

This article was downloaded by: [Marie Beaulieu]

On: 16 April 2012, At: 17:50

Publisher: Routledge

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



Journal of Elder Abuse & Neglect

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/wean20>

Institutional Abuse of Older Adults: What We Know, What We Need to Know

Lynn McDonald PhD ^a, Marie Beaulieu PhD ^b, Joan Harbison PhDRSW ^c, Sandra Hirst PhD ^d, Ariella Lowenstein PhD ^e, Elizabeth Podnieks BSNEd ^f & Judith Wahl BALLB ^g

^a Institute for the Life Course and Aging, University of Toronto, Toronto, Ontario, Canada

^b Department of Social Work and Gerontology Research Centre, University of Sherbrooke, Sherbrooke, Quebec, Canada

^c School of Social Work, Dalhousie University, Halifax, Nova Scotia, Canada

^d Brenda Strafford Centre for Excellence in Gerontological Nursing, University of Calgary, Calgary, Alberta, Canada

^e Department of Gerontology and Center for Research and Study of Aging, University of Haifa, Haifa, Israel

^f Ryerson University, Toronto, Ontario, Canada

^g Advocacy Centre for the Elderly, Toronto, Ontario, Canada

Available online: 08 Dec 2011

To cite this article: Lynn McDonald PhD, Marie Beaulieu PhD, Joan Harbison PhDRSW, Sandra Hirst PhD, Ariella Lowenstein PhD, Elizabeth Podnieks BSNEd & Judith Wahl BALLB (2012): Institutional Abuse of Older Adults: What We Know, What We Need to Know, *Journal of Elder Abuse & Neglect*, 24:2, 138-160

To link to this article: <http://dx.doi.org/10.1080/08946566.2011.646512>

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: <http://www.tandfonline.com/page/terms-and-conditions>

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae, and drug doses should be independently verified with primary

sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand, or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

Institutional Abuse of Older Adults: What We Know, What We Need to Know

LYNN McDONALD, PhD

Institute for the Life Course and Aging, University of Toronto, Toronto, Ontario, Canada

MARIE BEAULIEU, PhD

Department of Social Work and Gerontology Research Centre, University of Sherbrooke, Sherbrooke, Quebec, Canada

JOAN HARBISON, PhD, RSW

School of Social Work, Dalhousie University, Halifax, Nova Scotia, Canada

SANDRA HIRST, PhD

Brenda Strafford Centre for Excellence in Gerontological Nursing, University of Calgary, Calgary, Alberta, Canada

ARIELLA LOWENSTEIN, PhD

Department of Gerontology and Center for Research and Study of Aging, University of Haifa, Haifa, Israel

ELIZABETH PODNIEKS, BSN, EdD

Ryerson University, Toronto, Ontario, Canada

JUDITH WAHL, BA, LLB

Advocacy Centre for the Elderly, Toronto, Ontario, Canada

Although Canadian policies support “aging in place,” there still will be a number of older adults who will require institutional care in the future. Most research on elder abuse, however, has focused on domestic abuse and has paid less attention to institutional abuse. The purpose of this article is to comprehensively review current research to identify gaps in knowledge and methodological issues in the study of institutional abuse. Overall, 49 studies in English and 20 studies in French were reviewed, and 11 key-informant interviews were conducted with methodological

Address correspondence to Lynn McDonald, Institute for the Life Course and Aging, University of Toronto, 263 McCaul Street, Room 328, Toronto, Ontario M5T 1W7, Canada.
E-mail: lynn.mcdonald@utoronto.ca

experts. Methodological challenges are addressed in light of the review and interviews.

KEYWORDS elder abuse, institutions, nursing homes, prevalence, incidence, neglect, mistreatment

INTRODUCTION

Anecdotal evidence suggests that the problem of elder abuse and neglect in institutional settings is widespread (Hawes, 2002). According to the World Health Organization in 2002, the mistreatment of older people in facilities for continuing care has been identified in almost every country where these institutions exist (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). In Canada, the proportion of people aged 65 or older living in institutions has remained stable at approximately 7% since 1981 (Ramage-Morin, 2005). However, over the same period as the elderly population increased, the actual number living in institutions rose from about 173,000 to more than 263,000 (Ramage-Morin, 2005). If the same level of institutionalization is maintained, it has been projected that over half a million Canadians will require long-term care by 2031 (Trottier, Martel, & Houle, 2000).

The need for greater attention to institutional abuse stems from a number of conditions. First, according to Statistics Canada, in 2006, Canadians aged 65 and over comprised 13.7% of Canada's population, a larger proportion than in the United States (Statistics Canada, 2007), and by 2031, the aged will account for approximately one quarter of the Canadian population (Statistics Canada, 2007). Second, Canada's population aged 80 years and over will almost double, from 1.2 million in 2006 to 2 million in 2026. Third, women, on average, live longer than do men, and as a result they represent two-thirds of those over age 80 (Turcotte & Schellenberg, 2007). Accordingly, in Canada, gender differences exist, with more females institutionalized than males (Statistics Canada, 2003).

Finally, of the older adults in Canada, approximately 7% live in long-term care facilities, and 20 to 30% of them will likely spend the last years of their lives in a care setting (Division of Aging and Seniors, 2006). It is the oldest seniors, those 85 years and older, who constitute the largest age group in long-term care settings (Public Health Agency of Canada, 2001). Residents of long-term care settings are more likely to have some degree of cognitive impairment and a disabling condition (Spector, Fleishman, Pezzin, & Spillman, 2001). Only about 12 to 13% of residents are married and many others lack a close family member who lives within an hour of the facility (Hawes, 2002). Thus, residents in long-term care facilities tend to be frailer and more dependent on others to provide care, and therefore are more vulnerable to abuse and neglect.

Most research on elder abuse and neglect has focused on the prevalence, causes, risk factors, and interventions for older adults living in the community and has paid less attention to those living in congregate housing (Comijis, Pot, Smith, Bouter, & Jonker, 1998; Lowenstein, Eisikovits, Band-Winterstein, & Enosh, 2009; O'Keefe et al., 2007; Sanmartin & Iborra, 2007; Thomas, 2000). This is extraordinary since abuse in institutions has been common knowledge since Peter Townsend published his landmark study in the *Last Refuge* in 1962.

Awareness of a problem but not knowing the extent or nature of it makes it difficult to create evidence-based policies that would provide a blueprint for resources and programs necessary to ameliorate the abuse. This project represented an initial attempt to understand these changing conditions. The specific objectives of the literature review were (a) to identify and summarize research on the incidence and prevalence of abuse in institutional settings, the types of abuse, and the risks and causal explanations of it; (b) to identify knowledge gaps and possible future research directions; and (c) to develop strategies for collecting Canadian prevalence data and to identify issues and challenges associated with them.

METHODS

Two teams of researchers undertook separate reviews of the extant research on institutional abuse in the English and French literature. A search was undertaken of over 22 databases, followed by searches of university online book catalogues and the Internet. The third strategy involved searches of Canadian government websites and archives, and websites of Canadian and international elder abuse advocacy organizations. The reference lists of all relevant materials retrieved were inspected for potentially relevant articles not previously identified. The inclusion criteria for the abuse research in institutions were as follows: (a) published between 1998 and 2008, unless seminal articles or reports prior to this decade; (b) collected qualitative or quantitative data; (c) published in English or French; and (d) published in other languages if relevant to the focus of review. Due to the amount of material retrieved, the following exclusion criteria were applied: (a) quantitative studies that included five or less cases; (b) studies about the quality of care in institutional settings that did not explicitly relate to elder abuse; (c) theses and dissertations; and (d) studies that evaluated assessment instruments used to identify elder abuse. A total of 49 studies in English and 20 studies in French were selected for review after application of the criteria: 65 studies from peer-reviewed journals and 4 studies from the gray literature. Each study selected was critically appraised for quality using Law et al.'s (1998) evidence-based review format that was adapted for research on institutional elder abuse. Data on the designs, methods, data sources,

samples, measures, results, and other variables in the studies were summarized in tables. International key informants who had conducted national prevalence studies, whether about domestic or institutional abuse, also were interviewed about the methodological issues faced in launching a prevalence study ($N = 11$).

RESULTS

There were four qualitative studies and one quantitative study of abuse and neglect in institutions in the English Canadian research. The qualitative studies addressed staff labor appeals following allegations of abuse (Bigelow, 2007), financial abuse of mentally incompetent older adults (Bond, Cuddy, Dixon, Duncan, & Smith, 1999), and two studies of resident perceptions of abuse (Hirst, 2000, 2002). Another study (Bravo, Dubois, De Wals, Hebert, & Messier, 2002) that investigated the relationship between regulatory status, quality of care, and mortality was included because of its implications for elder abuse. The French studies were retrieved from Québec, France, and Switzerland. Five of the 20 retrieved studies adopted a quantitative approach: one on the prevalence of abuse in France (Despont & Rapin, 2000; A. M. Durocher, di Pompeo, Puisieux, Dewailly, & A. Durocher, 2000), types of abuse (Durocher et al., 2000), risk factors (Daloz, 2007; Despont & Rapin, 2000; Durocher et al., 2000; Plamondon & Nahmiash, 2006), methods of prevention (Tremblay, 2004), and explanations of abuse (Terreau, 2007). The qualitative studies were more extensive and covered issues like the dignity of older people (Malo, 2000), definitions (Scodellaro, 2006; Thomas, Scodellaro, & Dupré-Lévêque, 2005), interventions (Lajeunesse, 2000; Roulet Schwab & Christen-Gueissaz, 2006), and the rights of older adults (Charpentier & Soulière, 2007; Labbe, 1998). There were no incidence or prevalence studies of abuse and neglect in Canadian institutions.

Evidence for Institutional Abuse

A review of the research revealed that there are few new studies world wide since the trail blazing research of Pillemer and Moore (1989). The countries with recent studies included Germany, the United States (US), and Sweden. In Germany, Goergen (2001, 2004), following on his 2001 pilot, used a multimethod study to examine abuse and neglect using 251 in-depth interviews in 8 nursing homes and a survey of 361 staff in 27 nursing homes randomly selected in one area of Germany. The measures of abuse were based on the Conflict Tactics Scale (Strauss, 1979), commonly used in studies of family violence, and the scales developed by Pillemer and Moore (1989).

Over 70% of staff reported in the survey that they had behaved at least once in an abusive or neglectful way toward residents over a one-year

period. Psychological abuse and neglect were the most common forms reported by over 50% of the sample. Sexual abuse was not reported. More than 70% of staff reported they had observed at least one incident of abuse or neglect by their coworkers during the same period. In the in-depth interviews, 70% of nursing staff reported that they had engaged in at least one incident of abusive or neglectful behavior, whereas slightly more staff (77%) had witnessed one or more incidents. The fact that there was no correlation between the ratio of residents to staff but a correlation between the ratio of residents to the ratio of registered nurses for observed incidents suggests that it is not the number of the staff but the quality of the staff that may help prevent abuse. The response rate was only 36% and, as a result, prevalence rates are not conclusive.

In the United States, Allen, Kellest, and Gruman (2003) analyzed nursing home complaints ($N = 3443$) related to resident care and abuse from 1998 to 2000, based on data from the Ombudsman Reporting System in Connecticut and all nursing homes in the state. Resident abuse, gross neglect, and exploitation included the subcategories of physical, sexual, verbal, or mental abuse, financial exploitation, resident-to-resident physical or sexual abuse, as well as other incidents (e.g., overdose of medication). Of the nearly 4,000 complaints received, 8% were about abuse. Abuse complaints were made against 122 nursing homes: physical abuse ($N = 50$), gross neglect ($N = 23$), verbal abuse ($N = 23$), financial exploitation ($N = 16$), sexual abuse ($N = 15$), and resident to resident abuse ($N = 14$). Larger facilities, unionized staff, and the presence of semiprivate rooms were associated with higher rates of abuse and care complaints. While the sample was large, it was biased toward those who report since not all families or older residents report, and findings only apply to Connecticut.

Harris and Benson (1999) conducted the first national study on the prevalence of theft in American nursing homes. A multistage cluster sampling technique was utilized where 47 nursing homes agreed to participate in the survey representing 417 family members as proxies and 1,116 employees. The response rate for the nursing homes was 97%, and the response rate for employees was lower at 22%. Based on the family responses, the researchers suggest that the prevalence rate for theft in nursing homes is one in five residents. Staff members who are abused by patients and hold negative attitudes toward them are at the greatest risk for engaging in theft. The response rate for staff was low and did not accurately reflect all levels of the nursing hierarchy. The report of family members could be misleading because they attributed the theft to the confusion of the resident.

In Sweden, using a cross-sectional representative survey, 499 nursing staff from 19 residential settings participated in a survey about their knowledge of elder abuse in these settings (Saveman, Astrom, Bucht, & Norberg, 1999). Within the preceding year, 11% of the staff reported being aware of

at least one incident of abuse, and 2% reported that they themselves had been abusive toward residents. Of the incidents reported, 74% were physical abuse, 71% psychological abuse, and 56% neglect and maltreatment. The definition of elder abuse provided in the study was borrowed from a European elder abuse project so that a few cross-national comparisons could be made. Because the sample is based on two representative municipalities, the study is generalizable to others in Sweden.

In the gray literature, a widely cited U.S. government report provided some evidence of the circumstances within institutional settings that directly and/or indirectly indicate abuse. A study for the U.S. House of Representatives investigated physical, verbal, and sexual abuse in nursing homes (Minority Staff of the Special Investigations Division, 2001). This study analyzed data collected during a two-year period in two U.S. government databases: (a) the Online Survey, Certification, and Reporting system that compiled reports from nursing home inspections; and (b) reports of the results of state investigations into nursing home complaints. Researchers found that over 30% of nursing homes had been cited for an abuse violation with actual or potential harm to residents. Of these nursing homes, 7.8% were cited for violations that caused actual harm and 1.5% for violations that caused actual or potential death or serious injury. The study represents reports from numerous agencies and is biased according to who can and who does report.

Two studies undertaken by nongovernmental organizations provide evidence of the extent of elder abuse in institutions. A study undertaken by the Atlanta Long-Term Care Ombudsman Program (2000) and the Atlanta Legal Aid Society involved interviews with a nonrandom sample of 80 residents from 23 nursing homes, including 10 that were previously identified as "problem homes." Definitions of abuse, including physical, psychological, and sexual assault as well as neglect, were provided. Forty-four percent of those interviewed reported that they had been abused, and 38% reported witnessing the abuse of other residents. Ninety-five percent of residents said that they had either experienced neglect or witnessed the neglect of other residents.

The National Center on Elder Abuse (Teaster, Dugar, Mendiondo, Abner, Cecil, & Otto, 2006) conducted a nationwide study of elder abuse based on a survey of Adult Protective Services (APS) administrators who provided state-level data on reports of elder and vulnerable adult abuse. Thirteen state APS programs had authority to investigate elder abuse in long-term care settings and reported 6.2% of all substantiated cases of abuse occurred in these settings, while 1.8% occurred in assisted living facilities (and either workplaces or motels/hotels). The number of substantiated reports from these 13 states was not provided.

Weatherall (2001) was the first researcher to investigate the extent of elder abuse in New Zealand's residential facilities using definitions of elder

abuse and neglect adopted from Age Concern New Zealand, a national non-government organization. Interviews were conducted with 26 managers from 27 facilities in one city chosen from a Ministry of Health list of facilities. The study revealed that nearly all managers (92%) identified at least one instance of abuse toward a resident in the prior year. Eight facilities had at least one resident who was admitted within the past 6 months due to elder abuse. Psychological abuse was the most prevalent form and was usually perpetrated by a staff or health care worker.

Types of Abuse

A number of studies have examined a range of types of abuse in institutional settings. These studies are mainly quantitative and rely on confirmed or alleged cases of elder abuse that have been brought to the attention of professionals or via self-report. Study populations include the administrative and care staff of institutions, the residents themselves, their friends, and family members. The degree of and type of abuse reported is a matter of what questions were asked and/or how answers were interpreted. Most studies do not stray from the common types of abuse, including physical, psychological, and financial abuse [e.g., Hirst (2000, 2002) in Canada; Furness (2006) in Great Britain; Despont & Rapin (2000), Thomas et al. (2005) in France; Goergen (2001) in Germany; and Jogerst, Daly, & Hartz (2005) in the United States]. There is little agreement on definitions, so the rates reported vary widely. For example, while Goergen (2004) used a combination of the Conflict Tactics Scale and the instrument used by Pillemer and Moore (1989) in his institutional study, Saveman et al. (1999) used a European measure, which is much broader, militating against cross-country comparisons. Two types of abuse are garnering more attention of late.

A less-researched type of abuse, sexual abuse has received more recent attention. Roberto and colleagues (2004, 2005) examined female adult sexual abuses cases in Virginia, USA. They collected data from 125 cases of sexual abuse against women from APS units across the state over a five-year period. They showed that most identified perpetrators were older males. Family members were most likely to abuse women living in the community, whereas women living in facilities usually were abused by another resident. Related studies by Teaster and colleagues (2003, 2004) showed that women are disproportionately represented among sexual abuses cases, and women aged 70–79 are more likely to be victims of unwelcome interest than older women. In their case study approach, examining 20 residents involved in civil suit cases in the US, Burgess, Dowdell, and Prentky (2000) showed that victims of sexual abuse in nursing homes were predominantly female (90%), 60 years and older (85%), white (80%), with cognitive impairment due to dementia or other cognitive/neurological disorders (85%), and nonambulatory.

Roberto and Teaster (2007) examined sexual abuse among men, studying 17 cases from APS in Virginia, finding that the most frequently experienced abuse was kissing and fondling and unwelcome interest in their body. The related work of Teaster and colleagues (2007) studied 26 cases of alleged sexual abuse of older men in nursing homes over a six-month time period across five states. They found that the institutional sexual abuse of older men crosses traditional cultural, gender, and role boundaries for victims and perpetrators.

Studies have considered sexual abuse specifically involving older adults with dementia. Burgess and Phillips (2006) conducted a retrospective record review of 284 cases of elder sexual abuse that were brought to the attention of professionals involved in the cases. Older people with dementia, compared to those without a diagnosis, were abused more often by persons known to them, presented behavior cues of distress rather than verbal disclosures, were easily confused and verbally manipulated, and were beaten. Suspects who were identified had a lower chance of being arrested, indicted, or plea bargained.

The second type is resident to staff violence, which has been alluded to as one of the main causes of abuse in a number of studies dating back to the earliest study on institutional abuse (Pillemer & Moore, 1989). Newer studies confirm these original findings (Goergen, 2004; Harris & Benson, 1999) suggesting that this is an important area of research. Of the 13 articles reviewed, eight were quantitative studies (Almvik, Rasmussen, & Woods, 2006; Payne & Appel, 2007), two were qualitative studies (Shaw, 2004), two were mixed method studies (Armstrong et al., 2008; Synder, Chen, & Vacha-Haase, 2007), and one was a government report (Canadian Institute for Health Information, 2008).

The frequency of aggression varied greatly within the studies. The Canadian Institute for Health Information's (2008) study of five nursing homes found that 10% of residents were physically abusive and 16% were verbally abusive to staff or other residents. Similarly, Åström, Karlsson, Sandvide, Bucht, Eisemann and colleagues (2004) found that 10.3% of nursing staff reported incidents of violence during the year of investigation. In contrast, some of the studies reported higher rates of violence, 37.5% in Norway (Almik et al., 2006) and 55% in Sweden, (Åström et al., 2002). Armstrong et al. (2008), in a nonrandom sample, found that 89.7% of personal support workers indicated they had experienced some form of physical violence from residents and their family members while at work.

In terms of resident characteristics, the Canadian Institute for Health Information (2008) found that the odds of residents exhibiting aggressive behaviors were almost four times (3.9) higher for those with delirium, three times higher for residents with either signs of depression or insomnia, and 2.5 times higher for those dependent in activities of daily living. For those residents assessed with depression and delirium, the prevalence of

aggressive behavior was over seven times higher (72%) than for those with no signs of these conditions. Factors that provoked the residents vary but are related to resistance to care (e.g., Almvik et al., 2006; Åström et al., 2004).

Risk Factors

Research conducted on the specific factors believed to be associated with elder abuse and neglect is limited to a few studies (e.g., Godkin, Wolf, & Pillemar, 1989), and these are constrained by methodological challenges. Growing interest in risk factors stems from the need for protocols to assess individuals at risk, to evaluate the nature of the abuse and neglect, and to select relevant interventions. The chief factors that have been linked with abuse include the type of abuser, the intergenerational transfer of violence, dependency, the law, stress, financial factors, and structural factors such as size or ageism.

In terms of structural risks, Allen et al. (2003) conducted a retrospective case record review of 3,443 complaints registered with the Connecticut Long-Term Care Ombudsman Office. They found that larger nursing homes were associated with higher rates of abuse complaints, facilities with unionized staff were more likely to have abuse and care complaints, and the semiprivate room rate was positively associated with abuse complaints. Similarly, Goergen (2004), in his studies of employees in nursing homes in Germany, found that subtypes of elder abuse and neglect (e.g., staff shortages) had differential correlation patterns with measures of work stress for nursing home staff. A European study by Daloz, Bénony, Frénisy, and Chahraoui, (2005) showed that burnout on the part of staff meant that they did not intervene when they might have helped the person. Bredthauer, Backer, Eichner, Koczy, and Nikolaus (2005) showed that when adjusting for age, existing comorbidity, and baseline functional abilities, a resident's length of survival was not significantly affected by the regulatory status of an institution.

Numerous studies have shown that patients diagnosed with dementia and/or delirium, again severe in nature, were more likely to be restrained than patients with other diagnoses (Bredthauer et al., 2005; Saveman et al., 1999; Teaster et al., 2007; Teaster & Roberto, 2003, 2004; Wang, 2005, 2006). Burgess and Philips (2006), in their retrospective record review of 284 cases of elder sexual abuse that were brought to the attention of professionals, found older adults with dementia were abused by persons known to them such as family members and caregivers. Goergen's (2004) study found that self-reported abuse and neglect correlated significantly with ratios of residents with special impairments (e.g., dementia) to nursing staff. In terms of financial risk factors, a significantly strong negative association was found between adults aged 60 and older and financial exploitation (Jogerst et al., 2005).

Causal Explanations

It has been argued that establishing an explanation for abuse and neglect in institutions could be more important than determining prevalence, because understanding reasons for abuse and neglect will make it easier to develop preventative programs (Hawes, 2002). Unfortunately, there has been little theorizing about abuse and neglect in institutions (Ansello, 1996; Schiamberg & Gans, 1999). Several American researchers developed and tested a model of the potential causes of elder abuse in nursing homes early on in the study of elder abuse (Pillemer & Bachman-Prehn, 1991). More recently, Wallace (2002) developed a flexible theoretical framework that encompasses social, psychological, and physiological factors within a social structural context. The proposed model can be applied equally well to domestic or institutional abuse, but is yet to be tested. If nothing else, there is widespread acknowledgement in the literature that it is a complex phenomenon. Goergen's (2001) pilot study revealed that nurses attributed the causes of elder abuse and neglect to many factors. Among the frequent causal factors mentioned were the lack of staff, work overload, and personality characteristics and personal problems of staff. Nurses linked elder abuse and neglect to broader structural issues such as the lack of funding for elder care, ageism, and the prioritizing of economics over concern for human welfare. Many nurses believed that abuse was triggered by certain characteristics of residents, particularly those who were difficult, aggressive, or had mental health issues. Goergen's (2004) larger study revealed that certain institutional features such as the ratio of residents to professional nurses, staff characteristics such as burnout and use of alcohol to cope with stress, and resident aggression were implicated in abuse and neglect by staff.

In Payne and Gray's (2002) study of ombudsmen's perspectives on abuse in nursing homes, stressed-out workers and vulnerable residents were the predominant explanations given for why elder abuse occurred. Other explanations for why staff abuse residents included greed, immorality, lack of training, workload, family problems, lack of knowledge, poor screening, system failure, drugs, and lack of cooperation on the part of residents.

A conceptual model of how staff can develop immunity to negatively responding to residents arose out of Shaw's (1998) grounded theory study of staff's responses to aggressive residents. Staff that have this immunity can resist engaging in behaviors that are deleterious to themselves and/or residents because they have a certain frame of mind that protects them from the negative impact of residents' aggression. Staff that lose this immunity or do not have it in the first place are at risk of abusing or neglecting residents. Loss of immunity can happen because of stressors in the workplace, poor pay, burnout, staff's personal circumstances, and an institutional culture in which staff receive scant acknowledgment of their emotional needs and are treated as expendable beings.

Limitations of the Research

The majority of the quantitative studies suffered from small samples sizes and less rigorous methodologies that employed nonrandom sampling (Almvik et al., 2006; Armstrong et al., 2008). Definitions varied across studies, making comparisons difficult (Goergen, 2004), and many were surveys of chart reviews (Allen et al., 2003). The results of several studies may not be generalizable to other countries based on where the data collection took place due to cultural differences and the regulations of the country. Moreover, this rationale applies to U.S. studies conducted in only a number of states and their generalizability to the entire country. The validity and reliability of measurement instruments often were not reported (Harris & Benson, 1999).

Research relating to the types abuse had a number of flaws. For example, the chart review studies only examined reported cases of sexual abuse, while the actual number is probably greater. Furthermore, data collected by APS may differ in terms of severity and complexity from cases of sexual abuse that are not reported. In many of the studies, identified cases of abuse were passed on to researchers at the discretion of APS and may not represent all substantiated cases of older adult sexual abuse for any collection year. In most studies, underreporting is more likely than overreporting (Jogerst, Daly, Dawson, Peekasa, & Schmuck, 2006). Cases of elder abuse may not be reported because the older person did not know how—or did not want—to report the abuse, or because the older person may not have been physically able to do so due to some form of cognitive impairment. Reliance on self-reporting is problematic. Older adults who have been abused may not feel comfortable talking about elder abuse (outside of “official” reporting of it) for fear of reprisal. Staff members may be reluctant to admit their own abusive behavior or that of their colleagues for fears of reprisal, including the possibility of criminal sanctions. Similar conclusions can be made of second hand data related to reporting of abuse by nursing staff (Jogerst et al., 2005). These limitations reflect the inherent difficulties of reaching a hidden and sensitive problem.

Although there is growing body of studies on resident to staff violence, which is likely to assist in understanding the causes of institutional abuse, the research remains preliminary. There are no random samples used in any of the studies reported above. The definitions of abuse vary from study to study, are subjectively defined, and only represent the views of staff. Part of the problem confronting researchers is the difficulty in establishing causal direction of the abuse, because it is likely to be interactional, and most studies have been cross-sectional and retrospective in nature.

The qualitative studies were helpful, but on a grander scale they were nonaccumulative and difficult to integrate. While qualitative studies tend to be culturally sensitive, there are problems with transferability to other contexts that are culturally different. Most studies did not discuss methodology,

data collection procedures, and data analytic strategies. Multiple sources of data and multiple methods for the purposes of adding depth and/or for triangulation were hallmarks of the better studies (Goergen, 2004). Almost all studies were atheoretical. Theoretical development does not appear to be a serious consideration of researchers at this time.

Missing Knowledge

Little is known about the extent of elder abuse in institutional settings. Reliable data is lacking on the prevalence of resident abuse in Canada and in other countries. Studies that have investigated specific types of abuse draw attention to the multifaceted nature of it and suggest that physical and psychological abuse, financial/material abuse, and neglect are commonly experienced by elder residents. Exploratory research on sexual abuse of elderly residents has brought attention to a formerly unstudied area of abuse in institutional settings. Risk factors related to the characteristics of perpetrators remain poorly understood.

Research is needed that includes information about the ethnicity of elder victims and/or their alleged perpetrators. An increasing number of staff that speak English or French as a second language are working as front-line providers of care (Purdon et al., 2007). Research is needed to explore the dilemmas that arise when staff and residents from differing linguistic and cultural backgrounds experience poor communication and whether abuse arises from the misunderstandings that may occur. Research also is needed to advance understanding of the dynamics involved in the denial of abuse, the acceptance of abuse as a part of institutional life, and the fear of reporting known or suspected abuse on the part of residents, family members, and institutional staff. There is a need to investigate the effectiveness of laws and institutional policies that protect staff who blow the whistle on abuse and whether these laws and policies lead to higher reporting rates of abuse from long-term care settings.

There is some evidence that structural factors, particularly inadequate staffing levels and undertrained staff, contribute to the likelihood of abuse. There is scant knowledge about the causes of elder abuse in institutions, although there are a few hypotheses about burn out, the organizational environment, regulations, etc. It may be time to look to other disciplines for help with theory, like the field of complex organizations where several frameworks could tie the hypotheses together into useful frameworks.

Research Challenges

The review of the research raises significant challenges that will have to be addressed to establish basic information in Canada (or other countries) where there are no prevalence studies and only small-scale nonrandom

investigations that, at best, indicate that abuse and neglect in long-term care exists.

Prevalence studies are needed to identify how many older adults are mistreated in institutions at a given point in time or during a given time frame. Prevalence studies indicate the extent of the current problem of abuse, which in turn suggests where and how to accurately target limited resources for policies on education and intervention. Incidence studies provide information about how many persons are abused for the first time during a specified time period. For example, the National Elder Abuse Incidence Study (NEAIS), done in the community but not yet in institutions, reported an incidence rate of 1.2% for the United States (Thomas, 2000). Information based on incidence can help determine the causes of institutional abuse and enhance our ability to evaluate the effectiveness of the prevention programs institutions have put into place. Because incidence studies can be used to estimate how much institutional abuse and neglect can be anticipated in the future, this would inform Canada's preparation for the aging generation of "baby boomers" and their use of institutions.

Canada also requires studies that address the concerns and feelings of older adults in institutions, their family's experiences, and the views of staff providing the care. In the case of staff, it would be important to pursue who is actually abusing whom (the interactional nature of abuse) and what the "lived experiences" of staff are in times of strained resources. The outcomes for older adult victims of abuse need serious consideration. The rates of depression for older persons living in institutions are quite high (Parmelee, Katz, & Lawton, 1989), and there is emerging information that abuse may be related to mortality (Wolf, 1997).

DISCUSSION

Study Focus

Given the absence of prevalence or incidence studies of institutional abuse in Canada and a long standing history of qualitative work in English and French Canada, a prevalence study would be a valuable starting point for national research on institutional abuse. A difficult task and, typically, one of the first tasks in any study of abuse and neglect is to choose the definitions. In light of this challenge, the NEAIS approach to establishing a definition appears to be promising. For this approach, the most inclusive set of components was used to make it possible to exclude certain categories in the future for comparisons with other studies (Thomas, 2000). The definitions were pilot tested at two sites by the professionals that would be participating in the study. The same pilot test could be applied to residents if they were the chosen focus for study, as illustrated in the British feasibility study

(Purdon et al., 2007). A theoretical framework, such as the one proposed by Bonnie and Wallace (2002), would be helpful in delimiting a study.

The group that constitutes the focus of the study depends on the research question that is being asked and the kind of data that is collected. Different types of possible research questions that would generate different kinds of data include the following: how many residents experience abuse in a given time period, how many incidents occur in nursing homes in a given time frame, how many staff have abused one or more residents, how many staff have witnessed abuse and neglect, or all of the above. At the population level, what is the proportion of nursing homes in which abuse or neglect has occurred (Hawes, 2002)? A variety of sampling frames and data collection strategies would have to be considered, depending on what question is to be answered.

The few available prevalence studies on institutional abuse and neglect have focused on nursing staff (Hawes, 2002; Pillemer & Moore, 1989), while the most recent institutional investigation used a multimethod approach (Goergen, 2004). A British feasibility study of the prevalence of institutional abuse included a pilot study and interviews with experts. For the feasibility study's pilot component, researchers from the National Centre for Research interviewed 39 cognitively-able residents from four nursing homes (Purdon et al., 2007). The study recommended that the residents themselves be studied since families are not always aware of mistreatment or may fear retaliation, and staff and management have a vested interest in not revealing mistreatment. The conclusion from the pilot was, "On the whole, the residents selected for the pilot were happy to take part in the survey and we had very few refusals" (Purdon et al., 2007, p. 7).

In contrast, the study by Goergen (2004) focused on residents, different types of staff, and advocates. Institutional abuse and neglect are too complex to *not* select multiple sources of data—an argument consistent with the theoretical perspective offered by Bonnie and Wallace (2002). There is also the argument that without the inclusion of staff in a prevalence study, theoretical development is one-sided and a description of a facility becomes more challenging.

Initial decisions have to be made about the type of institution that will be chosen. This is not an easy selection because there is enormous variability. Creating a sampling frame of care facilities is difficult because they vary in terms of size and levels of care, models of care, how they are funded, whether they are for-profit or not-for-profit, and whether they are licensed or not. Some of these factors such as size, staff-resident ratios, and level of staff education, are known to be associated with abuse, so decisions about the types of facilities to be included in studies could be influenced by these possibilities (Goergen, 2004; Lindbloom, Brandt, Hough, & Meadows, 2007). The sampling frame will likely come from lists maintained by government agencies.

Sampling

Sampling will likely follow a form of multistage sample design according to geographic area, type of facility, and type of residents and/or staff (Hawes, 2003). Institutional size is an important consideration in large-scale prevalence studies because oversampling of large institutions may protect anonymity, especially where there is mandatory reporting, and may lower costs through fewer researcher visits. The size of the sample will depend upon the level of precision required for key estimates, the extent of subgroup analysis (e.g., analysis by type of abuse), and cost. The British draft proposal for a prevalence study recommended a minimum sample size of 500 distributed across 70 to 100 care homes, but recommended a much larger sample size for optimal results.

All studies and experts underscored the challenge of interviewing residents because of the need to collect data about the cognitively impaired who are the most likely to be abused or neglected and who have rarely been studied (Goergen, 2004; Hawes, 2002; Purdon et al., 2007). The only way to address the problem of cognitive disability was to use proxies. In the British pilot exercise, the proxy was chosen by the interviewer on site, who went through a decision tree. The underlying principle was that it would be too controversial to use a staff member as an informant because of the inevitable suspicion that staff would minimize the behavior of themselves and their colleagues if they thought they had acted inappropriately toward the selected resident. The hierarchy of alternative informants was: first, the resident; second, another resident as a proxy informant; third, a relative who visits frequently; and finally, any other regular visitor to the care home. An obvious problem with this approach would be if the selected resident was on a unit where all the residents were cognitively impaired.

The British interviewers tested each resident's cognitive ability prior to the beginning of the interview using the Abbreviated Mental Test Score (AMTS), a measure effectively used in the UK community survey of abuse and neglect (O'Keefe et al., 2007). Based on feedback from the interviews, the AMTS was described as not useful because it did not appear to correlate well with the respondent's cognitive function (Purdon et al., 2007). The interviewers thought that some of the questions on the screening AMTS were not important to the residents' everyday life, and even though the resident may not have answered some questions (e.g., the year) correctly, they still were interviewed successfully. Nevertheless, it was felt that some screening mechanism was required, that administrators should not be allowed to select which residents should be interviewed, and that the screen should be relevant to life in a care facility.

In comparison, the German study, which also interviewed residents ($N = 63$), had considerable trouble with the use of proxies. If the respondent was cognitively impaired, the staff was requested to contact a relative

to be a proxy. Staff rarely, if ever, did this for the interviewers, so in the final analysis, most residents were cognitively intact. Only 17 families were interviewed in this study (Goergen, 2004). The other danger with the use of families is that they tend to report levels of higher care than the residents themselves (Hawes, 2003). The use of multiple sources of data would be one way to circumvent any number of these problems (Hawes, 2002).

Although some researchers opposed the use of staff as informants for individual residents, a number of the experts interviewed made a strong case for interviewing staff to assess prevalence rates. Pillemer said, "Staff are willing to talk, and often at great length, about abusive actions they have observed, and even in which they have engaged" (Pillemer & Moore, 1989, p. 319). The proxy issue would disappear and the staff could be interviewed by telephone, which might make response rates higher and would be a less expensive. The response rate to the staff survey in the Goergen (2004) study was 36%, while it was 85% in the Pillemer study (Pillemer & Moore, 1989).

Four issues were identified in the interviews with experts. The first issue (also reported in the British pilot) was the necessity of interviewing the administrator of the institution to get their cooperation, so that data about the institution such as size and staffing ratios could be collected. It is worth noting that only 54% of the 57 homes in the Pillemer study agreed to participate. In the British pilot, there were numerous rejections early in the process, but the rate was not reported. The second issue was the importance of sampling according to the occupational structure of nursing, since all levels of the hierarchy have some effect on abuse and neglect—either on who perpetrates it or who will talk about or report it. The finding by Goergen (2004) that it is the quality of the staff in terms of their education rather than the raw number of staff that predicts an abusive environment is a significant finding because staff "mix" is a different issue. Part of the problem is securing a large enough sample from each stratum of staff. A third concern when interviewing staff, which is not mentioned in any of the studies, is the importance of interviewing across shifts and on weekends when staffing levels tend to be lower (Hawes, 2003).

A fourth concern is the preservation of staff anonymity and protection from employer retribution, regardless of whistle-blowing laws. If management knows who was interviewed, retribution is possible, as Goergen (2004) implied in his study where a ward was randomly chosen and the staff interviewed. The problem becomes even more acute in those jurisdictions where mandatory reporting of suspected abuse or neglect is required. In the consent process, the respondent would have to be told, depending upon the legislation, that any reasonable reports of abuse relayed in the interview would have to be reported to the appropriate authorities, although the reports would be anonymous since researchers do not identify respondents. The procedure would likely apply to telephone interviews as well. In Britain, Germany, and Israel the only responsibility of the researchers is to refer the

resident or the staff to support services, as required. In a number of jurisdictions in the United States, the abuse usually has to be witnessed by the researcher before it can be reported, making the demands on the researcher less onerous than in Canada. Legal council for each jurisdiction would have to be sought to ensure that reporting laws were respected. In some jurisdictions, the legislation is expected to make recruitment challenging and to substantially lower response rates.

Data Collection

Both the research review and the experts identified the pros and cons for face-to-face interviews, technically-assisted interviewing, and telephone interviews. The consensus was that face-to-face interviews with residents were probably the most accurate given the frailty of the population and the need to collect data about the cognitively impaired. As noted earlier, the British pilot had a positive experience with this approach, with few refusals and a good quality of information collected. One problem mentioned was that the residents had ignored recall periods specified by the researchers (e.g., abuse in last 12 months) when reporting on their experiences of abuse and neglect (Purdon et al., 2007). The other problem was that the residents had some trouble nominating another resident to talk about. The last issue was that the respondents did not want to use CAPI (Computer Assisted Personal Interviewing) for the more “delicate” parts of the interview where they used the computer to answer the questions themselves. The residents also did not want to do the paper and pencil test and preferred to be interviewed by the interviewer.

Overall, the experts and the literature noted that resident interviews provided valuable data about the nature and severity of the abuse and its antecedents, and it allowed for probes and some observational data. The disadvantages of resident interviews were illness and language barriers, fear of retaliation, and the presence of the perpetrator on site in the interview setting. Some of the communication issues could be solved through the use of interpreters and “picture” questionnaires but little can be done about the other factors. The advantages of interviewing families are that they can provide both sides of the picture in that they describe the mistreatment but also provide information about the behavior problems of the victim, which lends some strength to the interactional approach to abuse and neglect. Some of the challenges of interviewing family included their fear of retaliation, the family member having their own infirmities such as cognitive impairment, and the family member not knowing all the relevant information (Bonnie & Wallace, 2002).

Discussions with experts indicated that telephone interviews should not be used with older adults in institutions because of their frailty. Some thought the telephone interview was suitable with staff because it tended to

provide a greater sense of anonymity, but the Georgen study would allay such fears and argued for face-to-face interviews with staff. Few studies used medical or staff records, and the views offered about this method for capturing abuse and neglect events were numerous. While the record might provide objective data about incidents, their history, and the ameliorative actions taken, only severe cases were likely to be documented, the definitions would vary, and there would be missing data (Bonnie & Wallace, 2002; Goergen, 2004). Nevertheless, resident records could be used for the purpose of triangulation with consent from the older person.

There was discussion with the experts about the use of the sentinel method, which has been used successfully in community studies (Tatara et al., 1998; Thomas, 2000). Sentinel observers may help to identify cases that otherwise would not be detected, and the observers are more likely to be versed in detection criteria, to use standardized reporting, and to have few vested interests. Bonnie and Wallace (2002) argued that sentinels may be the most effective way to measure abuse and neglect in long-term care settings. Disadvantages of using this method are that sentinel observers are often professionals who have other obligations, are subject to human variation in their observational skills, and their presence in some settings may raise ethical issues.

From a legal standpoint, it is important that researchers familiarize themselves with the legislation in the jurisdiction(s) where they are conducting their research and have plans in place to respond to cases of abuse if (or when) they arise in the course of research. Researchers also should be cognizant of the fact that such legislation can have an impact on recruitment into a study. For example, if staff members know that any mention of abuse they may make during an interview will be reported, they may be less inclined to participate. The same would apply to older adults and their families who may not want to participate because of reprisals.

CONCLUSION

The review of the research, the problems and gaps identified, and the directions for future research point to the need for a prevalence study of elder abuse in institutional settings in Canada (and other countries). The results of this review can be used to design a pilot study, which can inform a national prevalence study to fill the important gap in research.

REFERENCES

- Allen, P. D., Kellett, K., & Gruman, C. (2003). Elder abuse in Connecticut's nursing homes. *Journal of Elder Abuse & Neglect*, 15(1), 19–42.

- Almvik, R., Rasmussen, K., & Woods, P. (2006). Challenging behavior in the elderly—Monitoring violent incidents. *International Journal of Geriatric Psychiatry, 21*, 368–374.
- Ansello, E. F. (1996). Causes and theories. In A. Baumhover & S. C. Beal (Eds.), *Abuse, neglect and exploitation of older persons: Strategies for assessment and intervention* (pp. 31–51). Baltimore, MD: Health Professions Press.
- Armstrong, H., Armstrong, P., Banerjee, A., Daly, T., Lafrance, S., & Szebehely, M. (2008). *Out of control: Violence against personal support workers in long-term care*. Toronto, Canada: York University.
- Åström, S., Bucht, G., Eisemann, M., Norberg, A., & Saveman, B. (2002). Incidence of violence towards staff caring for the elderly. *Scandinavian Journal of Caring Sciences, 16*(1), 66–72.
- Åström, S., Karlsson, S., Sandvide, A., Bucht, G., Eisemann, M., Norberg, A., & Saveman, B. (2004). Staff's experience of and the management of violent incidents in elderly care. *Scandinavian Journal of Caring Sciences, 18*(4), 410–416.
- Atlanta Long-Term Care Ombudsman Program. (2000). *The silenced voice speaks out. A study of abuse and neglect of nursing home residents*. Atlanta, GA: Atlanta Legal Aid Society. Retrieved from <http://www.atlantalegalaid.org/abuse.htm>
- Bigelow, B. J. (2007). What happens when the wheels fall off? Elders abuse complaints and legal outcomes in residential care facilities in Canada. *American Journal of Forensic Psychology, 25*(2), 35–64.
- Bond, J. B., Cuddy, R., Jr., Dixon, G. L., Duncan, K. A., & Smith, D. L. (1999). The financial abuse of mentally incompetent older adults: A Canadian study. *Journal of Elder Abuse & Neglect, 11*(4), 23–38.
- Bonnie, R. J., & Wallace, R. B. (Eds.). (2002). *Elder mistreatment: Abuse, neglect, and exploitation in an aging America*. Panel to Review Risk and Prevalence of Elder Abuse and Neglect. Committee on National Statistics and Committee on Law and Justice, Division of Behavioral and Social Sciences and Education, National Research Council of the National Academies. Washington, DC: The National Academies Press.
- Bravo, G., Dubois, M., De Wals, P., Herbert, J., & Messier, L. (2002). Relationship between regulatory status, quality of care, and three-year mortality in Canadian residential care facilities: A longitudinal study. *Health Services Research, 37*, 1181–1196.
- Bredthauer, D., Becker, C., Eichner, B., Koczy, P., & Nikolaus, T. (2005). Factors relating to the use of physical restraints in psychogeriatric care: A paradigm for elder abuse. *Zeitschrift Fur Gerontologie Und Geriatrie, 38*(1), 10–18.
- Burgess, A. W., Dowdell, E. B., & Prentky, R. A. (2000). Sexual abuse of nursing home residents. *Journal of Psychosocial Nursing, 38*(6), 10–18.
- Burgess, A. W., & Phillips, S. L. (2006). Sexual abuse, trauma and dementia in the elderly: A retrospective study of 284 Cases. *Victims & Offenders, 1*, 193–204.
- Canadian Institute for Health Information. (2008). *Caring for nursing home residents with behavioural symptoms: Information to support a quality response*. Retrieved from http://secure.cihi.ca/cihiweb/products/ccrs_aib_aggressive_behaviour_e.pdf
- Charpentier, M., & Soulière, M. (2007). Pouvoirs et fragilités du grand âge. *Nouvelles pratiques sociales, 19*, 128–143.

- Comijs, H., Pot, A. M., Smit, H. H., Bouter, L. M., & Jonker, C. (1998). Elder abuse in the community: Prevalence and consequences. *Journal of the American Geriatrics Society, 46*, 885–888.
- Daloz, L. (2007). Représentations des soignants négligents/maltraitant : Etude préliminaire sur 21 sujets épuisés en gériatrie. *La Revue de Gériatrie, 32*, 653–662.
- Daloz, L., Bénony, H., Frénisy, M. C., & Chahraoui, K. (2005). Burnout et maltraitance dans la relation soignante. *Annales Médico Psychologiques, 163*, 156–160.
- Despont, O., & Rapin, C. (2000). De la maltraitance vers la reconnaissance. *Krankenpflege—Soins infirmiers, 93*(3), 56–59.
- Division of Aging and Seniors. (2006). *Healthy aging in Canada: A new vision, a vital investment, from evidence to action—A background paper*. Retrieved from http://www.health.gov.nl.ca/health/publications/vision_rpt_e.pdf
- Durocher, A. M., di Pompeo, C., Puisieux, F., Dewailly, P., & Durocher, A. (2000). La maltraitance des personnes âgées dans un cadre familial élargi. *La Presse Médicale, 29*, 880–884.
- Furness, S. (2006). Recognizing and addressing elder abuse in care homes: Views from residents and managers. *Journal of Adult Protection, 8*(1), 33–49.
- Godkin, M. A., Wolf, R. S., & Pillemer, K. A. (1989). A case-comparison analysis of elder abuse and neglect. *International Journal of Aging and Human Development, 28*(3), 207–225.
- Goergen, T. (2001). Stress, conflict, elder abuse and neglect in German nursing homes: A pilot study among professional caregivers. *Journal of Elder Abuse & Neglect, 13*(1), 1–26.
- Goergen, T. (2004). A multi-method study on elder abuse and neglect in nursing homes. *Journal of Adult Protection, 6*(3), 15–25.
- Harris, D. K., & Benson, M. L. (1999). Theft in nursing homes: An overlooked form of elder abuse. *Journal of Elder Abuse & Neglect, 11*(3), 73–90.
- Hawes, C. (2002). *Elder abuse in residential long-term care facilities: What is known about prevalence, causes, and prevention*. Testimony given before the U.S. Senate Committee on Finance, June 18.
- Hawes, C. (2003). Elder abuse in residential long-term care settings: What is known and what information is needed? In R. J. Bonnie & R. B. Wallace (Eds.), *Elder mistreatment: Abuse, neglect, and exploitation in an aging America* (pp. 446–500). Washington, DC: The National Academies Press.
- Hirst, S. P. (2000). Resident abuse: An insider's perspective. *Geriatric Nursing, 21*(1), 32–38.
- Hirst, S. P. (2002). Defining resident abuse within the culture of long-term care institutions. *Clinical Nursing Research, 11*, 267–284.
- Jogerst, G. J., Daly, J., Dawson, J. D., Peekasa, C., & Schmuck, G. (2006). Iowa nursing home characteristics associated with reported abuse. *Journal of the American Medical Directors Association, 7*(4), 203–207.
- Jogerst, G., Daly, J., & Hartz, A. (2005). Ombudsman program characteristics related to nursing home abuse reporting. *Journal of Gerontological Social Work, 46*(1), 85–98.

- Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (2002). Abuse of the elderly. *World Report on Violence and Health* (pp. 123–143). Retrieved from http://whqlibdoc.who.int/publications/2002/9241545615_chap5_eng.pdf
- Labbe, K. (1998). En institution, la personne âgée démente a-t-elle le droit de prendre des risques? *Gérontologie*, *107*, 43–47.
- Lachs, M., & Pillemer, K. (1995). Abuse and neglect of elderly persons. *New England Journal of Medicine*, *332*, 437–443.
- Lajeunesse, Y. (2000). Entre théorie et pratique: Une démarche d'utilisation des contentions physiques. *La Revue de Gériatrie*, *25*, 655–662.
- Law, M., Stewart, D., Letts, L., Pollock, N., Bosch, J., & Westmorland, M. (1998). *Critical review form, Qualitative studies*. Retrieved from http://www.srs-mcmaster.ca/Portals/20/pdf/ebp/qualreview_form1.doc
- Lindbloom, E. J., Brandt, J., Hough, L., & Meadows, S. E. (2007). Elder mistreatment in the nursing home: A systematic review. *Journal of the American Medical Directors Association*, *8*(9), 610–616.
- Lowenstein, A., Eisikovits, Z., Band-Winterstein, T., & Enosh, G. (2009). Is elder abuse and neglect a social phenomenon? Data from the first national prevalence survey in Israel. *Journal of Elder Abuse & Neglect*, *21*, 253–277.
- Malo, P. Y. (2000). Des conduites sécuritaires au risque de la maltraitance. *Gérontologie et Société*, *92*, 135–150.
- Minority Staff Special Investigations Division, Committee on Government Reform, U.S. House of Representatives. (2001). *Abuse of residents is a major problem in U.S. nursing homes* (Report prepared for Rep. Henry A. Waxman, U.S. House of Representatives). Retrieved from <http://www.hospicepatients.org/ilaswan/nursinghomesabuse.pdf>
- O'Keeffe, M., Hills, A., Doyle, M., McCreadie, C., Scholes, S., Constantine, R. . . ., Erens, B. (2007). *UK study of abuse and neglect of older people: Prevalence survey report*. London, England: National Centre for Social Research.
- Parmelee, D. A., Katz, I. R., & Lawton, M. P. (1989). Depression among institutionalized aged: Assessment and prevalence estimation. *Journal of Gerontology*, *44*, 22–29.
- Payne, B. K., & Appel, J. K. (2007). Workplace violence and worker injury in elderly care settings: Reflective of a setting vulnerable to elder abuse? *Journal of Aggression, Maltreatment & Trauma*, *14*(4), 43–55.
- Payne, B. K., & Gray, C. (2002). Theoretical orientation and responses to abuse in nursing homes: A survey of ombudsmen from across the United States. *Journal of Social Work in Long-Term Care*, *1*(4), 31–54.
- Pillemer, K., & Bachman-Prehn, R. (1991). Helping and hurting: Prediction of maltreatment of patients in nursing homes. *Research on Aging*, *13*, 74–95.
- Pillemer, K., & Moore, D. W. (1989). Abuse of patients in nursing homes: Findings from a survey of staff. *The Gerontologist*, *29*, 314–320.
- Plamondon, L., & Nahmiash, D. (2006). Portrait de la vulnérabilité et des risques dans la population âgée vivant en HLM. *Vie et Vieillesse*, *5*(1), 27–36.
- Public Health Agency of Canada. (2001). *Statistical snapshots No. 1, "Canada's seniors: A growing population."* Ottawa, Canada: Public Health Agency of Canada.

- Purdon, S., Speight, S., O'Keeffe, M., Biggs, S., Erens, B., Hills, A. . . ., Tinker, A. (2007). *Measuring the prevalence of abuse of older people in care homes: A development study*. Part of the UK Study of Abuse and Neglect of Older People (Draft Report, P2641). Prepared for Comic Relief and the Department of Health, London, UK).
- Ramage-Morin, P. L. (2005). Successful aging in health care institutions. Supplement to *Health Reports*, *16*, 47–56. Catalogue no. 82-003. Ottawa, Canada: Statistics Canada.
- Roberto, K. A., & Teaster, P. B. (2007). Sexual abuse of vulnerable young and old men. *Journal of Interpersonal Violence*, *22*, 1009–1023.
- Roberto, K. A., Teaster, P. B., & Duke, J. O. (2004). Older women who experience mistreatment: Circumstances and outcomes. *Journal of Women and Aging*, *16*(1/2), 3–16.
- Roberto, K. A., Teaster, P. B., & Nikzad, K. A. (2005). Sexual abuse of vulnerable young and old women: A comparative analysis of circumstances and outcomes. *Violence Against Women*, *11*, 473–504.
- Roulet Schwab, D., & Christen-Gueissaz, E. (2006). Prévention de la maltraitance des personnes âgées. Recherche-action réalisée dans quelques établissements médico-sociaux. *Éthique & Santé*, *3*, 151–155.
- Sanmartin, J., & Iborra, I. (2007). *First national study on elder abuse in the family in Spain*. Valencia, Spain: Queen Sofia Center for the Study of Violence.
- Saveman, B., Astrom, S., Bucht, G., & Norberg, A. (1999). Elder abuse in residential settings in Sweden. *Journal of Elder Abuse & Neglect*, *10*(1/2), 43–60.
- Schiambing, L. B., & Gans, D. (1999). An ecological framework for contextual risk factors in elder abuse by adult children. *Journal of Elder Abuse & Neglect*, *11*(1), 79–103.
- Scodellaro, C. (2006). La lutte contre la maltraitance des personnes âgées: Politique de la souffrance et sanitarisation du social. *Lien social et Politiques-RIAC*, *55*, 77–88.
- Shaw, M. M. C. (1998). Nursing home resident abuse by staff: Exploring the dynamics. *Journal of Elder Abuse & Neglect*, *9*(4), 1–21.
- Shaw, M. M. C. (2004). Aggression toward staff by nursing home residents: Findings from a grounded theory study. *Journal of Gerontological Nursing*, *30*(10), 43–54.
- Snyder, L. A., Chen, P. Y., & Vacha-Haase, T. (2007). The underreporting gap in aggressive incidents from geriatric patients against certified nursing assistants. *Violence and Victims*, *22*, 367–379.
- Spector, W. D., Fleishman, J. A., Pezzin, L. E., & Spillman, B. C. (2001). *Characteristics of long-term care users* (Paper commissioned by the Institute of Medicine, Committee on Improving Quality in Long-Term Care. Publication No. 00-0049). Rockville, MD: Agency for Healthcare Research and Quality.
- Statistics Canada. (2003). *Cycle 16 of the general social survey: Caring for an aging society*. Retrieved from <http://www.statcan.gc.ca/pub/89-582-x/89-582-x2003001-eng.pdf>
- Statistics Canada. (2007). *Portrait of the Canadian population in 2006, by age and sex, 2006 Census* (Catalogue no. 97-551-XIE). Ottawa, Canada: Statistics Canada.

- Strauss, M. A. (1979). Measuring intrafamily conflict and violence: The Conflicts Tactics (CT) Scales. *Journal of Marriage and the Family*, 41, 75–88.
- Tatara, T., Kuzmeskus, L. B., Duckhorn, E., Bivens, L., Thomas, C., Gertig, J. . . . Croos, J. (1998). *National elder abuse incidence study: Final report*. Washington, DC: National Center on Elder Abuse, American Public Human Services Association.
- Teaster, P. B., Dugar, T. A., Mendiondo, M. S., Abner, E. L., Cecil, K. A., & Otto, J. M. (2006). *The 2004 survey of state adult protective services: Abuse of adults 60 years of age and older* (Report prepared for The National Center on Elder Abuse by grant No. 90-AM-2792 from the Administration on Aging, U.S. Department of Health and Human Services). Retrieved from http://www.ncea.aoa.gov/NCEARoot/Main_Site/pdf/2-14-06%20FINAL%2060+REPORT.pdf
- Teaster, P. B., Ramsey-Klawnsnik, H., Mendiondo, M. S., Abner, E., Cecil, K., & Tooms, M. (2007). From behind the shadows: A profile of the sexual abuse of older men residing in nursing homes. *Journal of Elder Abuse & Neglect*, 19(1/2), 29–45.
- Teaster, P. B., & Roberto, K. A. (2003). Sexual abuse of older women living in nursing homes. *Journal of Gerontological Social Work*, 40(4), 105–119.
- Teaster, P. B., & Roberto, K. A. (2004). Sexual abuse of older adults: APS cases and outcomes. *The Gerontologist*, 44, 788–796.
- Terreau, C. (2007). Épuisement professionnel et maltraitance des personnes âgées en institution. *Soins-Gérontologie*, 65, 37–40.
- Thomas, C. (2000). The first national study of elder abuse and neglect: Contrast with results from other studies. *Journal of Elder Abuse & Neglect*, 12(1), 1–14.
- Thomas, H., Scodellaro, C., & Dupré-Lévêque, D. (2005). Perceptions et réaction des personnes âgées aux comportements maltraitants: Une enquête qualitative. *Étude et Résultats*, 370, 1–11.
- Tremblay, L. (2004). Réduire les contentions, c'est positif! *Objectif Prévention*, 27(3), 4–7.
- Trottier, H., Martel, L., & Houle, C. (2000). Living at home or in an institution: What makes the difference for seniors? *Health Reports*, 11(4), 49–61. Catalogue no. 82-003. Ottawa, Canada: Statistics Canada.
- Turcotte, M., & Schellenberg, G. (2007). *A portrait of seniors in Canada, 2006*. Catalogue no. 89-519-XIE. Ottawa, Canada: Statistics Canada, Social and Aboriginal Statistics Division.
- Wallace, H. (2002). *Family violence: Legal, medical, and social perspectives* (3rd ed). Boston, MA: Allyn & Bacon.
- Wang, J. (2005). Psychological abuse behavior exhibited by caregivers in the care of the elderly and correlated factors in long-term care facilities in Taiwan. *Journal of Nursing Research*, 13, 271–279.
- Wang, J. (2006). Psychological abuse and its characteristic correlates among elderly Taiwanese. *Archives of Gerontology and Geriatrics*, 42, 307–318.
- Weatherall, M. (2001). Elder abuse: A survey of managers of residential care facilities in Wellington, New Zealand. *Journal of Elder Abuse & Neglect*, 13(1), 91–99.
- Wolf, R. S. (1997). Elder abuse and neglect: An update. *Reviews in Clinical Gerontology*, 7, 177–182.