Feature Article

Examining barriers to self-reporting of elder physical abuse in community-dwelling older adults

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ABSTRACT

One out of 10 older adults experiences elder abuse in their lifetime, though less than one third of these cases ever get reported. The purpose of this study was to describe older adults’ perceptions of physical abuse (PA) as a type of elder abuse including reasons why they may or may not self-report. An author developed vignette scale was used to present three types of PA and three barriers to reporting for each of three living situations. Older adults (n = 76) rated perceptions of whether or not the situation is abusive, likelihood of reporting and likelihood of reporting when presented with each of three barriers. The study participants had a consistent perception of PA; however the barriers affected their likelihood of reporting, which varied across types and situations. The results provide further evidence that reporting abuse is multifactorial and have implications for educational interventions.

Family members are the most loving and nurturing source of care for older adults, but they are also the most likely perpetrators of elder abuse. It is widely accepted by nurses that having family at the bedside is a positive thing and indicates available social support and help. However, despite recommendations from several professional nursing groups (e.g. forensic nursing, public health nursing) and the American Medical Association reporting of older adults and their family members for elder abuse is not routinely done. This puts the task to report elder abuse on the older adult which is problematic.

A 2010 national survey found that 1 out of 10 cognitively-intact community-dwelling older adults had been a victim of any type of elder abuse in the previous year. Furthermore, 1.6% had experienced physical abuse (PA) in the previous year. However, only 31% of these occurrences were reported to the authorities. Physical elder abuse has serious outcomes for older adults including injuries, psychological and physical trauma, increased emergency department visits, increased likelihood of hospital admission and increased mortality rates.

It has been acknowledged in the literature that older adults are not likely to self-report abuse. Proposed barriers to self-reporting include a wide range of views about definitions of abuse, fear of retribution, isolation, rationalizing abusers’ behaviors, dependency of the abuser on the older adult, reluctance to report family members and fear of being institutionalized, although the relationship of these proposed barriers to reporting PA of older adults remains unclear.

Older adults may have different perceptions about the definition and context of elder abuse, and therefore the specificity and scope of information that needs to be reported. When comparing older women from different socioeconomic backgrounds, women from high socioeconomic status included PA in their description of elder abuse but women from low socioeconomic status did not. Older adults also have described abuse as the commission of actions by another party, rather than acts of omission. Additionally older adults have described abuse as consisting of intentional acts, acts that are deliberate and with an intention to produce harm. In 1994, Hudson and Carlson began psychometric evaluation of a vignette instrument intended to measure older adult’s perceptions of abusive acts however this instrument has two issues. First, the definition of elder abuse on which the instrument is based is dated and no longer the accepted definition for research. Second, the instrument uses a semantic differential scale and this type of scale has been criticized as being problematic for older adults.

There is a need for prevention strategies and educational interventions to help increase reporting of elder abuse. In the designing of these strategies the older adult’s perceptions about abuse need to be considered. Moreover, it is especially important to consider the perceptions of cognitively-intact community-dwelling older adults.
older adults. First, considering this group is important because they have been identified in the literature as a ‘low risk’ group due to their status as socially embedded independent adults, which naively ignores the scope of diverse encounters by older adults coupled with physiological aging changes that make them vulnerable, and perceptions of older adults as naïve, frail persons who are easy targets for abuse. It has been suggested that the aggression experienced in elder abuse between family members is a product of the longstanding relationship dynamic based on power and control which is established long before the need for caregiving; therefore, making them an ideal target group for prevention and intervention efforts. Additionally, interpersonal violence is universal and can affect anyone regardless of age, race, ethnicity, social status and health status; therefore, ignoring cognitively-intact, community dwelling older adults in elder abuse research negates everything we know about interpersonal violence.

Therefore, the purpose of this research study was to describe community-dwelling older adults’ perceptions of PA as a type of elder abuse including reasons why they may or may not self-report PA, with the goal of developing educational interventions in the future.

Methods

The research question was addressed in a descriptive correlational study design. The university IRB granted exempt status for the study.

Sample

A convenience sample of community-dwelling older adults, age 60 years and older, was recruited from three senior centers and included members who frequented the sites and their respective meals-on-wheels clients representing Delaware’s three counties and its urban to rural demographic distribution. Senior center participants represent primarily active older adults with a diversity of living arrangements, disabilities, health status, and needs, for which the senior center environment may be their only social outlet or an enhancement to a very social life. While center membership was estimated at 6000 older adults less than one-fourth actually visited the sites during data collection. Meals-on-wheels participants represent primarily home-bound older adults with low visibility in society and research; their only socialization may be the weekday visit by a meal delivery volunteer. The views of both groups of community-dwelling older adults are important for the diversity of variables that contribute to their susceptibility to elder abuse.

Measures

The participants completed a demographic form and a vignette designed Older Adults’ Perceptions of Physical Abuse Scale (OAPPAS). The 20-item demographic form elicited older adults’ background (i.e., age, gender, education, and marital status), resources (i.e., financial status, caregiving assistance, frequency of family communication) and health (i.e., self-rated status, use of assistive device, disability). Items included closed-ended (i.e., age at last birthday), dichotomous (i.e., Do you walk with an assistive device?), rating (i.e., rate health: excellent, good, fair, poor), and multiple choice questions. Choice of items was based on the elder abuse literature, taking into consideration known family and social variables associated with risks of elder abuse and was used to examine the differences between two groups.

The 30-item OAPPAS consists of three vignette scenarios, each depicting a different living situation within which are presented three different types of PA actions, three possible barriers to reporting, and a forced-choice question asking to whom the respondent would report abuse with five options: police, doctor/nurse, friend, family member, and adult protection services. The three living situations include: older adult living independently with adult child caregiver visits, older adult living independently with paid caregiver visits, and older adult living with adult child. The three types of PA actions include physical touching, medication handling and restraints; and the three potential barriers chosen from the literature include: threat of placement in a skilled nursing facility, adult caregiver having limited resources, and older adult having limited resources (Appendix A). The physical touching includes hitting or burning the older adult. Medication handling includes acts of over-dosing or withholding needed medications from the older adult. Restraints include situations which restrict older adults’ movement and independence, such as locking them inside the house or hiding their cane so they cannot walk. Vignette design was chosen as it allows the investigator to examine context of perceptions.

For each vignette the respondent is asked to define each of the three PA actions on a 4-point Likert scale, with response options labeled definitely abuse (scored 4), probably abuse, probably not abuse, definitely not abuse (scored 1); and the likelihood of reporting the PA on a 4-point scale, with response options labeled definitely report (scored 4), probably report, probably not report, definitely not report (scored 1). Both perceived definitions and likelihood of reporting were elicited because whether or not older adult victims would report abuse is meaningless without knowing how older adults perceive abuse. Next in each vignette the three barriers to reporting are presented, to which a respondent is asked again to rate the likelihood of reporting the PA on a 4-point scale from definitely report (scored 4) to definitely not report (scored 1) after considering each of the three barriers.

OAPPAS is theoretically grounded in the family social support systems model, wherein abuse is a breakdown in family function resulting in non-supportive, destructive behaviors that require external intervention. The vignettes and initial 27-items were derived from an analysis of popular media reports retrieved from online news sources over a period of two months and the literature. It was field tested with five older adult advisory panel members of a local senior center to determine its face validity (outward appearance), clarity, and readability, time to completion and relevance to the lay person. After completing the vignette questionnaire (which was timed to determine the estimated time to completion of 20–30 min) the older adult panel provided feedback on layout, wording and clarity of the vignettes and questions in a focus group discussion. The vignette items were revised based on panel feedback and included layout of questions (i.e., lettered answers in vertical format was changed to statements followed by a horizontal scale with word descriptors), layout of paper (i.e., from portrait to landscape), a grouping of questions for each vignette in close proximity to each vignette, and a large print statement on the front page reminding participants this is a survey not a test.

Content validity of OAPPAS was estimated using a panel of five professionals with expertise in elder abuse and included three nurse researchers from academic settings and two directors from Delaware’s Adult Protection Services (APS). They evaluated the vignette scenarios and items for their degree of relevance on a 4-point scale from none to very, and provided feedback on questionnaire format and design. Index of content validity (CVI) was 1.0 based on the averages of the ratings across scale-items. OAPPAS was revised based on the content experts’ feedback, and included the addition of a question about whom respondent would report abuse, (i.e., changed health care provider to nurse/physician), question order (i.e., multiple choice question moved from last to first following each vignette scenario), and suggestions for expanding the directions and placing them on a separate page. The
Procedures

So as to maximize an opportunity for participation in the study by home-bound, frequent and infrequent users of the senior centers, three strategies for recruiting were employed. First, the principal investigator (PI) presented the project at popular center events and answered questions. Following the PI’s presentations, data were collected in person and on-site by distribution of study materials (letter of invitation, demographic form and vignette questionnaire) which participants completed and returned to the PI. Second, data were collected when the PI was not on-site by numbered packets left at a central location. Persons hearing the PI’s presentation were given the option of picking up a packet at a later point in time from that central location. Interested persons accessed packets, completed forms at their convenience, and inserted them in a closed container in a secure location at each center. Third, recruitment of participants from meals-on-wheels recipients included two phases. A flier explaining the project and how to contact the researcher with questions was delivered with the meals. Including informational fliers with meals is a common practice at the senior centers. Thereafter, data collection packets were delivered with the meals and if older adults wished to participate they completed the forms and returned them to the meal delivery volunteer on a subsequent visit. Meal delivery volunteers were responsible only for delivery and pick up of study materials which was consistent with their usual tasks, therefore they received no special training on the study.

Analysis

The data were entered into SPSS for statistical analysis. Descriptive statistics were used to describe the sample demographics as well as situations and actions the sample perceived to be abusive and to determine which barriers were most important in considering reporting PA. Independent t-tests were used to examine differences between the groups (senior center and meals-on-wheels). Logistic regression analysis was used to evaluate change in reporting after introduction of barriers. For the logistic regression analysis the data from OAPPAS were transformed to dichotomous responses (definitely/probably abuse = yes abuse, definitely not/probably not abuse = not abuse; definitely/probably would report = yes I’d report, definitely not/probably not report = no reporting). The dichotomous responses were used in Figs. 1 and 2.

Results

The sample (N = 76) had a mean age of 74.25 years (range 60–95 years, SD 8.8), was 68% female, 49.3% widowed and 10% home-bound and receiving meals-on-wheels. Most participants lived alone (47.9%) and in a house (74%). A majority of the sample felt comfortable with their financial status with enough money to meet basic needs (62.2%). Assistive devices, such as walkers, were used by 29.6% of the sample and 36.8% reported having a physical impairment. Participants (72.6%) reported they required no assistance with ADLs or IADLs. Relationship with family members was reported as either excellent (45.2%) or good (46.6%). Reported level of disability was the only response that was statistically different between the two groups, with meals-on-wheels participants reporting a higher level of disability (p = 0.002).

Independent t-tests indicated that there were no statistical differences among answers to the OAPPAS between the senior center and meals-on-wheels groups. Therefore, their answers were combined for subsequent analyses. For all three OAPPAS vignette scenarios participants indicated they would most likely report the abuse to a family member (Table 1). Also, participants indicated they would be more likely to report the abuse to the police than to a doctor or nurse.

OAPPAS scenario A described an older adult living independently with adult child caregiver visits. When presented with the actions describing PA through physical touching and medication handling, most older adults identified these actions as abusive but fewer indicated they would report abuse (Fig. 1). When presented with the actions describing PA by restraints only 25.4% of older adults identified the action as abusive. However when the three barriers were presented perceived likelihood of reporting dropped for threat of placement in SNF (61.1%), adult child limited resources (27.8%) and personal limited resources (50%) (Fig. 2). Selecting definitely/probably would report restraint abuse was the only significant independent predictor for reporting abuse after considering each of the three barriers: placement in SNF (p = 0.006, OR = 7.1), adult child limited resources (p = 0.001, OR = 11.3), and personal limited resources (p = 0.014, OR = 4.5).

OAPPAS scenario B described an older adult living independently with paid caregiver visits. The majority of older adults identified all three PA actions as abusive and indicated they would report all three. In this vignette scenario PA through medication handling was scored the lowest, with only 88.6% of older adults reporting....
identification of abuse (Fig. 1). Perceived likelihood of reporting decreased when presented with each of the barriers, though threat of institutionalization had the greatest decrease (77.3%) (Fig. 2). None of the items from vignette scenario B or from the demographic variables predicted the responses after considering the barriers.

OAPPAS scenario C described an older adult living with an adult child. As in scenario B, the majority of older adults identified all three PA actions as abusive and indicated they would report all three. However, scores were more variable in this vignette, with 88.9% identifying physical touching as abuse, 97.2% identifying medication handling as abuse, and 85.7% identifying restraints as abuse (Fig. 1). Again, perceived likelihood of reporting decreased when presented with each of the barriers (Fig. 2). In this scenario, the barrier of adult child with limited resources had the greatest decrease with only 62.1% indicating they would still report abuse. None of the items from scenario C or from the demographic variables predicted the responses after considering the barriers.

Upon examination of responses across OAPPAS scenarios, more older adults indicated the situation was abusive in scenario C when the adult child was withholding medication to purposely make the elder sick and require hospital care (97.2%), than an adult child withholding medication because it is expensive (85.3%) in scenario A. Additionally, most participants did not perceive being locked out of their basement which contained their food pantry under the pretense of preventing falls down the stairs (scenario A) as abusive (25.4%) though they did perceive being locked inside their house with the pretense of getting lost if allowed to go out (scenario C) as abusive (85.7%).

Discussion

The findings from this study suggest that older adults are able to identify physically abusive situations, though the perceptions of abuse vary by both the abusive act and by who is the perpetrator. The participants perceived acts by a paid caregiver to be abusive at a higher rate compared to an adult child caregiver. This underscores the dynamic role family relationships play in elder abuse.

Perceptions of abuse changed based on the context of the act. For example, the participants were presented with two situations of an adult child withholding medication in scenarios A and C and the majority identified inappropriate medication handling as abusive. Nandlal and Wood17 found that older adults perceive actions to be abusive when they have negative consequences. The older adults in this sample may have perceived consequences to be different in the vignettes based on their personal values, experience or knowledge causing some of the variability in answers. There is likely variability in the value placed on a level of independence, safety and strength of the argument that aligns with the logic of probability for the participants in this study. For example, it may be acceptable to be locked out of one’s basement if it prevents falls but not acceptable to be locked in one’s house, thereby preventing freedom to exit at will. Perhaps the probability of falling and the generally known downward cycle that follows a fall (e.g., fracture, hospitalization, immobility, infection and death), is perceived to be a greater consequence than the probability of getting lost upon exiting one’s house. These are important distinctions to consider in designing educational interventions for community-dwelling older adults. Additionally, healthcare professionals need to be aware of the variation in perceptions and provide educational materials/resources and contacts to assist their patients in understanding the nature of abuse and reasoning behind it, while reinforcing that there is no excuse for any degree of elder abuse. However, more research on the contextual aspects of reporting elder abuse, including perceptions of actions and consequences, is warranted.

![Table 1](image)

<table>
<thead>
<tr>
<th>Who would you report abuse to?</th>
<th>Scenario A (n = 59)</th>
<th>Scenario B (n = 59)</th>
<th>Scenario C (n = 65)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>Police</td>
<td>39 (23)</td>
<td>16.9 (10)</td>
<td>21.5 (14)</td>
</tr>
<tr>
<td>Doctor/nurse</td>
<td>6.8 (4)</td>
<td>8.5 (5)</td>
<td>13.8 (9)</td>
</tr>
<tr>
<td>Friend</td>
<td>6.8 (4)</td>
<td>5.1 (3)</td>
<td>15.4 (10)</td>
</tr>
<tr>
<td>Family member</td>
<td>37.3 (22)</td>
<td>40.7 (24)</td>
<td>35.4 (23)</td>
</tr>
<tr>
<td>APS</td>
<td>8.5 (5)</td>
<td>27.1 (16)</td>
<td>12.3 (8)</td>
</tr>
<tr>
<td>No one</td>
<td>1.7 (1)</td>
<td>1.7 (1)</td>
<td>1.5 (1)</td>
</tr>
</tbody>
</table>
Additionally, while many researchers have suggested reasons why an older adult may not self-report abuse,12,13 the results of this study begin to fill the gap in the context of the rationale. However, they also raise further questions about the complexity of these perceptions and the value placed on individually perceived consequences. Consistent with current thought, the threat of being placed in a skilled nursing facility was an important barrier to self-reporting. This finding has implications for educating older adults about intervention options for victims of abuse. Nursing home placement is not the usual intervention for victims of abuse. Bringing about awareness of safe houses and short-term residences with independent living options may encourage older adult victim's in immediately dangerous situations to self-report if they are able.

For OAPPAS scenarios A and C, which described an adult child as the perpetrator, limited resources were an additional barrier. The older adult participants were reluctant to report abuse if the adult child was dependent on them for support. This supports Pillemers hypothesis that the dependency of the adult child on the older adult is an important factor in the development of elder abuse.20 Pillemers suggested the pressure of the dependency may cause the adult child to respond with abusive actions,20 and these data suggest the older adults may make exceptions for their adult children because of their dependency thereby creating a cycle of abuse. Additionally, participants were reluctant to report abuse if their caregiving needs were increasing and they had limited options for caregivers. It would be important to include descriptions of community-based services in educating older adults about elder abuse. This finding also has implications for healthcare professionals to assess family relationships and ask about alternate available caregivers. The absence of an alternate caregiver may impede an older adult’s likelihood of self-reporting abuse.

Most of the participants did not select doctor/nurse as the person they would confide in about elder abuse. This highlights the need for elders to be screened at every healthcare visit. While community-dwelling older adults may have a long-term relationship with their primary healthcare provider, episodes of illness versus usual annual exams or screenings the frequency of contact with their provider and the nature of the client–provider relationship will likely determine how comfortable an older adult is with contacting the provider about the sensitive topic of being a victim of abuse. Based on these data, healthcare professionals should ask about the possibility of abusive acts in a variety of situations, rather than asking simple specific questions such as “do you feel safe at home”. This finding is also important as it suggests educational interventions for community-dwelling older adults should explain the role healthcare providers can provide in reporting and intervening in elder abuse.

The study has several limitations that must be considered in evaluating the findings. The study was originally designed to test several hypotheses and a sample size of 184 was estimated through a power analysis.21 However, due to difficulty recruiting, less than 100% of the participants filled in the entire questionnaire. This reduced the power of the study to test certain hypotheses. The participants who did not complete the questionnaire may have had different perceptions or approaches to elder abuse. Additionally, the OAPPAS was field tested with a panel of older adults the items and content may not have captured appropriateness of word choice that may vary by generation, culture and beliefs, experience or awareness of elder abuse, and reading level. Therefore, when respondents were asked to imagine themselves in certain situations they may not have understood or had a frame of reference with which to interpret the response resulting in missing answers.22

The passage of the Elder Justice Act, a section of the Affordable Care Act, increases the federal response to elder abuse and is intended to provide funds for increasing prosecution efforts, increasing the forensic capacity as well as funds for the creation of victims’ services such as safe havens.23 These are all important programs for combating the public health epidemic of elder abuse. However, an essential first step is increasing public awareness of elder abuse and creating opportunities for community-based educational programs to increase reporting and victim identification.

Acknowledgments

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References


Appendix

Scenario C

You are an elder living with your adult child.

21. Who would you report abuse to?

<table>
<thead>
<tr>
<th>Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police</td>
</tr>
<tr>
<td>Doctor/nurse</td>
</tr>
<tr>
<td>Friend</td>
</tr>
<tr>
<td>Family member</td>
</tr>
<tr>
<td>Adult protective services</td>
</tr>
</tbody>
</table>

You need help bathing. Your adult child helps you into the shower and turns it on, but it is too hot and it scalds you despite your protests. You now resist whenever you need to be bathed.

22. Is this abuse? Definitely abuse
23. Would you report abuse? Definitely would

Your adult child is increasingly frustrated taking care of you and working full time. Your adult child gives you your medication everyday. Your adult child has been withholding your heart pill from you hoping you would get sick and be admitted to the hospital or a nursing home.

24. Is this abuse? Definitely abuse
25. Would you report abuse? Definitely would

One afternoon, you went for a walk and got lost because of construction on local streets. The police find you and call your adult child. From then on, when your adult child goes somewhere they lock you in the house.

26. Is this abuse? Definitely abuse
27. Would you report abuse? Definitely would

Considering the above scenario, would you report abuse if:

- You have no other family member to be your caregiver so you may be placed in a nursing home.
- Your adult child is financially dependant on you and cannot afford their home without your help.
- You are unable to take care of yourself so you cannot live by yourself.

28. Would you report abuse? Definitely would
29. Would you report abuse? Definitely would
30. Would you report abuse? Definitely would