The Abused Elderly

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The family has always been perceived as a safe haven for the aged; however, violence within the family has existed since ancient times as documented by historical and literary readings. It is only within the last few decades of this century that abuse of the aged has been acknowledged by the health care community. It is currently impossible to identify accurately the extent of this problem and it has been suggested that aged abuse is at the stage child abuse was 20 years ago—the stage of missing data.

The major impediment to defining the problem has been the difficulty of developing a universally acceptable definition of the term "abuse." A variety of definitions currently prevail. Falckoni (1982) differentiates between physical and psychological abuse. Two additional types were identified by Lau and Kosberg (1978) as material abuse and violation of rights. Other researchers have broadened their definitions to include neglect. For example, Johnson (1979) and Anderson...
(1982) view neglect through failure to meet the needs of the elder as representative of abuse. Anderson goes on to identify the categories of physical abuse, physical neglect, emotional abuse, and emotional neglect. Other investigators use broad based definitions, which include the phases: passive and active neglect, emotional anguish, financial abuse, material deprivation, deliberate neglect, and benign neglect. However, Seland, Rosalie, and Kane (1984) caution that including too many broad types of abuse will result in an overstated problem. They suggest adopting two narrow definitions: 1) abuse as physical, emotional bodily or sexual maltreatment; and 2) neglect as the omission on the part of the responsible party to provide for the normal needs of the person in their care.

This present scope of definitions renders it virtually impossible to determine the etiology of abuse. By combining such different behaviors, the researcher loses the ability to identify causal factors, and thus is prevented from developing an adequate knowledge base in this area.

The authors suggest that the broad heading of maltreatment be used, and that this be subdivided into the various types of abuse and neglect. A suggested differentiation of elderly maltreatment, in particular abuse and neglect, is shown in Table 1.

**Inadequate Reporting**

A second factor impeding clarification of the maltreatment issue is inadequate reporting. Data from the United States indicate that more than one million elderly individuals were victims of abuse. Statistically, Lau and Kosberg estimate one in ten elderly experience maltreatment; while Block (1980) suggests it may be seen in one out of two households.

The number of 65 plus Canadians who have been abused is difficult to estimate with accuracy. In Manitoba, Shell (1982) documented its incidence at 2.2%. A second Manitoban study by King (1984) analyzed 25 cases of suspected abuse and found 20 were substantiated. Findings in

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**TABLE 1**

**TYPES OF MALTREATMENT**

<table>
<thead>
<tr>
<th>Description</th>
<th>Abuse</th>
<th>Neglect</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Act of commission;</td>
<td>Act of omission; implies passive involvement by abuser</td>
</tr>
<tr>
<td></td>
<td>implies active involvement by abuser</td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>Nonaccidental injury, eg, bruises, fractures, lacerations, rope burns (restraints)</td>
<td>Malnutrition, Dehydration, Failure to meet basic needs</td>
</tr>
<tr>
<td>Psychosocial</td>
<td>Verbal abuse and threats, Belittling, Social isolation, Attacks on self-esteem</td>
<td>Failure to interact, Failure to meet usefulness and stimulation needs, Failure to involve in decision-making process</td>
</tr>
<tr>
<td>Financial/material</td>
<td>Removal of resources without consent</td>
<td>Failure to supply care requirements</td>
</tr>
</tbody>
</table>

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**TABLE 2**

**LEGAL PROTECTION OF CANADA’S ELDERLY**

<table>
<thead>
<tr>
<th></th>
<th>Abuse protection</th>
<th>Neglect protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>Criminal Code</td>
<td>Not addressed</td>
</tr>
<tr>
<td>Psychosocial</td>
<td>Not addressed</td>
<td>Not addressed</td>
</tr>
<tr>
<td>Financial/material</td>
<td>Not addressed</td>
<td>Not addressed</td>
</tr>
</tbody>
</table>

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**TABLE 3**

**LEGAL PROTECTION OF UNITED STATES’ ELDERLY**

<table>
<thead>
<tr>
<th></th>
<th>Abuse protection</th>
<th>Neglect protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>Majority of states</td>
<td>Majority of states</td>
</tr>
<tr>
<td>Psychosocial</td>
<td>State specific</td>
<td>State specific</td>
</tr>
<tr>
<td>Financial/material</td>
<td>Majority of states</td>
<td>State specific</td>
</tr>
</tbody>
</table>

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It has been suggested that aged abuse is at the stage child abuse was 20 years ago—the stage of missing data.
The presence of a confused elderly individual within the home has the potential of straining family relationships, and, in some cases, may result in abuse.

**TABLE 4**
HIGH RISK PROFILE (ABUSED)
- Female
- Caucasian
- Physically and/or cognitively impaired
- Dependent
- Exhibits problematic behavior

**TABLE 5**
HIGH RISK PROFILE (ABUSER)
- Family member (daughter)
- Ill-prepared or reluctant to provide care
- Ineffective coping patterns
- Life in disarray
- Alcohol or drug abuse
- Marital conflict
- Lack of communication skills

Nova Scotia (Haley, R.G., Unpublished data, 1983) and Newfoundland (Frecker Association on Gerontology, 1983) also supported the presence of aged abuse. Additional research is required to determine the full extent if the problem in this country is to be identified.

Incomplete statistical data is also reflective of the lack of mandatory reporting laws in Canada. Currently, there is no provincial or federal policy regulating reporting of suspected or actual aged abuse. Current legislation limits abuse to physical acts only (Table 2).

This lack of protection is even more apparent when compared to legislation in the United States (Table 3). Such legislation, although differing in their terminology and definitions, does address the elderly as a specific population to be protected (Thobaben, 1985). This is not yet done in Canada.

In spite of inadequate reporting techniques, it is generally felt that the problem of abuse in the elderly is at least as serious a problem as child abuse. Documentation difficulties are additionally compounded by the elderly victims. They rarely report acts of abuse and/or neglect. There are reasons for this: lack of physical or mental ability to report incidents; a lack of opportunity to voice their complaints; a desire not to get their children into trouble; embarrassment that they are subject to such treatment; fear of reprisals if they do complain; fear of abandonment in an institution. They also question whether they will be believed. These fears often outweigh the elder's fear of maltreatment causing episodes to go undetected, and thus unreported.

Having accepted that the elderly are subject to maltreatment by their families, there is then an attempt to explain the etiology of domestic abuse/neglect. This is done by describing the profiles of the abused, the abuser, and the crisis that precipitates maltreatment.

**Profile of the Abuser**

The literature strongly identifies family members (usually the daughter) as the most frequent abusers of older individuals. The significance of a family history of abuse is unclear. Steele (Johnson, 1979) states that abusers are usually relatives who were themselves neglected in their own childhood with or without physical abuse; thus a circular causality develops. Their role models taught them that maltreatment will solve problems. Koin (1984), on the other hand, states that there is nothing to support the idea that a child who was abused will in turn abuse their parents in old age.

Attitudes of abusers towards the aged have also been investigated. Abusers tend to describe the elderly as rigid and complaintive more fre-
When family members find their own lives in turmoil, they also find it more difficult to provide the care required by the older family member.

![Equilibrium (homeostasis) and Adaptive mechanisms](image1)

![Stressors and Ineffective mechanisms](image2)

Conceptually, however, it may be described as a disturbance in a steady state. This definition is based on the assumption that individuals attempt to maintain a state of equilibrium through adapting to stimuli in their internal and external environments. This is represented diagrammatically as a seesaw (Figure 1). In a state of crisis however, it is suggested that one's adaptive mechanisms are replaced by ineffective ones, and equilibrium is not achieved. There is also a lack of external resources to support adaptation. In such a crisis, the individual experiences helplessness, disorganization, and increasing tension.

In the maltreatment syndrome, this tension is manifested through the ineffective coping mechanisms of abuse and/or neglect. The imbalance has been produced by two stressors: 1) the problematic behavior of the elderly individual; and 2) the personal life disarray experienced by the caregivers themselves. This is supported by the fact that rarely is abuse and/or neglect premeditated (Anderson). This is represented diagrammatically in Figure 2.

It is hypothesized that constant stress experienced by the abuser lowers the maltreatment threshold. The caregiver is confronted with increased physical work, sleepless nights, constant vigilance, social isolation, frustration, low self-esteem and intra-family role conflict. Recognizing the tremendous burden placed on the family caregiver by a parent who is physically and/or cognitively impaired is important.

It is suggested that neither the characteristics of the elderly individuals nor the caregiver in isolation produce maltreatment; however, these characteristics working in association with a crisis situation can precipitate maltreatment. This is reflected schematically in Figure 3.

The Nurse's Role

The nurse potentially can come...
into contact with an abused and/or neglected elderly patient in a variety of settings: emergency departments, acute care units, community health agencies, or the home setting. Into each situation is brought one’s own attitudes, beliefs, and biases. These influence how the nurse handles a potential or actual maltreatment episode.

Self-awareness becomes the nurse’s initial responsibility. It implies a personal evaluation of one’s feelings towards older patients and one’s own aging process. If negative attitudes are held, it may result in an inability to discriminate the signs of maltreatment or a reluctance to act on data collected.

Additionally, self-awareness implies recognition of personal attitudes toward maltreatment. They may affect one’s ability to communicate openly with the elderly patient, the primary caregiver, and the immediate family. It is not uncommon when maltreatment is suspected that empathy and concern are felt for the victim and anger is projected towards the abuser. Objectivity through skilled communication and sensitivity is essential.

Assessment

The nurse’s assessment role begins at the initial contact with the elderly patient and continues with each subsequent interaction. The high risk profiles of the abused elderly and abuser presented in Tables 3 and 4 serve as part of the knowledge base on which to formulate one of three hypotheses: 1) the situation is not one of maltreatment; 2) the situation is one of potential maltreatment; and 3) the situation is one of actual maltreatment. If the situation is one of the latter two possibilities, the nurse proceeds with a more detailed assessment, which includes observational, interviewing, and measurement skills.

Assessment is multifaceted and focuses on the elderly individual, the primary caregiver, and the immediate family in which the elderly individual resides. For the elderly patient, the assessment process includes biophysiological and psychosocial behaviors. They may have a history of frequent visits to the emergency department, multiple bruising, fractures, lacerations, or abrasions in various stages of healing. The bruises are usually located on the face in a cluster formation. Head injuries, the result of extreme hair pulling, may also be present. The patient may also be overmedicated.

Neglect may be suspected if the physical examination shows that the aged patient is malnourished, dehydrated, or demonstrates wasting of subcutaneous tissue. Poor hygiene may indicate that no one is attending to basic personal needs. The condition and type of clothing and its suitability for the presenting weather conditions should be noted (Falconi).

Psychosocial indicators may include: wariness of contact with adults, extreme withdrawal or aggressiveness in certain situations, infantile behavior, poor social interaction with peers, and expression of ambivalent feelings toward family.

In assessing the primary caregiver, the nurse gains information about lifestyle, family structure, caregiving skills, and personality. Indicators of stress should also be noted. There are numerous questions to answer: does the caregiver have realistic expectations of the elderly individual? Is there knowledge and utilization of community and family resources? How is affection demonstrated? What other responsibilities does the caregiver have? For example, is the patient’s daughter responsible for not only her aging mother but also an ailing husband or rebellious teenager as well? In a Manitoba study, the amount of caregiver’s time required by their elderly parent ranged from 9 hours a week for limited help to 27 hours for extensive help (Shapiro, 1985). The stress of such responsibilities in a context of other high risk factors may be the catalyst to an abusive situation.

Finally, the family system itself is examined for its strengths: strong family ties, a sense of responsibility for their elders, adequate financial resources, or a large extended family nearby; and for its weaknesses: poor communication skills between members, role conflicts, and unrealistic expectations. To gain a clear understanding of the situation, the nurse communicates with the family and patient together as well as exclusively. Spending exclusive time with both parties may give each the opportunity to speak more candidly as well as allow the nurse to note for congruences or contradictions among family members.

A variety of tools have been developed to assist in this assessment process. These include Ferguson and Beek’s (1983) tool, H.A.L.F. which is an acronym for four factors recognized as having the potential for contributing to aged abuse: health status of the elderly client; family and older adult’s attitudes towards aging; living arrangements; and finances. Another instrument, labelled The Elder Assessment Protocol (TEAP), was developed by Fulmer and Cahill (1984), which consists of nine assessment categories. A third tool, devised in Canada, was presented by Ross (1985).

Several barriers may interfere with the assessment of maltreatment of the elderly. For example, neglect in the form of malnutrition, incontinence, falls, or withdrawal can be difficult to recognize as these states may be a result of chronic/multiple illness or misinterpreted as “normal” aging. To illustrate, most instances of abuse present in emergency units. Here, the patient may be cared for by a professional with limited knowledge of aging or aged abuse. Patients spend only a short time in emergency departments and it has been noted that doctors spend considerably less time with old patients than with young ones. Thus, the indicators of maltreatment are not recognized. In addition, as discussed earlier, detection can be difficult as the elderly rarely report acts of abuse and/or neglect for a variety of reasons: lack of ability or opportunity, fear of reprisal or institutionalization, or fear that they may not be believed.
In assessment, then, the nurse faces two challenges: 1) to fine tune assessment and communication skills that will facilitate the diagnosis of potential or actual maltreatment; and 2) to develop a strong sense of advocacy for the elderly patient in need of help.

It is important to stress that precision in documenting is vital. The objective of record keeping is to present a complete written description of the event. This includes evidence of maltreatment, a factual assessment of the patient, any observations of the primary caregiver, any interactions noted between the aged individual and the family, and any explanation given as to the cause of the presenting condition or injury. However, caution must be taken that a nursing diagnosis of abuse and/or neglect is based on facts and not on personal feelings. It is suggested that there is consultation with other health team professionals prior to finalization of such a diagnosis.

Interventions
Acting on the diagnosis, the nurse intervenes in four primary areas: personally; with the elderly individual; with the primary caregiver and family; and with society. There are no simple techniques to deal with such a complex issue.

On a personal level, the nurse needs a sound knowledge of the normal biophysiological and psychosocial aging processes. Awareness of interpersonal dynamics and developmental theory within the context of the aging family is also required. Added to this base is knowledge of aged abuse, including provincial and federal laws regarding maltreatment and community resources available in abusive situations. With this information at hand and the courage of professional convictions, the nurse is prepared to intervene.

Interventions with the elderly individual are both short and long-term in nature. Short-term techniques relate to the urgency of the situation. Emergency interventions must occur when the elder’s basic safety and subsistence needs are not being met. However, some theorists caution health care professionals to avoid “the rescue syndrome” (Falconi). This requires a realistic appraisal of both the required and the available interventions. In each situation, the nurse must keep in mind the environmental circumstances of the client and family.

Long-term interventions are directed primarily at meeting higher level needs, resulting in a positive lifestyle for the individual. Building on strengths and recognizing weaknesses, the patient is assisted to a state of optimum physical health. For instance, the older abused patient often suffers from low self-esteem and has difficulty trusting. The nurse provides consistency to facilitate the development of trust coupled with care and affection. Interaction with peers is encouraged and opportunities for this provided.

Interventions with the abuser are also both short and long-term in nature. Short-term management might mean relief of some of the stress being experienced by the abuser. If stress is related to the dependency of the older adult, this can be partially alleviated by referral to available community services such as respite beds, day care facilities, and day hospitals.

Long-term interventions see the nurse in the role of counselor. This relates to helping the abusive caregiver explore personal feelings about the aged adult, what factors are especially disturbing, how the response is triggered, and what other mechanisms are available to deal with stress, the goal being to reduce abusive risk factors. Despite their behavior, most abusers do care about their older family member and are not happy about what they are doing. They require a nurse who understands how difficult the situation is and who will not condemn.

Another intervention strategy is
education, for example, role modeling to the adult caregiver how to provide care or how to deal with the problematic behavior of the elder.

Because elderly abuse is a family concern, the family’s needs must also be addressed. One technique is education about normal aging to change ageism attitudes. Facilitating the family’s involvement of kin and friends in providing care so that dependency needs are shared is also beneficial (Ferguson & Beck). It is suggested by Ferguson and Beck that role theory be applied to realign family responsibilities, thus encouraging the growth of each member.

Finally, on a societal level, nursing interventions are long term. First are those actions directed towards educating the public about “growing old” in our society and effective ways of dealing with their own as well as their parents’ aging. Second are those techniques that educate the general population regarding the incidence, characteristics, and etiological factors of aged abuse and neglect. Additionally, the nurse can encourage the development of self-help support groups for persons who face difficult situations in caring for their aged family members and who are potentially abusive.

A final intervention is research. It has previously been acknowledged that elder abuse and/or neglect as a social problem is in its infancy. There are numerous problems that need addressing: the lack of clearly defined categories; the need for more valid documentation and statistics regarding the scope of the problem; and questions to be answered: how can the elderly be encouraged to report abuse? Does maltreatment by family members cease with institutionalization or does it then become neglect? What is the nature and extent of maltreatment within institutions?

To intervene effectively in all of these areas, nurses need to lobby for legislation that recognizes and defines maltreatment of the elderly. With such legislation in place, the development of a registry to report abuse/neglect could be developed.

The detection and treatment of elder maltreatment would be greatly advanced by such a system. Nurses would then be more effective in the assessment and intervention of aged abused.

**Conclusion**

Elderly abuse and/or neglect is increasingly being recognized as a major health problem within our society. The nursing profession can make a positive impact on this syndrome in their attempts to provide quality care to the aged. Through detection, education, clinical intervention, and research, nurses can help older patients approach their last days in dignity and safety.

**References**


Lau, E., Kosberg, J. Abuse of the aged by informal care providers. *Aging/September/October 1979.*


