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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.

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Family members are the most loving and nurturing source of care for older adults,[1] but they are also the most likely perpetrators of elder abuse.[2,3] 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.[4,5] 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.[6] Furthermore, 1.6% had experienced physical abuse (PA) in the previous year. However, only 31% of these occurrences were reported to the authorities.[6] 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.[4,7–11]

It has been acknowledged in the literature that older adults are not likely to self-report abuse.[12,13] 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,[1,12,14,15] 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.[16] Older adults also have described abuse as the commission of actions by another party, rather than acts of omission.[17] Additionally older adults have described abuse as consisting of intentional acts, acts that are deliberate and with an intention to produce harm.[17] 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.[18] 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.[19]

There is a need for prevention strategies and educational interventions to help increase reporting of elder abuse.[20] 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

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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[21]; 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). Physical touching includes hitting or burning the older adult. Medication handling includes acts of overdosing 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.[22]

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 likeliness 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,[23] 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.[24,25] 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