30.0%), followed by Israel (18.4%), India (14.0%), Europe (10.8%), Mexico (10.3%), United Sates (9.5%), and Canada (4.0%). After excluding studies that did not use substantive thresholds to screen for emotional abuse, aggregated elder abuse prevalence ranged from 2.2% to 14.0%, with a mean of 7.1% (95% CI: 2.9%–11.2%). Among these studies using emotional abuse threshold criteria, India had the highest aggregated elder abuse prevalence (14.0%), followed by the United States (7.6%), Europe (6.03%), and Canada (4.0%).

It should be emphasized that prevalence rates reported in existing population-based elder abuse studies likely underestimate the true population prevalence. Older adults tend to underreport personal problems such as interpersonal violence (Wallace & Bonnie, 2003). More important, elder abuse prevalence surveys carried substantial participation bias in that they generally excluded a group of older adults that is potentially most vulnerable to the problem: individuals with cognitive impairment. A number of smaller studies using convenience clinical/social service samples have been conducted on dementia caregivers, using a time frame of mistreatment within the past year (Cooney, Howard, & Lawlor, 2006; Cooney & Wrigley, 1996; Cooper et al., 2008; Coyne, Reichman, & Berbig, 1993; Paveza et al., 1992; Pillemer & Suitor, 1992; Pot, van Dyck, Jonker, & Deeg, 1996; Wiglesworth et al., 2010). In these studies, physical abuse prevalence ranged from 1.0% to 23.1% with a mean of 10.9% (95% CI: 4.8%–16.9%). Elder emotional abuse prevalence ranged from 27.9% to 62.3% with a mean of 39.5% (95% CI: 27.6%–51.5%). Elder neglect prevalence ranged from 4.0% to 15.4% with a mean of 11.1% (95% CI: 0%–26.5%). Studies did not report on the prevalence of elder sexual abuse or financial exploitation. Aggregated elder abuse prevalence ranged from 27.9% to 52.0% with a mean of 38.4% (95% CI: 25.2%–51.6%). Thus, it appears that elder abuse prevalence is much higher among cognitively impaired older adults in the community compared with their cognitively intact counterparts. Also excluded from population-based prevalence studies are individuals in nursing homes; although prevalence estimates do not exist for institutional care, preliminary evidence suggests that rates may be higher than in the community (Castle, 2012; Goergen, 2001; Pillemer & Moore, 1989; Pot et al., 1996).

These results suggest that the extent of elder abuse is sufficiently large that social service and health professionals who serve older adults are likely to encounter it on a routine basis. For example, using the prevalence rates just described, a clinician seeing 20 older adults a day may encounter a victim of elder abuse daily (Lachs & Pillemer, 2004). Further, as our discussion of risk factors below shows, some subpopulations that are overrepresented in the elder service system (e.g., dementia patients) have higher risk of abuse. If prevalence rates remain the same, the absolute number of elder abuse incidents will rise in accordance with a rapidly growing

older adult population. Countries will experience this rise in elder abuse cases differently depending on differential rates of population growth. Nevertheless, prevention programs in all countries are well-justified to help reduce prevalence and buffer the effect of a global aging population.

Risk Factors

The development of effective prevention programs is predicated on an understanding of risk factors for mistreatment. In this section, we follow the ecological model (Wallace & Bonnie, 2003) in reporting the main risk factors, focusing on the levels of the individual (victim and perpetrator), relationship, community, and society that are associated with risk of elder abuse. We focus on population-based studies (Supplementary Table), selected case-comparison studies, and systematic reviews to identify risk factors. Similar to the approach used by Sethi and colleagues (2011), risk factors were assigned to one of three categories based on the strength of evidence: (a) *strong* risk factors validated by substantial evidence, (b) *potential* risk factors for which the evidence is mixed or limited, and (c) *contested* risk factors for which there is lack of clear evidence (Table 1).

Individual-Level Risk Factors (Victim)

Strong

Functional dependence or disability

Across countries, older adult functional dependence or physical disability has consistently been found to be associated with greater risk of elder abuse, including emotional and financial abuse in the United States and China (Acierno et al., 2010; Amstadter et al., 2011; Burnes et al., 2015; Laumann et al., 2008; Peterson et al., 2014; Wu et al., 2012), physical abuse in the United States (Burnes et al., 2015), and aggregate elder abuse in Mexico and Portugal (Gil et al., 2015; Giraldo-Rodríguez & Rosas-Carrasco, 2013).

Poor physical health

Poor health has also been consistently associated with elder abuse across countries (Chokkanathan & Lee, 2005; Giraldo-Rodríguez & Rosas-Carrasco, 2013; Lowenstein, Eisikovits, Band-Winterstein, & Enosh, 2009; Naughton et al., 2010; Pillemer & Finkelhor, 1988), including financial abuse in the United States, United Kingdom, and Canada (Laumann et al., 2008; O'Keeffe et al., 2007; Podnieks, 1993); physical, sexual, and emotional abuse in Israel (Lowenstein et al., 2009); and neglect in the United States, Canada, and Israel (Acierno et al., 2010; Amstadter et al., 2011; Burnes et al., 2015; Lowenstein et al., 2009; Pillemer & Finkelhor, 1988; Podnieks, 1993).

Cognitive impairment/dementia

Although most population-based studies of elder abuse excluded individuals with cognitive impairment, other research has found relatively high rates of mistreatment committed by dementia caregivers (as outlined above) or identified cognitive impairment as a strong risk factor (Lachs et al., 1997; Sethi et al., 2011).

Table 1. Risk Factor Strength of Evidence

Level	Risk factors	Strength of evidence	Protective actors	Strength of evidence
Individual (victim)	Functional dependence/ disability	Strong	Social support	Strong
	Poor physical health	Strong		
	Cognitive impairment	Strong		
	Poor mental health	Strong		
	Low income/SES	Strong		
	Gender	Potential		
	Age	Potential		
	Financial dependence	Potential		
	Race/ethnicity	Potential		
Individual (perpetrator)	Mental illness	Strong	Living arrangement	Strong
	Substance abuse	Strong		
	Abuser dependency	Strong		
Relationship	Victim–perpetrator relationship	Potential		
	Marital status	Potential		
Community	Geographic location	Potential		
Societal	Negative stereotypes on aging	Contested		
	Cultural norms	Contested		

Notes: Strong: risk factors validated by substantial evidence that have unanimous or near unanimous support from several studies. *Potential*: risk factors for which the evidence is mixed or limited. *Contested*: risk factors for which there has been a hypothesis concerning increased risk, but for which there is a lack of clear evidence.

Poor mental health
Studies across countries have found a relationship between poor mental/emotional health of the victim and elder abuse, including overall mistreatment in Mexico (Giraldo-Rodríguez & Rosas-Carrasco, 2013) and Ireland (Naughton et al., 2010). Depression or depressive symptoms have been associated specifically with emotional and physical abuse in the United Kingdom (O'Keeffe et al., 2007), China (Wu et al., 2012), and Canada (Podnieks, 1993).

Low income/SES
Low income has predicted aggregated elder abuse in Mexico (Giraldo-Rodríguez & Rosas-Carrasco, 2013), Ireland (Naughton et al., 2010), and India (Chokkanathan & Lee, 2005); financial (Peterson et al., 2014), emotional and physical abuse (Burnes et al., 2015), and neglect (Acierno et al., 2010) in the United States; and physical and sexual abuse in Canada (Brozowski & Hall, 2004, 2010).

Potential
Gender
International studies, including reports from Portugal (Gil et al., 2015), India (Chokkanathan & Lee, 2005), Ireland (Naughton et al., 2010), Israel (Lowenstein et al., 2009), and Mexico (Giraldo-Rodríguez & Rosas-Carrasco, 2013), indicate that women are more likely than men to experience elder abuse; specifically, emotional (Laumann et al., 2008) and financial abuse (Lowenstein et al., 2009). However, a recent study conducted in Seoul, Korea (Oh, Kim, Martins, & Kim, 2006) found that men were more likely to experience emotional and financial abuse.

Age
In the United States, younger age has been consistently associated with greater risk of elder abuse, including emotional, physical, financial abuse, and neglect (Acierno et al., 2010; Burnes et al., 2015; Laumann et al., 2008). However, studies from Mexico and Europe report that older individuals are at heightened risk (Gil et al., 2015; Giraldo-Rodríguez & Rosas-Carrasco, 2013; Naughton et al., 2010).

Financial dependence
Evidence from studies conducted in Europe, Asia, and Africa suggest that financial dependence is linked to elder abuse and neglect (Lachs & Pillemer, 2004; Olofsson, Lindqvist, & Danielsson, 2012; Pot et al., 1996).

Race/ethnicity
Findings related to race/ethnicity come from the United States and Canada and suggest that specific racial/ethnic groups have divergent risk trends in relation to different types of elder abuse. Compared with Caucasians, African American older adults may be at increased risk of financial abuse and psychological abuse (Beach, Schulz, Castle, & Rosen, 2010; Laumann et al., 2008) and aboriginal older adults have demonstrated higher risk of physical and sexual abuse (Brozowski & Hall, 2010), whereas Hispanic older adults have shown lower risk of emotional abuse, financial abuse, and neglect (Burnes et al., 2015; Laumann et al., 2008).

Individual-Level Risk Factors (Perpetrator)

Knowledge about elder abuse perpetrator risk factors remains a major gap. To date, population-based elder abuse studies have collected data from older adults, as opposed to trusted others. Without generating a random sample of individuals who are in a trusting relationship with an older adult, it is difficult to ascertain actual factors that place these trusted others at risk of perpetrating elder abuse. Information about perpetrators available from existing population-based elder abuse studies is also restricted by methodological specifications that are often put in place to protect older adult respondents (e.g., closed-ended questions over the phone). Despite these limitations, several studies describe perpetrator characteristics and we are able to construct a preliminary profile of elder abusers.

Strong
Mental illness
Poor psychological health (Cooney et al., 2006; Vandeweerd, Paveza, & Fulmer, 2006) including depression and anxiety (Pot et al., 1996; Wiglesworth et al., 2010) are common among elder abuse perpetrators (Sethi et al., 2011). In the United States, studies show that caregiver depression is predictive of physical (Coyne et al., 1993; Paveza et al., 1992) and verbal abuse (Vandeweerd et al., 2006) and, further, that abusers are more likely to experience psychiatric hospitalization than nonabusers (Pillemer & Finkelhor, 1988).

Substance misuse
Drug or substance misuse is also common among elder abuse perpetrators (Anetzberger, Korbin, & Austin, 1994; Homer & Gilleard, 1990; von Heydrich, Schiamberg, & Chee, 2012; Wolf & Pillemer, 1989). Alcohol and drug problems have been linked with verbal and financial abuse in Canada (Podnieks, 1993) and financial abuse in Ireland (Naughton et al., 2010) and the United Kingdom (O'Keeffe et al., 2007).

Abuser dependency
Studies have also shown that abusers are likely to be dependent on their victims for emotional support, financial help, housing, and/or other assistance (Anetzberger, 1987; Greenberg, McKibben, & Raymond, 1990; Iborra, 2008; Pillemer, 1986, 2004; Sethi et al., 2011; Wolf, Strugnell, & Godkin, 1982).

Victim–Perpetrator Relationship-Level Risk Factors

Potential
Relationship type
Perpetrator relationship type appears to vary according to mistreatment type and culture. In the United States, Israel,

and Europe, the most common perpetrator of elder emotional and physical abuse is a spouse/partner (Amstadter et al., 2011; Burnes et al., 2015; Laumann et al., 2008; Lowenstein et al., 2009; O'Keeffe et al., 2007; Pillemer & Finkelhor, 1988; Soares et al., 2010), whereas the most common perpetrators of these mistreatment types in Asian countries are children and children-in-law (Chokkanathan & Lee, 2005; Oh et al., 2006).

Marital status

Some studies from the United States, Canada, and Europe indicate that being married is associated with aggregated elder abuse (Pillemer & Finkelhor, 1988), emotional and physical abuse (Podnieks, 1993; Soares et al., 2010). However, other studies from the United States, Europe, Mexico, and China have found that being single, separated/divorced, or widowed is associated with higher odds of aggregated elder abuse (Giraldo-Rodríguez & Rosas-Carrasco, 2013; Naughton et al., 2010; O'Keeffe et al., 2007) and each of the individual mistreatment types (Burnes et al., 2015; Laumann et al., 2008; O'Keeffe et al., 2007; Podnieks, 1993; Wu et al., 2012).

Community-Level Risk Factors

In addition to characteristics of the victim, perpetrator, and victim–perpetrator relationship, community contexts may also place certain individuals at greater risk for abuse.

Potential

Geographic location

Studies conducted in Canada (Brozowski & Hall, 2004, 2010) and Southwestern Nigeria (Cadmus & Owoaje, 2012) reported that individuals living in urban areas were at greater risk for elder abuse. Residing in a specific country may also be a risk factor for abuse. For example, a prevalence study of seven European countries found that residing in Greece was associated with increased risk of sexual abuse, whereas residing in Portugal was associated with increased risk of financial abuse (Soares et al., 2010).

Societal-Level Risk Factors

Speculation has also been made about societal-level factors that may place individuals at higher risk of elder abuse. Although data are lacking, two factors are frequently cited in the literature.

Contested

Negative views on aging (ageism)

Some authors have suggested that negative attitudes and stereotypes about older people may contribute to societal acceptance of elder abuse (Nelson, 2005; Sethi et al., 2011). Older individuals may be perceived as fragile, dependent (Bytheway, 1994), or burdensome, making it more permissible for younger generations to mistreat them (Penhale, Parker, & Kingston, 2000).

Social and cultural norms

Although empirical evidence remains limited, scholars speculate that the normalization of violence may further perpetuate violent behavior toward older people (Browne, 1989; Penhale, Parker, & Kingston, 2000).

Protective Factors

There is limited empirical evidence regarding factors that may protect individuals from elder abuse or promote resilience after mistreatment. However, a body of research suggests that two factors may confer protection from elder abuse.

Strong

Social Embeddedness/Social Support

Studies conducted in the United States (Acierno et al., 2010; Amstadter et al., 2011; Schafer & Koltai, 2015; von Heydrich et al., 2012), Canada (Podnieks, 1993), Europe (Chokkanathan & Lee, 2005; Garre-Olmo et al., 2009; Melchiorre et al., 2013; Naughton et al., 2010; Soares et al., 2010), India (Chokkanathan & Lee, 2005), and Israel (Lowenstein et al., 2009) have found that higher levels of social support and greater embeddedness in a social network lower the risk of elder abuse.

Living Arrangement

Studies from the United States and Europe have shown that a shared living environment is a major risk factor for aggregated elder abuse and, more specifically, physical and financial abuse (Naughton et al., 2010; Peterson et al., 2014; Pillemer & Finkelhor, 1988).

Prevention

The most pressing need in the field of elder abuse is for interventions that have the potential to prevent mistreatment. Selecting and evaluating prevention options poses a considerable challenge, however, because reliable evaluation data do not exist on any of the options (Ploeg, Fear, Hutchison, MacMillan, & Bolan, 2009; Sethi et al., 2011; Stolee, Hiller, Etkin, & McLeod, 2012). Indeed, it is unfortunate that the greatest gap in knowledge about elder abuse lies in the area of prevention, given the pressing nature of the problem. Only approximately 10 intervention studies have been conducted with even minimally acceptable methods, and the results of most of these efforts have been negative or equivocal (Ploeg et al., 2009). No international comparative studies of prevention programs have been conducted. Further, no information exists on the cost-effectiveness of programs; indeed, there are virtually no descriptive data of any kind of the costs incurred by any elder abuse interventions.

Despite the lack of effectiveness data from rigorous controlled designs, the seriousness and scope of the problem of elder abuse require countries and communities to take action to prevent it. We have, therefore, identified five interventions as "promising" based on the evidence from multiple case studies or program descriptions that report beneficial effects of the

program. We do so with the caveat that program initiators must proceed with caution, given the absence of randomized, controlled intervention studies in elder abuse. However, we believe that guidance from the descriptive literature can be useful in identifying programs that merit further testing.

Caregiver Interventions

Caregiver interventions were among the first models used to prevent elder abuse. These interventions provide services to relieve the burden of caregiving, such as housekeeping and meal preparation, respite care, education, support groups, and day care and are promoted as abuse-prevention strategies. There is suggestive evidence that these interventions, when directed specifically to abusive caregivers, may help prevent revictimization (Nahmiash & Reis, 2001; Reay & Browne, 2002). Further, there is some indication that the potential for the onset of abuse may be reduced by caregiver support interventions (Livingston et al., 2013; Sethi et al., 2011). Caregiver interventions therefore are a promising approach to prevention.

Money Management Programs

Extensive case study reports suggest that individuals vulnerable to financial exploitation can be helped through money management programs (Nerenberg, 2003; Sacks et al., 2012). Such programs feature daily money management assistance, including help with paying bills, making bank deposits, negotiating with creditors, and paying home care personnel. These programs are targeted to groups at high risk for financial exploitation and in particular individuals with some degree of cognitive impairment and who are socially isolated. This intervention is also promising, as the preventive potential is high and with well-trained and accredited money managers, the risks of adverse outcomes are low.

Helplines

The most widely used intervention across countries is telephone "helplines," which allow individuals to seek advice and assistance regarding elder abuse. There is considerable case study evidence suggesting that helplines facilitate early intervention that can prevent or forestall mistreatment. Such helplines are typically staffed by trained volunteers or professionals. Because many elders experience shame about the abusive situation, helplines have the advantage of allowing callers to remain anonymous if they choose. In some countries, existing helplines have been expanded to support elder abuse victims. In other countries, hotlines have been established specifically for elder abuse victims, such as the "Helpline for Abused Older People" in Milan, Italy, which counsels abuse victims (Van Bavel, Janssens, Schakenraad, & Thurlings, 2010). The most extensive helpline system is a national network of helpline centers created by ALMA France that provides both immediate counseling and longer-term follow-up (Sethi et al., 2011). Helplines should be considered a promising intervention, given the positive case reports and lack of evidence of any adverse outcomes.

Emergency Shelter

The provision of emergency shelter is a hallmark of intervention for battered women, providing a safe haven to both escape abuse and to plan for the next stage of life (Moracco & Cole, 2009). Shelters, however, are underutilized by older women, who are often unaware of them (Straka & Montminy, 2006). Additionally, battered women's shelters typically are not designed to accommodate older women with physical health problems or dementia, and they do not offer services to abused men. Therefore, specialized shelter programs for elder abuse victims have been developed. These programs offer temporary relocation for victims, providing not only a safe environment but also a medically appropriate one. As such, they may prevent permanent relocation to a nursing home, providing security while allowing a plan for safety at home to be put in place. Descriptive studies of shelter programs suggest positive results (Heck & Gillespie, 2013; Reingold, 2006), indicating that this is a promising program option.

Multidisciplinary Teams

In all countries, effective elder abuse prevention requires the coordination of available services. The responses required for elder mistreatment cut across many systems, including criminal justice, health care, mental health care, victim services, civil legal services, adult protective services, financial services, long-term care, and proxy decision making. Case study and quasi-experimental evidence show that multidisciplinary teams (MDTs) are likely to be an effective response to coordinating care and reducing fragmentation, leveraging resources, increasing professional knowledge, and improving outcomes (Blowers et al., 2012; Navarro, Gassoumis, & Wilber, 2013; Rizzo, Burnes, & Chalfy, 2015; Teaster, Nerenberg, & Stansbury, 2003; Ulrey & Brandl, 2012). These teams can also drive collaboration between the elder justice field and other allied fields involved with older adults (Nerenberg, 2002). As one of the field's most promising practices, MDTs should be implemented and tested internationally. However, it should be noted that MDTs are at present more appropriate in higher-income nations, given that services must first be available in order to be coordinated. In lower-income countries, a higher priority is likely to be establishment of basic elder abuse services, with later attention to coordination.

In summary, given both a scarcity of resources in many countries and the lack of a solid evidence base, efforts to create comprehensive prevention approaches to elder abuse are still in their infancy. Substantial differences exist among nations; there are clearly much more expansive elder abuse service systems in high-income countries (Krug et al., 2002). Although there is a paucity of evaluation data, there is

consensus in the field internationally regarding the need to expand the range of services for elder mistreatment. However, there are several prevention options that are supported by preliminary evidence of their effectiveness and no reports of adverse outcomes. Programs with the greatest promise based on clinical, quasi-experimental, or single case study evidence are: (a) MDT approaches (particularly in countries where the service system is sufficiently developed to require coordination); (b) helplines for potential victims; (c) financial management for elders at risk of financial exploitation; (d) caregiver support interventions; and (e) emergency shelter for victims.

Although the literature on elder abuse interventions is not sufficiently developed to offer extensive guidance to countries and localities, this review suggests an important role for practitioners in promoting prevention and treatment approaches. It is vitally necessary that practitioners follow developments in the field, making them able to adopt evidence-based approaches as they are tested and disseminated. Practitioners can also play a critically important role as collaborators in applied research projects, providing locations for intervention studies and access to participants. Further, a key role for service providers engaged in the issue of elder abuse is to serve as advocates for service development in their regions and in their countries. In areas where such concerted advocacy has occurred, improvements in elder abuse intervention have often followed (World Health Organization, 2014).

Conclusion

Elder abuse is a growing international problem with different manifestations in different countries and cultures. Substantial variation in legal and legislative approaches to the problem also exists between different countries. Similarly, resources available to prevent and intervene in elder abuse, and the degree to which they are coordinated, vary considerably throughout the world. Promising prevention and intervention strategies are being developed primarily in higher-income countries (e.g., MDTs) that may have applicability to other societies, but these should be tested in the context of available resources and the local manifestations of elder abuse. In some countries, awareness campaigns may first take precedent over intervention and prevention efforts given limited public understanding of the problem. Irrespective of the local strategies employed, cases of elder abuse will only increase given the aging of the population worldwide, making it a public health problem of global importance.

The most urgent need at present is for a widely expanded research base that uses high-quality methods. There is a paucity of information about the nature and extent of elder abuse in low-income countries, and most studies have taken place in high-income nations. Culturally specific forms of elder abuse and cultural attitudes toward prevention and treatment (including potential barriers) remain virtually unexplored. Further, the applicability of transferring service models from high-income to low-income countries requires serious study, as resource-intensive options such as adult protective services may not be feasible in nations where the aging services sector is underdeveloped. Although multicountry studies have taken place in Europe, they should be expanded to low-income countries as well. Improved scientific knowledge about elder abuse is the key to developing effective prevention and treatment strategies and should be promoted worldwide.

Supplementary Material

Please visit the article online at http://gerontologist.oxfordjournals.org/ to view supplementary material.

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