Detection and Management of Elder Abuse: Nurse Practitioner Self-Perceptions of Barriers and Strategies

Catherine Pearsall

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Detection and Management of Elder Abuse:

Nurse Practitioner Self-Perceptions of Barriers and Strategies

by

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Submitted to the Doctoral Faculty

of the School of Nursing in partial fulfillment

of the requirements for the degree of

Doctor of Philosophy

Duquesne University

2006
Elder abuse is a serious and growing phenomenon, yet it is one of the most under-diagnosed and under-reported problems in the United States. Nurse Practitioners are uniquely positioned to identify, diagnose, and report elder abuse. Quantitative methodology underpinned by the theoretical framework of Carper’s Patterns of Knowing was utilized to assess the self-perception of nurse practitioners related to the barriers of detection and strategies for management of elder abuse. Two hundred potential participants were randomly selected from the AANP membership database yielding a 54.5% response rate (n=88). Nurse practitioners identified the following barriers as fairly or very important: resistance to intervention, denial of abuse, fear of reprisal by the abuser towards the elder, lack of professional protocol related to responding and assessing elder abuse, lack of knowledge about where to call for help, lack of professional protocol, lack of guidelines about confidentiality, difficulty in determining what constitutes elder abuse, and lack of knowledge about prevalence. Strategies perceived to be helpful included: one agency to call, list of resources, directory, resource package for practice, professional guidelines, continuing education and elder abuse education in practice, central library resource, and an elder abuse newsletter. The majority of responding nurse practitioners (57.9%) reported that they saw suspected cases of elder abuse on a monthly or weekly basis. When asked about educational preparedness 62.5% did not feel that their undergraduate nursing program adequately prepared them to detect and manage elder abuse and 42.1% of respondents did not feel that their nurse practitioner program adequately prepared them. The results of this
study provide nursing knowledge about the self-perceptions of nurse practitioners related to elder abuse and new information that can be utilized to further nursing research.

Dissertation Advisor: Dr. Kathleen Sekula
Dedication

This dissertation is dedicated to my loving family. Your support and encouragement was unyielding. You provided me with the courage to move on, pushed me when it seemed I could not move on any further, and carried me when I could no longer stand. You offered me the opportunity to make my dream a reality. Without your love and faith this would not have been possible. This dissertation belongs to you as much as it belongs to me.

To my Mother and Father who instilled in me the core value of education. You came to a new country alone yet full of hope. Hope to live in a country where you were free to follow your faith, freedom, and dreams wherever they may lead you. Hope to raise your family in a land where individuality was encouraged. Although you did not possess the gift of a higher education, you instilled the value of education in me. Perhaps, it is through the desire to provide your children with more than what you have that you continually encouraged me to learn. Poppa, you were unable to hold on to physically see me reach this milestone, yet I know that from your place in heaven you are there with me every step of the way. Mamma, thank you for your unique humor and your ability to make me smile through the good times and the bad.

To my son Kenny, who is certainly my most precious gift. You have brought so much joy in my life from the minute that you were born to the present second. Your strength and your ability to look at life in logical and clear focus has been the rock that has assisted not only me, but also our whole family during our most wonderful and most challenging times. Thank you for making it easy to be a mother. Thank you for always being there to lend a hand and to offer your strength.
To my daughter-in-law Cori, who is the love of my son’s life. You are the daughter that I never had. Your inner and outer beauty is illuminating. I am grateful to have you shine onto my life. Thank you for your support and your kind heart.

To my new granddaughter Emma, who is the new jewel of our family. What a precious bundle of joy, perfection, and innocence. Your presence has given me new energy and was the fuel that made me stay up to all hours of the night to finish my dissertation. I want to have the time to play with you this summer. You are our family’s hope for the future.

Lastly, but most importantly, this dissertation is dedicated to my husband and the love of my life, Ken. You are my best friend and were there every step of the way. You rubbed my back after hours of laboring at the computer, you did the laundry and took good care of our old faithful Basset Hound Bernice, you provided me with space when I needed it and recognized when you needed to take me out for a breath of fresh air and a change of scenery. You put me onto the bus that started this dissertation journey and knew that this was going to be a long and arduous road. You were there for me. Thank you for your love and for understanding. Thank you for waiting. I could never have done it without you. There is not much more that can be said.
Acknowledgements

This dissertation would certainly not have been possible without the guidance, expertise, support, and assistance from many individuals. I would like to acknowledge those who made this dissertation possible.

The entire faculty at Duquesne University School of Nursing provided the encouragement and challenge needed to formulate the foundation of doctoral study. Special thanks and acknowledgements are directed towards my dissertation committee as they provided endless support and direction throughout my dissertation journey.

First and foremost, I would like to acknowledge my dissertation chair Dr. Kathleen Sekula. Her exceptional expertise in Forensic Nursing and her enthusiasm opened my eyes to the reality of forensic nursing and helped me to formulate my interest in the topic of elder abuse. Her support, encouragement, and hours of dedicated feedback are unsurpassed. I am eternally grateful for her dedication and presence in my life.

I would also like to specially acknowledge Dr. Ann Wolbert Burgess, the external member of my committee. Dr. Burgess is a renowned researcher, author, educator, advanced practice psychiatric nurse, and pioneer in the study of assault. I was most honored to have her agree to sit on my committee. Her expert feedback and content critique proved to be invaluable.

Notable acknowledgement is directed towards one of my internal dissertation member, Dr. Kathleen Brown. Dr. Brown agreed to step in when my original internal dissertation member, Dr. Suzanne Edgett Collins was unable to remain as a committee member. Dr. Brown was chosen as an Internal Dissertation Committee member due to her expertise in Forensic Nursing as well as her working knowledge as a Nurse Practitioner. Her input and feedback is
much admired. I would also like to acknowledge Dr. Collins. Her expertise in nursing law and ethics were of great value during the beginning stages of dissertation development.

A very special acknowledgement goes to the additional internal member of my dissertation committee, Dr. John Kern. His extensive background and expertise in research and statistical reasoning provided me with support and much needed peace of mind when I needed it most. I could not have understood or designed the methodology of my study without his expert feedback and guidance.

I would also like to acknowledge others who helped me through the dissertation journey. To the faculty and staff at St. Joseph’s College Department of Nursing and St. Joseph’s College Administration. They were there to cheerlead my efforts and provided me with the role models and the support to work through this process.

In order for me to successfully pursue my goal of attaining a PhD, many sacrifices needed to be reluctantly made. Most of the sacrifices revolved around time. It was essential that I prioritized my time while attempting to meet all of my obligations. In doing so, I often needed to curtail time with my family and my friends. This was the sacrifice that I needed to make. I am especially thankful to those family and friends who understood and supported me during this time.
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Detection and Management of Elder Abuse:
Nurse Practitioner Self-Perceptions of Barriers and Strategies

I. Introduction

Approximately two million Americans aged 65 and older have been the victims of abuse or mistreatment by someone on whom they depend for their care or protection (National Center on Elder Abuse, 1998; Pavlik, Hyman, Festa, & Dyer, 2001). This problem will most likely increase in magnitude over the next decades, as the elderly population increases (Bonnie & Wallace, 2003). Elder abuse is one of the most under-diagnosed and under-reported problems in the United States; little is known about its characteristics, causes, or consequences or about effective means of management and prevention (Bonnie & Wallace, 2003).

Background

According to the Department of Health and Human Services, the population identified as persons 65 years or older numbered 35.9 million in 2003 (Administration on Aging, 2004). This represents 12.3% of the total population of the United States and equals approximately one in every eight Americans (Administration on Aging, 2004). It is estimated that by the year 2030, there will be 71.5 million older persons representing approximately 20% of the total population (Administration on Aging, 2004). This is more than twice their numbers since the year 2000 (Administration on Aging, 2004). The United States Census Bureau population statistics project that by the year 2050, this population will number approximately 80 million (1998). The “oldest old,” those 80 years or more, is the fastest growing segment of the older population (Nelson, 2002) and suffers abuse and neglect two to three times their proportion of the total elder
population (National Center on Elder Abuse, 1998). Census 2000 revealed that those aged 85 and over, which represents 1.5 percent of the total population, showed the highest percentage of population growth (2000). Life expectancy of people born in the United States has been rising throughout the past century and as the population ages, so does the incidence of age-related diseases and disabilities (Bonnie & Wallace, 2003). The risks of experiencing abuse and mistreatment increase as individuals age and become frail (Lachs, Williams, O'Brien, Pillemer, & Charlson, 1998).

Discussion of elder abuse first appeared in the literature in the 1960’s (Lachs & Pillemer, 1995). Researchers have attempted to determine the prevalence and clinical scope of this phenomenon since that time. Little information is available regarding the true extent of elder abuse (Nelson, 2002) in large part because surveillance is limited and the problem remains hidden (National Center on Elder Abuse, 2004). Victims are often reluctant to reveal abuse due to shame, self-blame, denial, fear of reprisal or a desire for privacy (Hirsch, Strattan, & Loewy, 1999). One study estimated that 84% of cases were not reported (National Center on Elder Abuse, 2004). The National Center on Elder Abuse (2004) reports a 3-5% prevalence rate. The Senate Special Committee on Aging estimates that as many as 5 million elder Americans are abused or neglected annually (National Center on Elder Abuse, 2004).

Statement of Problem

Elder abuse is difficult to detect as some elderly experience social isolation (National Center on Elder Abuse, 1998). However, even the most isolated elderly individuals may come in contact with the health care system at some point in time. Elderly patients visit their primary care providers an average of five times per year, yet primary care providers comprise only a small percentage of the cases reported to Adult Protective Services (APS) (Harrell et al., 2002).
For a dependent elder, the primary care provider may be the only opportunity for abuse detection, yet, unfortunately, many primary care providers attribute the medical findings which may, in fact, signal abuse to aging or an underlying disease (Hirsch et al., 1999). An analysis of the State of Michigan’s records of reported cases of suspected adult abuse for the years 1989-1993 revealed that physicians reported an average of only 2% of all reports of suspected elder abuse and that physician reporting rates were highest in small counties with low physician to population ratios (Rosenblatt, Cho, & Durance, 1996). It was suggested that increasing physician awareness of the problem of elder abuse could increase the number of cases screened for potential abuse and as such, increase the number of elder abuse reports to responsible agencies (Rosenblatt et al., 1996).

Few studies have specifically examined the barriers to elder abuse detection and reporting by primary care providers. Krueger and Patterson (1997) surveyed family physicians to determine their perceptions of barriers and strategies in the effective detection and appropriate management of abused elders. A lack of knowledge about the prevalence and definition of elder abuse, denial of abuse, resistance to intervention, lack of protocols and lack of guidelines regarding confidentiality were identified as important barriers to detection (Krueger & Patterson, 1997). An exhaustive search of the literature failed to reveal research or data on reporting practices of nurse practitioners in the area of elder abuse diagnosis or management. This study will explore the self-perception of nurse practitioners to the barriers and strategies for detecting and managing elder abuse utilizing the survey tool developed by Krueger and Patterson for the Research Subcommittee of the Elder Abuse and Self-Neglect Task Force of Hamilton-Wentworth (Krueger & Patterson, 1997).
Study Significance

Approximately two million Americans aged 65 and older have been the victims of abuse or mistreatment by someone on whom they depend for their care or protection (Pavlik et al., 2001). Four to six percent of older adults have experienced an incidence of domestic elder abuse, neglect, and/or financial exploitation (Wolf, 2000). Today, older individuals are living longer than ever before (1998). However, as the elderly population grows, so does the incidence of elder abuse. The number of reported cases of domestic elder abuse has increased from 117,000 in 1986 to 296,000 in 1996 (Wolf, 2000). Yet, this is just the “tip of the iceberg” as many cases are unrecognized and unreported (National Center on Elder Abuse, 1998). It is vital for nurse practitioners to be knowledgeable about the prevalence of elder abuse and the potential markers of abuse, in order to be instrumental in its prevention and early intervention. Identification of nurse practitioner’s self-perceived barriers and strategies for detecting and managing elder abuse can potentially expand nursing knowledge related to the elder abuse phenomenon.

Purpose of the Study

The purpose of this study is to assess the knowledge of nurse practitioners related to the detection and management of elder abuse in order to identify areas of needed education for nurse practitioners so that they might better serve elders who may be victims of abuse or neglect. A questionnaire was utilized to survey a random sample of nurse practitioners practicing in the United States.

Research Questions

1. What are the self-perceived barriers to the detection of elder abuse by nurse practitioners?
2. What are the self-perceived strategies for the management of elder abuse by nurse practitioners?

3. In what ways do the self-perception of nurse practitioners vary according to individual characteristics such as year of graduation, attendance at continuing education experiences, and experience with abused elder patients in current practice?

Definitions of Terms

Relevant terms are operationally defined as follows:

Barriers

A boundary. Something that separates or holds apart (The American Heritage Dictionary of the English Language, 2000).

Biomarker

Biomarkers are defined as any physical, physiological, or biochemical measure that may assist in the identification or diagnosis (Dyer, Connolly, & McFeeley, 2003). “A specific physical trait used to measure or indicate the effects or progress of a disease, illness, or condition” (The American Heritage Dictionary of the English Language, 2000).

Elder Abuse/Mistreatment

For the purposes of this study, the terms elder abuse and mistreatment will be used synonymously. Elder abuse is defined as any action or inaction by a person in a position of trust such as a friend, family member, neighbor or paid caregiver, that causes harm (physical, psychological, financial or through neglect) to an elderly person (Krueger & Patterson, 1997).

Elder

For the purpose of this study, an elder will be defined as being sixty years of age or older.
**Report**

“A formal oral or written presentation of facts” (Garner, 1999).

**Forensic**

The term forensic is defined as that which is related to or suitable to courts of law or public debate (Garner, 1999).

**Nurse Practitioner**

“A nurse practitioner (NP) is a registered nurse with advanced academic and clinical experience, which enables him or her to diagnose and manage most common and many chronic illnesses, either independently or as part of a health care team”. (American College of Nurse Practitioners, 2004)

**Assumptions**

- Participants are willing to honestly discuss their experience of self-perceptions of elder abuse.
- Participants honestly identify themselves as Nurse Practitioners.

**Scope and Limitations**

- The scope of this study will confine itself to a random survey of nurse practitioners who are members of the American Academy of Nurse Practitioners
- This study is limited by:
  - A sample that may not be representative of all Nurse Practitioners.
  - Potential of recall bias.
  - Participant’s subjective responses that may be inaccurate due to question misunderstanding, placebo affect, question structure and/or inaccurate responses.
Significance to Nursing

Elder abuse results in unnecessary suffering, pain, injury, violation of human rights and an overall decreased quality of life. Studies related to the effect of elder abuse on the victim’s physical and psychological well being are rare (Wolf, 2000). However, one study examined the effects of abuse on the mortality rate of elders with rather disturbing results (Lachs et al., 1998). Elders who have been abused, neglected or neglect themselves tend to die earlier than those who have not been abused. Lachs and colleagues (1998) reported a three-fold increase in the risk of death for community-dwelling elders who had a reported history of abuse. In general, family violence costs our society up to $5 billion annually in medical, police and court costs (Fisher & Dyer, 2003). Incidents of mistreatment have potential debilitating impact on the elder and even a single minor act of victimization can overtake an otherwise productive older individual’s life as the impact of abuse and mistreatment are magnified in this population due to decreasing physical, psychological and economic support systems (Bonnie & Wallace, 2003). Elder abuse affects the health and quality of life of the abused individual. As such, elder abuse identification has serious implications for nursing practice.

Theoretical Framework

The framework that underpins this research is that of Carper’s Patterns of Knowing. Carper (1978) identified four fundamental patterns of knowing which are essential for the teaching and learning of nursing and serves as a structure for thinking about a phenomenon. Carper’s views expanded the historical perspective of nursing as an art and a science and moved it from a narrow focus on empirics to a more comprehensive focus on the diversity of knowing (Fawcett, Watson, Neuman, Walker, & Fitzpatrick, 2001). According to Carper (1978) each
pattern is necessary for achieving mastery in a discipline, and increases awareness of the complexity and diversity of nursing knowledge.

The four patterns are distinguished according to logical type of meaning and designated as: (a) empirics, the science of nursing; (b) aesthetics, the art of nursing; (c) the component of a personal knowledge in nursing; and (d) ethics, the component of moral knowledge in nursing (Carper, 1978).

There has been much debate and discussion regarding the importance of evidence-based practice within nursing research and nursing practice which focuses on a conventional, atheoretical, medically dominated, empirical model of research versus other patterns of knowing that are less established but of increasing interest to the discipline of nursing (Fawcett et al., 2001).

Carper discusses the perceived self-conscious reluctance to include those aspects of knowing in nursing that are not the result of empirical investigation with the term knowledge possibly originating from the vigorous efforts to exorcise the image of the apprentice-type educational system (Carper, 1978). Elder abuse inquiry involves not only academic knowledge within the traditional empirical mode, but also knowledge which stems from the ethical and practical knowledge that can be applied to clinical practice (Kingsley, 2002). Understanding the complex issue of elder abuse requires inquiry into all four patterns of knowing for successful resolution of this phenomenon as each pattern of knowing is not mutually exclusive nor individually sufficient (Kingsley, 2002).

Empirics. The first pattern of knowing is that of empirics, which refers to the science of nursing where emphasis is on the generation of theory and on systematic research which is controlled by factual evidence (Carper, 1978). The purpose of this pattern of knowing is to describe, explain and predict phenomena of special interest to the discipline of nursing (Carper,
Aesthetics. The second pattern is the art of nursing identified as aesthetics, which places emphasis on expressiveness, subjective acquaintance, individual perceptions, and empathy (Munhall, 2001) and ventures outside the primary professional emphasis on the development of the science of nursing (Carper, 1978). The view of nursing as a moral art was first championed by Nightingale and is a term to which there is little definitional agreement (LeVasseur, 1999). The art of nursing was linked with a learning style that imitated acquisition of knowledge by accumulating un-rationalized experiences and may be a term that is excessively and inappropriately restricted (Carper, 1978). The focus is more on the particulars rather than the universal and addresses the artful performance of manual and technical skills (Fawcett et al., 2001). Knowing goes beyond empirical knowledge and speaks to a more abstract form of knowing where emphasis is on the developing appreciation of aesthetic meanings in practice and inspiration for developing the art of nursing (Fawcett et al., 2001). The mode of inquiry is via envisioning possibilities and rehearsing nursing art and acts (Fawcett et al., 2001). When dealing with victims of abuse the aesthetic art of knowing incorporates care based on the perceptive assessment and knowing of the unique particulars of a victim’s abuse situation and relationship, and involves analysis, understanding and interpretation of the subjective experiences of the elder. This analysis provides an appreciation of the elder abuse phenomenon (Kingsley, 2002).

Empathy “the capacity for participating in or vicariously experiencing another’s feelings” is emphasized as an important mode within the aesthetic pattern of knowing (Carper, 1978). Knowledge and understanding of alternate modes of perceiving reality will be developed when the nurse gains skill in perceiving and empathizing with the lives of others (Carper, 1978). An
increase in the variety of subjective experiences heightens the complexity and difficulty of the
decision making process (Carper, 1978). The more skilled nurses become at empathizing the
elder abuse situation, the more they will understand the victim’s personal reality of being abused
and as such, nurses will gain an often intuitive recognition of the large potential repertoire of
creative options and interventions (Kingsley, 2002).

Personal Knowledge. The third pattern of knowing identified as personal knowledge is
noted as the most problematic and the most difficult pattern to master and to teach, yet it is
essential to understanding the meaning of health in reference to individual well being (Carper,
1978). Personal knowing is concerned with interpersonal relationships of nurses and the
expressions of the quality and authenticity of the interactions between each patient and each
nurse (Fawcett et al., 2001). This personal knowing extends not just to others, but also to
relation with oneself as one strives to know the self. It is a state of being that cannot be
described or experienced, it can only be actualized (Carper, 1978). The mode of inquiry in the
personal pattern of knowing can be achieved through opening, centering, thinking, listening and
reflecting (Fawcett et al., 2001).

According to Kingsley (2002), the therapeutic use of self and personal knowing enables
nurses to develop rapport and trust within the nurse-client relationship. In order to begin to
acknowledge the uniqueness of each client’s experiences, the nurse must first learn to know their
own personal self and acknowledge their uniqueness. Each nurse needs to reflect on how and
why they know what they know and then integrate this knowledge into actual clinical practice.
Reflection and awareness into the nurse’s personal knowing will affect how nurses think about
themselves and their encounters with abuse and as such, will influence how they develop
effective encounters with victims and perpetrators of abuse (Kingsley, 2002).
Ethics. The fourth pattern is ethics, the component of moral knowledge in nursing (Carper, 1978). This encompasses descriptions of moral obligations, moral and non-moral values, and desired ends (Fawcett et al., 2001). The ethical component is focused on matters of obligation or what should be done. It goes beyond simply knowing the norms or ethical code of a discipline as it includes deliberate voluntary actions which are subject to the judgment of right and wrong. A moral dilemma develops in situations where ambiguity and uncertainty exists or when the consequences of one’s actions are difficult to predict. The mode of inquiry is via identification, analysis and clarification of beliefs and values (Fawcett et al., 2001). A professional moral code of working with elders includes an obligation to provide quality service, to respect the elder’s rights and to promote safety and well being. However, the professional obligation may be greater to ensure that actions or inactions do not cause further harm when the potential to influence a vulnerable elder’s decision exists (Kingsley, 2002). The obligations of right and wrong can become blurred when a difference in values, beliefs or goals exists between the nurse and the elder. Nurses need to recognize ethical patterns of knowing which includes a clear understanding of various ethical frameworks, codes and philosophical positions in regards to what is right and what is wrong while maintaining a commitment to honor their professional obligations for what should be done (Kingsley, 2002).

Summary

Little is known about the characteristics, causes, or consequences regarding the complex issue of elder abuse. Although it is widely reported as being under-diagnosed and under-reported, there is little data regarding the diagnosis and management practices of primary care providers. Furthermore, an exhaustive search of the literature failed to reveal research or data on reporting practices of nurse practitioners in the area of elder abuse diagnosis or reporting.
Carper’s Patterns of Knowing is a valuable conceptual framework to guide knowledge, organization and utilization when discussing cases of elder abuse (Kingsley, 2002). It is important for nurses to understand their own ways of knowing regarding elder abuse and to recognize how they situate their practice within their own framework of knowing and doing to gain successful resolution of elder abuse cases (Kingsley, 2002). Quantitative methodology underpinned by the theoretical framework of Carper’s Patterns of Knowing is utilized to explore this issue. The early diagnosis of and prevention of elder abuse is the motivating force for this study.
II. Review of the Literature

An extensive literature search was performed utilizing online data bases such as OVID, Proquest, Pubmed, HaPI, CINAHL and MEDLINE using the term elder abuse and the following keywords: detection, reporting, assessment, screening, Adult Protective Services (APS), mandatory reporting, elder mistreatment, diagnosis, nurse practitioners, health care providers, questionnaire, reporting barriers, patterns of knowing and management. The purpose of this review was to study existing research on the topic of elder abuse reporting by health care providers and to identify knowledge gaps. Articles retrieved for this review met the following criteria for inclusion: articles published in the English language and research articles/publications that discussed both the topic of elder abuse reporting and health care providers. Articles that contained the inclusionary information were then read closely for final inclusion and understanding.

Organization of the Literature

The review of the literature that follows is designed to provide the research background to the major issues raised by the research questions. It begins with a brief review of the basics of the phenomenon of elder abuse and focuses on the definition of elder abuse, causes of elder abuse, statistical data regarding prevalence of elder abuse and identifies the categories of elder abuse. The focus then shifts to elder abuse detection and discusses forensic markers, educational preparedness of healthcare providers and available screening tools. A discussion of the management of elder abuse follows with a review of the legislative history and reporting controversy of elder abuse. The latter section of the review summarizes pertinent existing research in the area of elder abuse detection and management by primary health care providers.
Elder Abuse

Elder Abuse Definition Controversy

The greatest impediment to epidemiological research in elder abuse is the differing definitions of elder abuse itself (Lachs & Pillemer, 1995). Many states, for example, include self neglect in their statutes and reporting statistics when describing the elderly who are living alone in the community and are unable to provide for themselves that which is necessary for physical and/or mental well being (Lachs & Pillemer, 1995). Some argue that these individuals should not be included in epidemiological studies of abuse of elderly persons, however, they account for a substantial proportion of the caseload of Adult Protective Services (APS) (Lachs & Pillemer, 1995). Many estimates of the frequency of elder abuse involve prevalence studies and they are difficult to compare due to the differences in definitions, sample characteristics, and methodologies used (Kleinschmidt, 1997). Even the age of an “elder” is in question as some researchers identify age 60 and above as elderly while others include only those individuals over the age of 65.

Literature indicates that the prevalence and perception of elder abuse may differ by ethnic and cultural group, although limited inquiry has been made into this research arena which further influences statistical analysis (Wieland, 2000). Wieland (2000) lists two reasons for this knowledge gap: most studies include predominately or exclusively white samples and ethnic group identity has not typically been viewed as a variable in elder abuse research. The United States is a multicultural society and as such, definitions for what constitutes elder mistreatment may differ drastically among various cultural groups (Windham, 2000).
Elder Abuse Statistics

The first ever National Elder Abuse Incidence Study (NEAIS) reported that based on a national estimate 449,924 elderly persons, aged 60 and over, experienced abuse and/or neglect in domestic settings in 1996 (National Center on Elder Abuse, 1998). Of this total, 70,942 (16%) were reported to and substantiated by APS, however the remaining 378,982 (84%) were not reported to APS (National Center on Elder Abuse, 1998). The estimated number rises to 551,011 elderly individuals, ages 60 and over, when self-neglect is added to the equation (National Center on Elder Abuse, 1998). Of this total, 115,110 (21%) were reported and substantiated by APS, with the remaining 435,901 (79%) were not reported to APS (National Center on Elder Abuse, 1998).

These results confirmed the “tip of the iceberg” theory of elder abuse. According to this theory, official reporting agencies such as APS are alerted to the most visible cases of abuse and neglect, however large numbers of incidents remain unidentified and unreported (National Center on Elder Abuse, 1998). In the NEAIS, community sentinels were solicited for information on their professional encounters with elderly clients and contacts (National Center on Elder Abuse, 1998). Case information was obtained from local adult protective service agencies as well as from specifically trained groups of individuals known as “sentinels” who were drawn from agencies that serve the elderly such as law enforcement agencies, senior citizen programs, banking institutions, hospitals and clinics (Wolf, 2000). Substantiated APS reports were combined with cases detected by community sentinels and an estimated prevalence rate of 1.3% in the year 1996 among non-institutionalized individuals over the age of 60 was determined (Hirsch et al., 1999). The “sentinel” approach has been employed in three federally sponsored child-abuse surveys (Wolf, 2000). The assumption which underlies this approach is
that reported cases reveal the proverbial tip of the iceberg and that many community cases are
never reported (Wolf, 2000). The National Elder Abuse Incidence Study estimated that for every
reported case, five cases were not reported, yet even this estimate is considered to be low as
many abused elderly are homebound and isolated and not seen in settings where sentinels would
identify them such as: banks, senior centers, hospitals or police stations (Wolf, 2000).

Cause of Elder Abuse

No one explanation for the cause of elder abuse exists. Abuse is a complex problem
which is rooted in multiple factors (Wolf, 2000). Caregiver stress and burden was once regarded
as a major causative factor of elder abuse. However, Anetzberger (2000) discusses the
complexity of elder abuse and the results of prior studies, which suggest that the etiology of elder
abuse is multifaceted, and that caregiver stress and burden is not the only dominant risk factor.
She stresses that the reality of elder abuse demands the development of new explanatory and
intervention models (Anetzberger, 2000). A number of socio-demographic factors have been
identified as possible contributors to elder abuse. Levine (2003) lists the following factors:
intra-family stressors including separation, divorce and financial strain, ageism, increased life
expectancy and medical advances that have prolonged years lived with chronic disease (Levine,
2003).

Elders are abused in homes, hospitals, nursing homes and in other institutions (Nelson,
2002). Prevalence or incidence data on elder abuse in institutional settings are lacking despite
the vast existing literature on issues of quality of care (Wolf, 2000). Most elder abuse and
neglect takes place in the home and is inflicted by family, household members and paid
caregivers (Smith, 2002). A survey conducted in one US state reported that 36% of nursing and
support staff reported having witnessed at least one incident of physical abuse by another staff
member during the prior year and 10% admitted to having committed at least one act of physical
abuse themselves (Wolf, 2000). A cross-sectional retrospective chart review of new in- and out-
patients conducted by a Montreal General Hospital Division of Geriatric Psychiatry in one
calendar year, studied the prevalence and correlates of four types of elder abuse and neglect in a
geriatric psychiatry service (Vida, Monks, & Des Rosiers, 2002). Although this study was
limited by a clinically derived and a relatively small sample size of 126 patients, it was reported
that elder abuse and neglect was suspected or confirmed in 16% of patients studied. Living with
non-spouse family, friends, or other persons in a non-supervised setting, along with a history of
family disruptions by widowhood, divorce, or separation were significantly correlated with
abuse, while statistically non-significant yet potentially important identifiers included female
gender, alcohol abuse, and low functional status.

Elders are most at risk from family members (Nelson, 2002). The perpetrator is a family
member in two-thirds of known cases of abuse and neglect and were identified as adult children
or spouses (National Center on Elder Abuse, 1998). Despite the popular image of elder abuse
occurring in a setting of a dependent victim and an overstressed caregiver, there is accumulating
evidence that it is neither caregiver stress levels nor the dependence level of the victim that are
the core factors leading to elder abuse (Wolf, 2000). It is now felt that stress may be a
contributing factor in abuse cases but it does not explain the phenomenon (Wolf, 2000). Recent
studies on the relationships between caregiver stress, Alzheimer’s disease, and elder abuse
suggest that it is the long-term or pre-abuse nature of the relationships which is the important
factor in predicting instances of maltreatment (Wolf, 2000). The mental status of the perpetrator
which includes emotional, psychiatric, and substance abuse problems, the dependency of the
perpetrator on the victim, and the lack of outside the home external support for the victim continue to emerge as elder abuse risk factors (Wolf, 2000).

A cohort of 2,812 community-dwelling adults over the age of 65 from the New Haven Established Population for Epidemiologic Studies in the Elderly were studied to determine the risk factors and prevalence of APS utilization by older adults in an eleven-year longitudinal study (Lachs, Williams, O'Brien, Hurst, & Horwitz, 1996). Referral to the state ombudsman on aging for protective services was the main outcome measure. The prevalence of APS use was 6.4% over the 11-year period. Self-neglect was the main indicator for referral accounting for 73% of the cases. Elder mistreatment, poverty, minority status, functional disability and worsening cognitive impairment were found to be risk factors for reported elder abuse.

A case controlled study conducted in Baylor College of Medicine Geriatrics Clinic in Texas, sought to describe the characteristics of abused or neglected patients and to compare the prevalence of depression and dementia in those referred because of neglect with that of those referred for other reasons (Dyer, Pavlik, Murphy, & Hyman, 2000). This institution provides interdisciplinary geriatric assessment and intervention to older people in Harris County. Forty-seven elders in this survey were referred to the clinic due to neglect while 97 were referred for other reasons. A total of 45 cases of abuse or neglect were identified with 37 (82%) diagnosed with self-neglect, 7 experienced multiple types of abuse and neglect (two cases of caregiver neglect with self-neglect, two cases of abuse with self-neglect, two cases of caregiver neglect and abuse and one case of all three forms of abuse and neglect). A statistically significant higher prevalence of depression (62% vs. 12%) and dementia (51% vs. 30%) was reported in victims of self-neglect compared to patients referred for other reasons which suggests that geriatric
clinicians should assess for neglect or abuse in their depressed or demented elder patients (Dyer et al., 2000).

One study investigated community characteristics associated with elder abuse by analyzing county level data which included county-level population adjusted numbers of abused elderly, abused children, children in poverty, high school drop-outs, physicians and other healthcare providers, hospital beds, social workers and caseworkers in the Department of Human Services subjects from ninety-nine counties in Iowa between 1984 and 1993 were studied in order to identify the relationship between elder abuse rates and county demographics (Jogerst, Dawson, Hartz, Ely, & Schweitzer, 2000). The study concluded that county demographics such as population density, children in poverty and reported child abuse were the community characteristics that were associated with an increased rate of elder abuse. Reported incidence of child abuse was identified as having the strongest correlation. Higher community rates of high-school dropouts, a higher number of chiropractors and nurse practitioners were the community characteristics that were associated with lower incidence of elder abuse (Jogerst et al., 2000).

Categories of Elder Abuse

Kleinschmidt (1997) reviewed 21 studies and identified four general types or categories of elder abuse identified in the literature: physical, emotional, financial and neglect. Some researchers included sexual abuse in the physical abuse category while others expanded the category list and included a separate category for sexual abuse. In addition, some researchers added yet another separate category for self-neglect (Kleinschmidt, 1997).

Physical Abuse. Physical violence or abuse, is an act that is carried out with the intent of causing physical pain or injury such as hitting, grabbing, slapping, pushing, or other bodily injury and which may result in sprains, bruises, abrasions, skeletal fractures, burns and other
wounds (Lachs & Pillemer, 1995). Some researchers also include sexual abuse within their definitions of physical abuse (Kleinschmidt, 1997).

**Psychological/Emotional Abuse.** Psychological or emotional abuse is commonly listed as a category of mistreatment (Lachs & Pillemer, 1995). This includes verbal or nonverbal insults, humiliation, and/or infantilization (Kleinschmidt, 1997) and is often defined as an act carried out with the intention of causing emotional pain or injury (Lachs & Pillemer, 1995). Psychological abuse often accompanies physical abuse (Lachs & Pillemer, 1995).

**Financial Abuse.** Material exploitation or the misappropriation of money or property is the third category identified in the literature. This would include the theft of social security or pension checks, coercion in financial matters and threats to enforce the signing or changing of legal document such as wills or deeds (Lachs & Pillemer, 1995). Some researchers restrict this definition to only illegal or improper use of only specific government benefits and often this form of elder mistreatment is not addressed in studies on elder abuse (Kleinschmidt, 1997).

**Neglect.** Neglect is often defined as the failure of a designated care giver to meet the needs of a dependent elderly individual (Lachs & Pillemer, 1995). Neglect may be further divided into intentional neglect, as when there is deliberate failure in care giving responsibilities with the intent to harm or punish an elderly person, or unintentional, which may be the result of ignorance or an inability to provide care (Lachs & Pillemer, 1995). Intent is a difficult concept to prove. This presents a problem in the literature, as intent-based definitions may technically not exist since intent may not be proven (Kleinschmidt, 1997). Some researchers consider abandonment a form of neglect (Kleinschmidt, 1997). Much of the controversy that surrounds the conceptual definition of elder abuse focuses on the issue of neglect. Cases of neglect raise difficult questions regarding who the responsible care giver is, what the specific responsibilities
are to the neglected individual, and whether this neglect was intentional or unintentional (Lachs & Pillemer, 1995).

**Self-neglect.** The area of self-neglect is occasionally discussed in elder abuse research as a category of elder abuse. This is often defined as an act being conducted by an elder which threatens the individual’s health or safety as in an individual who has difficulty performing activity of daily living skills and refuses assistance despite resulting problems (Kleinschmidt, 1997).

**Sexual Abuse.** Sexual abuse is defined as nonconsensual intimate contact of which the elderly are at particular risk as they may be too weak to resist advances or may be unable to recognize or report the abuse due to cognitive deficiencies (Kleinschmidt, 1997).

**Other.** The National Aging Resource Center on Elder Abuse (NARCEA) suggests that states use a separate category “all other types”. This would include violation of rights, medical abuse and abandonment (Kleinschmidt, 1997).

An argument exists that in our attempt to subdivide elder abuse into categories in order to assign blame, we are ignoring the needs of the victims themselves and that emphasis and resources should be directed to improving functions and quality of life (Lachs & Pillemer, 1995). In response to this argument, many researchers choose to avoid the terms abuse and neglect and instead refer to the problem as the mistreatment of the elderly or the inadequate care of the elderly which includes both the acts of omission and commission (Lachs & Pillemer, 1995).

**Elder Abuse Detection**

**Forensic Markers**

Abuse is often not witnessed by health care or legal professionals. Therefore, the legal system relies on other reporters and evidence to identify the existence of abuse (Dyer et al.,
Most extreme and heinous cases of mistreatment can be easily identified as abuse, for example; gunshot wounds, knife wounds, bite marks and rope-burns. The majority of cases however, are not as clear cut since they may mimic or be mistaken for physiologic and psychological changes that occur with age (Dyer et al., 2003) as elders respond differently from the younger individual in their response to injury (Centers for Disease Control and Prevention, 2001). In addition, elders recover at a slower rate from even minor injuries due to the age affect of the body’s ability to respond to injury and the disruption of physiologic balance (Brown, Streubert, & Burgess, 2004). A research gap exists in the literature, as there is a paucity of primary research data regarding forensic markers of elder abuse (Dyer et al., 2003). A discussion regarding potential forensic markers in each of the categories of elder abuse follows.

**Physical Abuse.** Numerous forensic markers have been identified through research that may indicate the occurrence of elder physical abuse. These may include: bruises, abrasions, lacerations, and fractures.

The result of blunt force with associated rupture of small blood vessels under the skin without breaking the skin, results in the superficial discoloration of the skin known as a bruise (Dyer et al., 2003) or a contusion (Brown et al., 2004). With age, generally the blood vessels become easier to rupture (Dix, 2000). A bruise can become noticeable hours or days after an initial insult. Blood escapes into the surrounding tissues and can track through fascial planes resulting in bruising distant from the site of injury. Eyelids, neck, and scrotum are very susceptible to sustaining a bruise. In the elderly, bruises occur more frequently and resolve more slowly than in a younger person and can last for months rather than one to two weeks (Dyer et al., 2003). Elder skin becomes thin, loose and transparent with a decreased vascularity and atrophy that makes it fragile. Elders bruise under less force or pressure than do younger
individuals (Brown et al., 2004). There is currently no way to determine exactly the amount of force needed to produce a bruise (Dix, 2000).

A classic study that was inspired by a case of child abuse looked at the question of the aging of a bruise (Langlois & Gresham, 1991). The goal was to determine whether it was possible to age a bruise by appearance. Photographs were obtained of bruises using high definition color film from three sources: patients presenting to the emergency department, in-patients and staff. Only bruises where case and age were known were utilized. Photographs were obtained in sequence from the time of appearance to resolution whenever possible. These were then assessed for the presence of particular colors and data was collected. A total of 369 photographs were obtained from 89 subjects with an age range of 10-100 years spanning over a five-month period of time. The main colors that were noted were blue, red, yellow and purple/black. Frequency of occurrence of each color was determined within each time interval for the two age groups and for the two age groups combined. Red was found to be commonly present in all age groups while purple/black was less commonly seen in bruises and their frequency of occurrence appeared to decrease with time. Yellow was found not to be present in bruises within the first two time intervals (0-6 hours and 7-18 hours), while it was observed with increasing frequency in the 157-288 hour time frame. The appearance of a yellow coloration was found to be highly significant, as a yellow colored bruise was very likely to be more than 18 hours old. Elders (individuals over the age of 65), showed a slower development of yellow color. Bilirubin, which is the result of hemoglobin metabolism, has been attributed to the yellow coloration in a bruise. Red, blue and purple/black appeared anytime from within one hour of bruising to resolution of up to 21 days (Langlois & Gresham, 1991). The issue of whether a bruise on an elderly victim can be accurately aged by appearance remains controversial. This
issue is currently under investigation. An accurate description of observed bruising should include the location, shape and color of the bruise using appropriate terminology (Brown et al., 2004).

Bruises alone do not necessarily indicate abuse as elders often have skin that is fragile, thin and easily injured, however it does necessitate further assessment (Humphries Lynch, 1997). The size, shape, and appearance of all bruises, patterns of injury, injuries in unusual locations, and burns must be carefully and thoroughly documented including as much objective information as possible (Humphries Lynch, 1997). Obtaining photographs of the injuries is often a helpful tool and any suspicious injuries warrant further investigation (Humphries Lynch, 1997).

The bruise pattern may suggest the cause of the injury, as a bruise can retain the shape of knuckles or fingers and parallel discoloration marks can indicate injury from a linear cylindrical object (Dyer et al., 2003). Brown, et al. (2003) stress the importance of performing an assessment of the entire body of an elderly assault victim for bruising. The neck, arms and legs may exhibit fingertip bruising from restraint. The face, breast, chest, abdomen and extremities may exhibit bruises from punches and may resemble the shape of a fist with a clear area in the center. The central clearing is created when the punch forces the blood from the capillaries away from the targeted location (Brown et al., 2004).

One study sought to develop a scoring system for bruise patterns as a tool for identifying abuse in children (Dunstan, Guildea, Kontos, Kemp, & Sibert, 2002). The aim was to determine whether abused and non-abused children differed in the extent and pattern of bruising and whether existing differences were sufficient to develop a score to assist in the diagnosis. The total length of bruising in twelve areas of the body (anterior chest and abdomen, back, buttocks, left and right arms, left and right face, left and right ears, other head and neck) was determined in
133 physically abused and 189 control children aged 1-14. Abuse cases were identified via a child protection database while the bruising patterns of control children were obtained from presentation to an ambulatory outpatient consultation for reasons other than abuse. Bruises were measured and details of bruises were recorded together with the maximum dimension of each bruise, and whether or not each bruise had a specific shape. Differences were noted between cases and controls in the total length of bruises. A scoring system was developed using logistic regression analysis using total lengths of bruising. The authors concluded that a scoring system can provide a measure that discriminates between abused and non-abused children, however it is noted that this score should not replace the complex analysis of abuse that includes a thorough history and physical examination (Dunstan et al., 2002). A review of the literature did not produce similar data regarding elder abuse.

Falls are the most common cause of injury in an adult and often result in bruising (Dyer et al., 2003). Falls are not always preventable and have numerous causes such as poor vision, accidents, and transient ischemic attacks. However, abusive or neglectful caregivers can attribute intentional bruises to an accidental fall. Falls alone are not indicative of elder abuse as 30% of community-dwelling elderly and 50% of nursing home residents fall. Most individuals who experience a fall will have one to three falls per year (Dyer et al., 2003).

Abrasions are denuded skin caused by friction, whereas lacerations are noted to be tears of the skin resulting from blunt trauma (Dix, 2000). Skin thickness, elasticity, and tensile strength decreases with age and abrasions can occur with minor trauma. Skin tears are common lacerations in the elderly and can occur on the forearms and occasionally on the legs when the epidermis splits from the underlying connective tissue resulting in a skin flap (Dyer et al., 2003). Abrasions may occur if an elder victim is pulled or dragged across a surface (Brown et al., 2004).
Abrasions retain the pattern of the causative agent better than any other form of injury, making careful documentation vital in identification of the mode of injury (Dyer et al., 2003). An elder’s skin will often tear, causing a laceration if the victim is punched, pulled or restrained (Brown et al., 2004).

Fractures include a frank severing or splintering of the bone as well as a compression of the intact bone. Elderly bones are thinner and less dense, exposing the older individual to an increased risk for fractures or bone disease. In addition, osteoporosis, chronic steroid use, cancer, osteomalacia, Paget’s disease, poor nutrition, alcoholism and age related sex hormone deficiencies weaken the bone and increase the risk for fracture. The most common sites of fracture are the hip and the distal wrist. Elders heal at a much slower rate with little or no data available on fracture resolution rate in the elderly population. A detailed history, examination, and assessment of medical records, is required to determine if a fracture should raise the suspicion of an abusive situation. Fractures of the head, spine, and trunk are found to be more indicative of assault injuries than are limb fractures, sprains, or musculoskeletal injuries. Fractures with a rotational component and spiral fractures of a large bone without a history of gross injury maybe indicative of abuse (Dyer et al., 2003). Arm fractures may occur while breaking a fall or by raising the arms to ward off an attacker’s blows (Brown et al., 2004). In addition, extremity fractures may occur in the attempt of an attacker to restrain an extremity during an attack. Rib and thoracic cage fractures may occur when force is exerted to the chest wall if a victim is forced to the floor, sustains blows from the arms or legs of a perpetrator or by other means of assault (Brown et al., 2004).

Psychological/Emotional Abuse. Most physical abuse is accompanied by a psychological component or psychological abuse may occur by itself (Humphries Lynch, 1997). This may be
difficult to identify unless examples of verbal threats, insults, or humiliation are witnessed (Humphries Lynch, 1997). A careful assessment may uncover subtle signs of depression, change in behavior, fear, anxiety, or withdrawal as the elder may be experiencing intimidation and punishment from the perpetrator (Wieland, 2000). Assessing for psychological abuse is challenging as often the practitioner needs to search for hidden clues in the dynamics exhibited by the elder and the caregiver. If a clinician can intervene when signs of psychological abuse is subtle, it maybe possible to not only stop the abusive psychological behavior, but also prevent escalation to a physical one (Humphries Lynch, 1997).

**Financial Abuse.** The inappropriate use of an elderly individual’s resources for personal gain is termed financial exploitation. This category makes up 12.3% of reports to APS and includes credit card and telemarketing fraud, predatory lending, and theft or extortion (National Center on Elder Abuse, 1998). These activities are often targeted at vulnerable elders who have cognitive impairment and are thus more vulnerable to trusting caregivers, relatives, and acquaintances. Financial exploitation is often unrecognized and it is believed that it occurs in conjunction with other types of abuse (Dyer et al., 2003).

Financial abuse can be devastating to the victim and is often traced to family members, trusted friends, and caregivers. It is likely to occur with the tacit acknowledgement and consent of the elder person (Bonnie & Wallace, 2003). A coercion to change a will or transfer assets abruptly and without forethought may be a warning sign (Wieland, 2000). The manifestations of financial abuse are not generally immediately evident and discoverable (Bonnie & Wallace, 2003).

**Neglect.** Dehydration is a potential forensic marker for neglect. Dehydration is caused by fluid withholding or if dehydration goes unrecognized for a long period of time. Inadequate staff
or family support may lead to dehydration. Decreased fluid intake or excessive water loss can cause an inadequate level of body fluid resulting in dehydration. The elderly are much more prone to dehydration as elderly have decreased body fluid reserves and thirst drives and, in addition, the central nervous system fluid regulation is altered. The most common cause of dehydration is medical illness; however, it can be used as a forensic marker for abuse or neglect when fluid withholding or neglect of care is identified during a thorough history (Dyer et al., 2003).

Determining whether decubiti are due to illness or due to abuse or neglect is difficult. Deep decubiti in multiple sites may indicate an abusive situation. A decubiti or bedsore is the result of circulatory failure secondary to pressure and shearing forces causing thrombosis of the microcirculation leading to tissue necrosis. The elderly are more prone to decubiti due to disease states and lack of mobility, not simply on the basis of age (Dyer et al., 2003).

Malnutrition is often used as a marker for caregiver or self-neglect. The term malnutrition refers to a poor health status resulting from decreased intake of necessary nutrients. A decrease in appetite may result from age related decline of both smell and taste. Illness, poor dentition, depression, dementia, malabsorption syndromes, cancer, and other disorders can lead to malnutrition. The loss of 40% of body weight can result in death. Medications can also contribute to malnutrition as they may cause mental impairment or appetite suppression. The most frequent institutional cause of malnutrition due to neglect is attributed to an inadequate number of staff to assist individuals who require eating assistance. In addition, improper feeding technique may lead to choking, aspiration, pneumonia, or death (Dyer et al., 2003).
Forensic markers for abuse or neglect in regards to use of medications may present in a number of ways. Abusive or neglectful caregivers may withhold required medications, consume the prescriptions themselves, or overdose an elder (Dyer et al., 2003).

Persons over the age of 65 have twice the national average death rate secondary to burns, this rate triples at age 75 and quadruples at age 85. Exposure to heat above 50 degrees Celsius results in a burn tissue injury and is classified by the affected body surface and the depth of tissue destruction (Dyer et al., 2003). Bowden and colleagues (1998) examined the relationship of adult abuse and neglect to burns in the University of Michigan Burn Center and found that 70% of the cases were due to neglect and abuse (Bowden, Grant, Vogel, & Prasad, 1988). In another study, conducted at the Fort Sam Houston Burn Unit, it was determined that 40% of burn cases in patients over the age of 60 were due to abuse or neglect and 36% of the cases were due to negligence (Bird et al., 1998). Data suggests that burns may be a forensic marker for self-neglect, caregiver neglect, or abuse (Dyer et al., 2003).

Self-neglect. The area of self-neglect is occasionally discussed in elder abuse research as a category of elder abuse. This is often defined as an act being conducted by an elder which threatens that individual’s own health or safety as in an individual who has difficulty performing activity of daily living skills and refuses assistance despite resulting problems (Kleinschmidt, 1997). This presents the ethical dilemma of patient autonomy versus beneficence and in some the belief that this reflects more a failure of society than an issue of elder abuse (Kleinschmidt, 1997). Elders who choose to neglect themselves so that their home and personal cleanliness falls drastically below the standards which society deems acceptable present a challenge to health and social service professionals (Adams & Johnson, 1998). One study examined nurses’ perception of self-neglect in older people living in the community by the administration of a semi-structured
questionnaire to a convenience sample of nurses (n=28) in order to ascertain if the concept held any meaning for them in their clinical practice and what they considered its key characteristics to be (Adams & Johnson, 1998). The researchers reported that all the nurses were able to identify patients who had shown features of ‘gross self-neglect’. Poor nutrition was identified as a key-identifying factor. The relationship between poor nutrition and resulting weight loss representing an important sign of self-neglect was stressed as a suggested venue for further research. This is an area which has not received due prominence in medical research, yet the establishment of a ‘failure to thrive’ diagnosis as a possible diagnostic related grouping for self-neglect may provide a scope for future nursing intervention (Adams & Johnson, 1998).

Lauder (1999) explored how the medical construction of self-neglect came to dominate the self-neglect literature. He presented the argument that although nurses frequently encounter patients who neglect their personal hygiene and household cleanliness, self-neglect is often identified within the parameters of the medical model where objectification and categorization is emphasized. According to the author, the medical model’s development of the construct of self-neglect operates under the assumption that there is a self-neglect medical syndrome that can be objectified and measured. This may obscure the fact that patients and professionals have differing ideas about what self-neglect is and what it is not. Different professional groups and those individuals who are categorized as self-neglecting may differ in their objective and subjective perception of self-neglect. Lauder challenges the notion of self-neglect on the basis that it is a normative judgment that involves the norms of cleanliness and hygiene. Nurses are encouraged to challenge the notion of self-neglect as a medical syndrome and nurses must be aware that there may be a number of differing constructions of self-neglect. Nurses should explore the patient’s own construction (Lauder, 1999).
Research and practice in the self-neglect arena have been hampered by a lack of theoretical development and it is felt that self-neglect is underconceptualized and needs to be studied within a broader theoretical context (Lauder, Anderson, & Barclay, 2002). Lauder, et al (2002) theorizes that sociological and psychological theories offer radically different venues for looking at this phenomenon than does the medical model. They seek to explain, understand and place emphasis on the dynamic and interpretative nature of self-neglect rather than simply classifying it as a medical disorder.

Dementia involves a progressive decline in memory or other areas of cognition that results in a reduced ability to care for oneself. Elderly patients who suffer from dementia often experience anxiety and depression in the early stages and delusions and hallucinations in later stages of disease. In the elderly, dementia is often accompanied by self-neglect and mental health problems and may be considered a risk factor for abuse as it makes victims more vulnerable to and less able to defer mistreatment by those who may prey on them. The capacity for self-care decreases as dependence on others increases, which increases risk for abuse and neglect by caregivers who may be unable or unwilling to provide assistance. In addition, self-neglect may be a forensic marker that abuse or neglect has occurred, as victimized elderly may become depressed and consequently may lose the desire or capacity for self-care (Dyer et al., 2003). Forensic interviewing of elderly patients with dementia or cognitive deficits present unique challenges as obtaining reliable and accurate report of the injuries and location of pain may be difficult (Burgess, Dowdell, & Brown, 2000).

The ability to maintain cleanliness and hygiene is an important component of good health and disease prevention. Impaired eyesight may increase the difficulty of maintaining a clean home or clothing, however, if cognition remains normal, elders are generally able to perform the
activities of daily living and maintain proper hygiene. Psychotic or demented individuals often lack the ability for self-care and depressed patients may be less inclined to care for themselves. For others, poor personal care may be a matter of personal choice and lifestyle and should not be blamed on age or on cognitive changes (Dyer et al., 2003). However, a decline in hygiene has also been suggested as a marker of neglect (Lachs & Pillemer, 1995).

Often, it is difficult to ascertain and distinguish declining capacity from eccentricity especially when the elder has lived by his/her own rules for many years and may have rejected a traditional lifestyle early on (Humphries Lynch, 1997). The decision to intervene may be more difficult in self-neglect than in cases of physical, psychological, or caregiver neglect. While trying to ensure the elder’s personal safety one must also respect the legal right to self-determination (Humphries Lynch, 1997). Patient education plays a valuable role in assisting in persuading the elder to accept assistance, while on some occasions needing to respect the right to decline services (Humphries Lynch, 1997). An effective intervention includes the assessment of functionality, informational, and motivational needs in addition to awareness of what services are available to the elder, while being sensitive to self-esteem matters of lifestyle and independence (Humphries Lynch, 1997).

Sexual Abuse. Sexual abuse, is rarely discussed in the literature and few prevalence estimates exist (Kleinschmidt, 1997). Sexual contact or exposure without consent is categorized as sexual abuse and includes those individuals who are not able to consent (Dyer et al., 2003). No reliable incidence data is available regarding the degree of sexual assaults on the elderly (Burgess, Prentky, & Dowdell, 2000). Sexual abuse is defined as nonconsensual intimate contact of which the elderly are at particular risk as they may be too weak to resist advances or may be unable to recognize or report the abuse due to cognitive deficits (Kleinschmidt, 1997). In
one study, aggregate data from APS case files in the state of Virginia yielded a total of 42 substantiated cases of sexually abused adults aged 60 years and older during a three year collection period (Teaster, Roberto, Duke, & Kim, 2000). The majority of the adults who experienced sexual abuse reported to APS were female, typically over 70 years old and resided in facilities such as nursing homes. The majority of the abusers were men who were either staff members or residents. The majority of the cases were not prosecuted either due to insufficient evidence or the elders were not able to participate in the prosecution.

Burgess, Prentky, and Dowdell (2000) explored the nature of perpetrators who target highly vulnerable individuals in nursing homes for sexual assault by reviewing files which included employee reports, in-service records, depositions of nursing home personnel, reports of abuse to human service agencies, expert evaluations, police reports, and trial testimony and criminal justice depositions of cases reported to law enforcement. Twenty case files were reviewed with 18 perpetrators identified who ranged in age from 16 to 82 and included 15 employees and three male residents of the nursing home categorizing two separate groups of offenders (Burgess et al., 2000). This descriptive study was limited by a relatively small sample, however it raised two principle areas of concern: the issue of victimology and fundamental liability issues as the majority of perpetrators were employees, leading to questions related to the issue of negligent hiring practices (Burgess et al., 2000). The victims of these nursing home sexual assaults were advanced in age and suffered from some degree of dementia which complicated the assessment and examination process and compounded the treatment and recovery (Burgess et al., 2000). According to this source, the impact of the trauma on the very frail constitutions of these victims resulted in the death of 11 of the 20 victims within 12 months of the rape (Burgess et al., 2000). Alternative methods of examination and treatment must be
developed and incorporated into nursing home policy and procedures as well as proper training of nursing/medical personnel in effective, humane methods of examination (Burgess et al., 2000). Sexual abuse of an elderly individual remains a taboo in our society, however victims remain unprotected when society refuses to acknowledge this issue (Heath, 1999).

A study comparing 53 sexual assault victims age 55 and older with 53 victims age 18-45 found that older victims (53%) were significantly more likely to sustain genital injury than the younger women (13%) (Muram, Miller, & Cutler, 1992). Women experience age related physiologic changes due to decreased estrogen levels which may alter the shape of the vagina, increase vaginal dryness, thinning of the vaginal walls which may result in pain and bleeding during intercourse and an increased rate of spontaneous vaginal or bladder infections (Dyer et al., 2003). An elder person’s skin is atrophic which makes it more fragile. As an individual ages, skin becomes thin, loose and transparent (Brown et al., 2004). As such, an elder sexual assault victim will exhibit more skin and mucous membrane injury than a younger victim. Extremities are more vulnerable to bruising in an elder. Bruising to the inner thighs is a common finding in sexual assault victims (Brown et al., 2004). The presence of oral venereal lesions, bruising of the uvula, bruising of the palate, bleeding and bruising of the ano-genital area as well as difficulty in sitting and walking may be indicative of abuse (Dyer et al., 2003).

A new diagnosis of a sexually transmitted disease may also be indicative of sexual abuse. In addition, behavioral changes such as withdrawal, fear, depression, anger, insomnia, an increased interest in sex or an increase in sexual or aggressive behavior could also trigger suspicion of sexual abuse (Dyer et al., 2003).

The elderly rape victims are often a neglected group, as they represent a vulnerable and poorly understood population (Burgess et al., 2000). Even the most experienced and skilled
clinicians may feel emotionally uncomfortable, uninformed, and lack confidence in their ability to intervene and manage suspected elder sexual abuse cases (Teitelman & Copolillo, 2002). Knowledge of what to assess and how to appropriately intervene can avert a potentially tragic consequence (Teitelman & Copolillo, 2002).

Teitelman and Copolillo (2002) presented guidelines for recognition and intervention of sexual abuse among persons with Alzheimer’s disease. They identified four avenues for screening for the presence of possible sexual abuse: being sensitive to the observable signs and symptoms associated with sexual abuse, determining the individual’s capacity to consent to sexual activity, using appropriate interviewing techniques and questions, and using more formal assessment tools when needed to determine the likelihood that sexual abuse occurred (Teitelman & Copolillo, 2002).

Safarik, Jarvis and Nussbaum (2000) examined the degree of empirical validity that criminal investigative analysis brings to the investigation and apprehension of offenders that perpetrate elder female sexual homicide. Data was collected by the Federal Bureau of Investigation’s (FBI) National Center for the Analysis of Violent Crime (NCAVC) via numerous sources and consisted of thirty-three solved cases of females identified as 60 years of age and older who were victims of serial sexual homicide. The offenders in these cases were arrested, convicted and deemed responsible for at least two sexual homicides each of elderly females. Four dependent variables: offender race, offender age, the relationship of offender to victim and the distance of offender’s residence from that of the victim were addressed. Of specific note:

- Elder white female serial sexual homicides may be perpetrated by offenders that are of dissimilar race as it was noted that 82% of the black offenders in this study victimized white females.
The majority of offenders were found to be significantly younger (ages 20 to 35) than their elderly victims.

It is highly improbable that the offenders repeatedly came in physical contact with the elderly females whom they subsequently raped and murdered in the course of other criminal activity such as burglary or robbery.

Often times, the theft of items from the victim was an afterthought for the offender (Safarik, Jarvis, & Nussbaum, 2000).

Other. The National Aging Resource Center on Elder Abuse (NARCEA) suggests that states use a separate category “all other types” when categorizing types of elder abuse. The “all other types” would include violation of rights, medical abuse and abandonment (Kleinschmidt, 1997).

Education

The National Aging Resource Center on Elder Abuse (NARCEA, 1992) conducted a study which sought to: investigate the degree to which elder abuse and neglect course content is a part of higher education curricula in aging, determine which specific elder abuse and neglect course content is or is not included in required and elective coursework and to describe the attitudes of instructors towards including elder abuse and neglect course content in the overall curriculum. This study utilized a questionnaire which was sent to 319 contact persons who represented gerontology instructional program members of the Association for Gerontology in Higher Education and yielded 211 usable responses (NARCEA, 1992). Only slightly over one-quarter of all courses offered within the undergraduate instructional units included content on aging, while approximately one-third of all courses offered within the graduate instructional units include content on aging and an extremely small number included course content on elder
abuse and neglect (NARCEA, 1992). Approximately 95% of both the undergraduate and graduate curriculums do not require courses with primary content in elder abuse and neglect, however, 76% of undergraduate curriculums and 68% of graduate curriculums include elective courses in this area as a segment or component of the course content (NARCEA, 1992). It has been suggested that increasing physician awareness of the problem of elder abuse will increase the number of cases screened for potential abuse and as such, increase the number of elder abuse reports to responsible agencies (Rosenblatt et al., 1996).

A randomized controlled trial was conducted utilizing nurses, care assistants and social workers who worked with elders, that compared the effectiveness of attending an educational course to printed educational material in improving management of elder abuse (Richardson, Kitchen, & Livingston, 2002). Eligible participants were randomly assigned to either group one, which attended an educational course or to group two, who were given reading material with the same content as the course and asked to complete a pre- and post-intervention questionnaire (Richardson et al., 2002). The main findings of this study included information that there was a lack of knowledge of good management in dealing with elder abuse and that educational course work was superior to printed material in increasing elder abuse knowledge and interventional management (Richardson et al., 2002).

An exhaustive search of the literature failed to reveal information regarding the educational preparation of nurse practitioners in the area of elder abuse. A lack of knowledge in the area of elder abuse interferes with awareness and alertness to elder abuse among health care professionals (Meeks-Sjostrom, 2004). A major gap in nursing knowledge exists in the area of elder abuse educational preparation of nurse practitioners.
Screening Tools

There have been few screening tools to identify potential elderly victims or perpetrators of abuse (Nelson, Nygren, McInerney, & Klein, 2004). Although these instruments performed fairly well in studies, they have not been tested in health care settings and there have been no identified studies of interventions in the elderly individuals (Nelson et al., 2004). A review of some of the most widely used screening tools follows:

**Indicators of Abuse (IOA) Screen.** Reis and Nahmiash (1998) designed and validated the 29-item Indicators of Abuse Screen to identify elder abuse cases based on previous risk factor research (Bonnie & Wallace, 2003). The majority of the validated elder abuse screens, have been designed to be completed by the potentially abused elder themselves or by a caregiver. This may present a concern related to accuracy as both the caregiver and the recipient could be concealing the abuse (Reis, 2000).

The IOA screen is designed to be administered by a professional instead of the caregiver or recipient. Even though this is a screening tool, it requires knowledge of the caregiver and recipient’s characteristics obtained via interview (Bonnie & Wallace, 2003). A sixty-item preliminary checklist was initially developed that included forty-eight possible indicators of abuse in addition to twelve background and demographic items, such as age and gender (Reis, 2000). These initial sixty items have been identified in prior research as being associated with abuse and involved mostly with problems of either the caregivers or the care recipients (Reis, 2000). The researchers felt that the problem-oriented view of abuse etiology was well supported by a number of theories (Reis, 2000). These problems included items such as a caregiver’s substance abuse, high degree of stress, or a recipient’s increased dependency or physical impairment (Reis, 2000). The purpose of this preliminary measure was to test the sixty items of
concern which had previously only been studied individually or only a few at a time (Reis, 2000). The initial goal was to identify which items presented a valid measure to reliability and which items would prove to be “myths” or unimportant in screening (Reis, 2000). This study was part of an extensive 3-year initiative called PROJECT CARE and was supported by Health Canada (Reis & Nahmiash, 1998). There were 341 participants in the IOA validation study. Inclusionary criteria included those care-recipients over 55 years of age who had unpaid caregivers, either a friend or relative, who provided regular assistance. Each case required an initial two to three hour home interview by a professional agency employee, usually a nurse or social worker. The purpose of the home visit was to complete an overall assessment that included a review of the recipient’s biological, psychological, and social problems. The preliminary IOA screen was then completed in approximately 20 minutes. From the 60-item initial checklist, a smaller 29-item subset was developed that was designed to predict whether abuse was likely to be present and reported rather impressive results (Reis, 2000). Sensitivity and specificity results indicated that these 29 items could predict whether abuse was likely to be present 78 to 84.4 percent of the time and non-abuse cases were successfully identified 99.2 percent of the time (Reis, 2000).

The overall findings indicated that abuse is strongly associated with the caregiver’s personal and emotional problems and that the caregiver’s risk factors rather than the receiver’s were most important factors in predicting abuse and neglect (Reis, 2000). In addition, it was found that several issues that were assumed to be an important factor in risk identification, such as the physical or emotional impairment of the care recipient or an increased need for help with activities of daily living did not signal abuse, nor does a situation where the caregiver is under
much stress or is socially isolated (Reis, 2000). These issues may certainly be important and may need intervention, however, they were not found to be abuse markers (Reis, 2000).

The typical abuse case profile was characterized by, “a troubled caregiver, who has difficulty getting along with others and a situation in which the care recipient has been abused in the past and in which there is inadequate social support” (Reis, 2000, pg 15). A strength to this tool is that it assesses both the caregiver and the care recipient and that it assesses multiple forms of abuse. A high false negative rate, limited applicability of the tool to assesses elder marital relationship, causes of domestic violence, and the need for in-depth knowledge of the participants is considered this tool’s major weaknesses (Bonnie & Wallace, 2003).

**Elder Assessment Instrument (EAI).** The Elder Assessment Instrument has been discussed in the research and used in clinical practice since 1984 (Fulmer, 2003). This tool uses a 41-item Likert scale which consists of seven subscales that review the signs, symptoms, and subjective complaints of elder abuse, neglect, exploitation, and abandonment. It is designed to identify elders at high risk of mistreatment and those who should be referred for further assessment if the following exists: evidence of mistreatment without sufficient clinical explanation, a subjective complaint by the elder of mistreatment, or the clinician believes there is high risk or probable abuse, neglect or exploitation. The EAI is appropriate for usage in all clinical settings and is completed by clinicians responsible for elder mistreatment screening (Fulmer, 2003). It is comprehensive and can be utilized for serial assessments (Bonnie & Wallace, 2003). The tool requires approximately 12-15 minutes to complete.

One study utilized grounded theory analysis to analyze transcripts of audio-recordings of the neglect assessment team (NAT) meetings at the Mount Sinai Medical Center in New York City (Fulmer et al., 2003). The goal of this analysis was to understand how expert neglect
assessment teams process and diagnose complex cases referred for possible elder mistreatment. Data was collected via the Elder Assessment Instrument in the Emergency Department (ED) at Mount Sinai and was then reviewed and evaluated by the NAT. All cases were classified into one of three possible categories: neglect present, no neglect present and unable to diagnose. Grounded theory analysis of the audio-recorded NAT meetings was utilized to evaluate the Elder Assessment Instrument data collected and discussed by the NAT. Recorded discussions took place over four sessions. Four practice cases from the literature as well as 19 cases discussed during four NAT meetings were audio taped and transcribed. Data was reviewed until saturation of themes was reached. Four major themes emerged from this analysis: understanding the underlying health status of the elder and caregiver, understanding the socioeconomic and life circumstances of the dyad, credibility of data collected by others, and the consequences of the assessment outcome.

1. Understanding the underlying health status of the elder and the caregiver emerged as an important theme. NAT members sought details of the reason for the elder’s visits to the ED, their health problems and chronic ailments as well as the capacity of the caregiver to satisfy the health care needs of the elder. Ambulation status was noted to be an important indicator of the level of function and dependency of the elder and as such, had an impact upon the NAT’s diagnosis of neglect. Elders who were frequently seen in the ED were considered to be at greater risk for neglect.

2. Understanding the socioeconomic and life circumstances of the elder and caregiver dyad emerged as another important theme. The NAT discussed the economic factors facing the elder such as health insurance, financial situation of the elder and caregiver and the caregiving relationship. Socio-cultural consideration and background was
considered to be an important factor when assessing neglect as the perception of neglect might arise from expectations based on a particular socio-cultural perspective.

3. The credibility of data collected by others also emerged as an important theme. The NAT were most comfortable when data was obtained directly from the elder patient and raised questions regarding how the instrument was administered and handled during the interview process when data was obtained from a clinician.

4. Lastly, the possible consequences of the outcome of the assessment process emerged as an important theme while discussing the case studies. Concerns were raised regarding what would happen to the elder or the caregiver as a result of an elder mistreatment diagnosis and how that would affect the caregiving relationship. It was recommended that this information be utilized in the development of future screening and assessment procedures (Fulmer et al., 2003).

*Hwalek-Sengstock Elder Abuse Screening Test (HSEAST).* Hwalek and Sengstock (1986) originally pooled more than 1000 items from existing elder abuse assessment protocols in order to develop a 15 item instrument that measured three abuse aspects: direct abuse or violation of personal right, vulnerability characteristics, and potential abuse. The goal of the original study was to identify a set of items that would differentiate those elderly who were abused from those in a control group who were known not to be abused in the hopes of creating a screening tool (Hwalek & Sengstock, 1986). Over time and with use of discriminate analysis, the original 15-item tool was validated (Neale, Hwalek, Scott, & Stahl, 1991) and it was found that a six-item tool effectively discriminated between abuse and non-abuse as well as the original 15 item tool (Wolf, 2000). This is a self reporting measure that is designed to be completed by the individual themselves (Wolf, 2000) and was the only self-reporting tool identified in this literature search.
This screen is designed to be followed by a more in-depth interview by a clinician if the scores warrant (Wolf, 2000).

**Caregiver Abuse Screen (CASE).** The Caregiver Abuse Screen is designed to be completed by the caregivers and it is a relatively quick and short eight item tool which assesses abuse and neglect (Bonnie & Wallace, 2003). Direct questions about mistreatment are avoided; the authors use wording that is designed to be non-blaming. This tool is designed for community use in order to screen for current physical, psychosocial, or financial abuse and neglect and is based on the larger elder abuse intervention and research project, PROJECT CARE (Reis, 1995). The tool’s authors stress the importance of caregiver screening based on studies reporting that care receivers report less abuse than caregivers and that caregiver’s characteristics such as substance abuse and a problem history more than care-receiver characteristics are felt to be of primary importance in abuse (Reis, 1995).

Kottwitz and Bowling (2003) piloted the Elder Abuse Questionnaire (EAQ) that is designed to measure the perception of elder abuse within a described population. Betty Neuman Systems Model was used as a framework for the study. The EAQ contains 25 items that were derived from Neuman’s variables related to physiological, psychological, socio-cultural, developmental, and spiritual stages of the multidimensional person. A descriptive study design was selected for the instrument development and the Likert scale was chosen as a method of data measurement. The population included the power of attorneys (POA) for 40 residents and 40 employees of a long-term care facility. The questionnaire was mailed to 40 resident’s POA and included in 40 employee’s pay envelopes with a self-addressed stamped envelope and resulted in a 61.25% participation rate (N=49). Results of the pilot indicate that the EAQ has strong to moderate reliability as an instrument based on a one-factor solution and was measured using
Cronbach’s coefficient alpha to compute the internal consistency of the questionnaire. The authors acknowledge that the population was narrowly focused and recommend that the EAQ be repeated in numerous populations for reliability comparison (Kottwitz & Bowling, 2003).

Elder Abuse Management

Legislative History

Elder abuse was brought from behind closed doors and onto the national stage when in the mid 1970’s testimony about “parent battering” was presented at a U.S. congressional subcommittee hearing on family violence (Wolf, 2000). Linked to family violence, elder abuse became a topic in the media when horrific case reports were uncovered by the U.S. House of Representatives Select Committee on Aging requiring state policy makers to react by pressing for special elder abuse legislation (Wolf, 2000).

In 1962, Congress passed the Public Welfare Amendments to the Social Security Act which authorized payments to the states to establish protective services for individuals with physical and/or mental limitations who were unable to manage their own affairs or who were neglected or exploited (Wolf, 2000). Title XX amendment to the 1974 Social Security Act, was adopted twelve years later and adult protective services (APS) became a state-mandated program covering all adults 18 years and older (Wolf, 2000).

As the APS system for reporting and investigating cases was already in place by the time elder abuse became a public concern, legislators were permitted to support action on elder abuse without having to call for additional state expenditures and in a few years time, most states followed by passing elder abuse laws or made amendments to existing adult protective services legislation to address this concern (Wolf, 2000). Congressional hearings in the 1980’s led to the creation of an Elder Abuse Task Force and in 1990 the US Department of Health and Human
Services established the National Institute on Elder Abuse (Wieland, 2000). Child abuse laws became the prototype for legislation in over three quarters of the states as a model statute on elder abuse did not exist. However, the inadequacies of this application of child abuse legislation to the elder abuse legislation soon became apparent (Wolf, 2000). The potential for violating civil rights by infatalizing elders along with new findings on the prevalence of spouse abuse which suggested that domestic violence model might be a more appropriate fit, necessitated policy makers to expand interventions and treatment possibilities to include the methods and instruments of the public health and criminal justice systems (Wolf, 2000). Laws answering the multifaceted nature of elder abuse and incorporating new conceptualizations on the state and federal levels are continually being amended (Wolf, 2000).

In an attempt to address the phenomenon of elder abuse, some states have drafted protective measures in identifying and combating elder mistreatment and have enacted statutes that require mandatory reporting, civil and criminal penalties and emergency interventions (Smith, 2002). All states and the District of Columbia include provisions governing the reporting of suspected elder mistreatment, with all but six of those jurisdictions mandating reports by specified categories of persons. The remaining states: Colorado, New Jersey, New York, North Dakota, South Dakota, and Wisconsin permit reporting; however they do not mandate it (Bonnie & Wallace, 2003).

Elder Abuse Reporting Controversy

Elder abuse laws are designed and intended to protect vulnerable citizens and to punish violators, yet they may be in conflict with the principles of medicine, raising doubts among clinical professionals about appropriateness and feasibility of reporting (Hirsch et al., 1999). While mandatory reporting is in place for child abuse, it has not been established in reporting for
elder abuse. Reporting potentially violates provider-patient trust and confidentially and may threaten the therapeutic alliance between the provider and the caregiver/abuser (Hirsch et al., 1999). Reporting is the most common and yet the most controversial intervention (Bonnie & Wallace, 2003). Supporters of mandatory reporting argue that by legally requiring reporting, those individuals who may initially be hesitant to report elder abuse fearing error or the fear of interference in another family’s personal affairs may be more forthcoming in identification (Smith, 2002). Opponents to mandatory reporting stress that an involuntary intervention into an elders’ life will only act to encourage ageism in society and deter elders from confiding in clinicians or seek medical assistance for fear that they will be a subject of investigation (Smith, 2002). The concept of mandatory reporting of suspected abuse was borrowed from the child abuse laws without the benefit of research data to demonstrate applicability to the older population (Bonnie & Wallace, 2003). The ongoing debate surrounding mandatory reporting raises numerous empirical questions regarding the effectiveness of these laws on the behavior of mandated reporters and the consequences of reporting on the lives of those affected by them (Bonnie & Wallace, 2003). Nurse practitioners interface with elders and are in a unique position to address the issue of elder abuse reporting.

**Pertinent Research Related to Clinician Elder Abuse Detection and Management**

The following literature review was conducted to describe and evaluate existing research and survey tools that measured a health care provider’s knowledge of elder abuse, screening methods, elder abuse reporting practices and perceived barriers to reporting. The retrieval process resulted in the identification of only five studies.

Harrell, et al. (2002) interviewed ten geriatricians using a standardized set of open-ended questions to identify how practicing geriatricians define, diagnose and address elder abuse and
neglect. The subjects were asked to identify what points in the history and physical led them to diagnose elder abuse. The purpose of this study was to obtain descriptive data regarding the diagnosis of abuse and neglect, signs and symptoms obtained from the history and physical examination, differences between how geriatricians define caregiver neglect and self-neglect and how suspicion for neglect is addressed in order to advance elder abuse knowledge and assist primary care physicians in making a diagnosis of elder abuse. A team, using both quantitative and qualitative methodology, analyzed the verbatim transcriptions. The average number of cases diagnosed per year was 8.7 with a range of 2-20. Rapport between the patient and caregiver, medical noncompliance, assessment of activities of daily living and instrumental activities were the most common reported identifying clues in the history. Bruising/trauma, general appearance, hygiene, malnutrition and dehydration were noted as the most common identifying clues on physical examination. Geriatricians emphasized the need to keep the diagnosis of abuse in mind for every patient. When asked to indicate the most important history and physical finding that alerted them to a diagnosis of elder abuse or neglect, the majority of geriatricians reported the need to assess the totality of the bio-psycho-social issues rather than focusing on a single part. Geriatricians presented a diversity of responses regarding interventions utilized in suspected abuse and neglect cases. Some reported the need to immediately notify APS. Whereas others, feeling that they had an established relationship with the patient, often attempted their own intervention as a first step prior to contacting APS. This diversity in treatment methodology requires further exploration (Harrell et al., 2002).

In another study, all general medical practitioners working in an inner London borough in the United Kingdom (UK) were asked to complete a questionnaire that asked about their knowledge and experience of elder abuse (Mc Creadie, Bennett, & Tinker, 1998). Seventy-three
practitioners responded (68% response rate) to questions regarding twenty situations where it would be reasonable to hold a suspicion of elder abuse. Five main types of abuse were grouped for analysis: physical, psychological, sexual, financial, and neglect. General practitioners were targeted, as they were felt to be the front-line professionals to whom the British public turned with a wide variety of medical and psychosocial problems and as such would play a key role in the identification and management of elder abuse. The first question directly inquired about the GPs experience with a case of abuse during the past twelve months. Forty-nine percent of GPs reported having known or suspected a case of an elder who sustained one or more types of abuse. Respondents were then asked about twenty “at-risk” situations that covered five types of abuse and asked to check appropriate boxes while responding to the following question: “With regard to the care of older people living in the community, during the last twelve months have you had any patients who are or might be in any of these situations?” (Mc Creadie et al., 1998). The response to these scenarios does not refer to the prevalence rate; rather it highlights the range of situations encountered by GPs and how common those scenarios are in GPs experience. The key findings of this study in regards to GPs knowledge and experience of elder abuse were as follows: 84% reported having had an older patient in at least one of these situations, 75% were aware of a patient in a situation involving risk of psychological abuse, 52% were aware of a risk of neglect and 47% were aware of a risk of physical abuse. This study raises two important questions: Are GPs failing to recognize abuse or failing to define situations as being abusive? How are they responding to these situations?

A Swedish study congruent with this UK study utilized the same questionnaire which was translated into Swedish to describe the awareness among Swedish general practitioners of elderly patients at risk of or suffering from abuse during a 12-month period (Saveman &
Sanvide, 2001). The questionnaire was sent to 110 physicians and yielded a 59% response rate. In this study, 25% of the responding GPs reported being aware of patients who were subjected to verified or suspected elder abuse when responding to the first question directly inquiring about the physicians experience with a case of abuse during the past twelve months, which is only half the percentage reported in the UK study. In this study, a large proportion of GPs (77%) reported having elder patients in situations where there is risk of abuse or neglect. This is very similar to the 84% reported in the UK study and once again raised the question: Are GPs failing to recognize abuse?

A self-administered four-page national survey comprised of 44 questions focusing on the magnitude of elder abuse was utilized to determine physician awareness of applicable state laws and the barriers to reporting suspected cases (Jones, Veenstra, Seamon, & Krohmer, 1997). A random sample of 3,000 members of the American College of Emergency Physicians yielded 705 completed surveys (response rate of 24%) that answered questions which included practice characteristics, number and type of suspected cases of elder mistreatment seen in the emergency department, number of cases reported, reasoning for not reporting cases, the availability of elder mistreatment protocols and their familiarity with local laws and reporting requirements. In this study: fifty-two percent of the respondents identified elder mistreatment as prevalent yet less so than spousal or child abuse, approximately 50% of suspected cases of elder mistreatment were reported, 31% reported having a written protocol for reporting suspected cases and they were generally unaware about applicable state laws, 25% were able to recall educational content regarding elder abuse, 74% did not believe that there was a clear-cut medical definition of elder abuse or neglect, 58% were uncertain that emergency physicians can accurately identify cases of abuse and 92% reported that states did not have sufficient resources to meet the needs of victims.
The results suggest that practicing emergency physicians are not confident in identifying or reporting elder abuse and this lack of confidence may reflect inadequacies of training, research and continuing education.

A questionnaire survey developed for the Research Subcommittee of the Elder Abuse and Self-Neglect Task Force of Hamilton-Wentworth was utilized in Krueger and Patterson’s (1997) study to determine family physician’s perceptions of barriers and strategies in the effective detection and appropriate management of abused elderly people. A total of 189 eligible physicians were randomly selected from the Canadian Medical Directory with 122 responding. The following barriers were identified: family/patient denial of abuse, resistance to intervention, not knowing where to call for help, lack of protocols to assess and respond to abuse, lack of guidelines about confidentiality, fear of reprisal and lack of knowledge of the prevalence and definition of elder abuse. The following strategies were noted to be helpful: a single agency to call, a directory of services, a list of resource people, an educational package, guidelines for detection and management, reimbursement for time spent on legal matters, continuing education, revision of fee structure and a central library of resources on elder abuse.

An exhaustive search of the literature failed to reveal research or data on the detection and management practices of nurse practitioners in the area of elder abuse. A major gap in nursing knowledge exists in the topic of elder abuse detection and management practices of nurse practitioners. The questionnaire survey developed by Kruger and Patterson for the Research Subcommittee of the Elder Abuse and Self-Neglect Task Force of Hamilton-Wentworth is specifically designed to determine a clinician’s perceptions of barriers and strategies in the detection and management of elder abuse. As such, it will be utilized to identify nurse practitioner self-perceived barriers and strategies for detecting and managing elder abuse.
Summary

Elder abuse and neglect is severely under-diagnosed and under-reported. All too often the signs of abuse mimic those of chronic disease and accidental injury. Many common maladies among the elderly may be the result of elder abuse and mistreatment, yet those signs are missed. The vital key to interpretation of these signs is not merely noting their presence, but also identifying their characteristics. This will help to further differentiate between a natural and an intentional occurrence. A gold standard forensic marker for abuse does not yet exist, however certain symptoms should alert suspicion.

The identification and intervention of abuse by clinicians is generally considered to be a professional responsibility (Nelson et al., 2004). Reporting suspected cases of elder mistreatment is the most common and yet the most controversial intervention used (Bonnie & Wallace, 2003). Adult protective statutes exist in all states and in the District of Columbia which include provisions governing the reporting of suspected elder abuse, yet all but six of those jurisdictions mandate reporting of suspected mistreatment by specified categories of individuals (Bonnie & Wallace, 2003). The controversy and debate concerns the effects of these laws on the behavior of mandated reporters and on the consequences of those reports on those affected by them (Bonnie & Wallace, 2003). Nurse Practitioners must be aware of the state statutes in the state where they practice. Intervention requires a multidisciplinary approach and involvement of Adult Protective Services (Wieland, 2000). Nurse Practitioners are in a unique position to identify and intervene in potential elder abuse cases.

It is apparent that there are major weaknesses in existing research in this field of study. There are a sizable amount of published and non-published reports available on elder abuse, yet the National Research Council identified fewer than 50 peer-reviewed articles that were based on
Empirical research (Bonnie & Wallace, 2003). A major weakness in current research is the unclear and inconsistent conceptual definition of elder abuse itself. Substantial additional research is required to improve, expand, and develop new measurement tools that would be applicable to a wide-range of clinical settings.

Elder abuse is a relatively new research focus, especially for nurse practitioners. Although a number of studies identified how physicians define, detect, report, and manage elder abuse, no such studies exist specific to nurse practitioners’ practice in this regard. The 2003 American Academy of Nurse Practitioners (AANP) surveyed 14,900 AANP members (American Academy of Nurse Practitioners, 2005). Thirty four percent responded to the survey (n=5036). The majority of respondents (61%) identified themselves as Family Nurse Practitioners whose scope of practice included adults, women’s health, gerontology and pediatrics. Nurse Practitioners play a crucial role in the identification of elder abuse, as they are especially well placed to detect and potentially prevent instances of abuse as even the most frail and elderly individuals come in contact with their care.

How do Nurse Practitioners define elder abuse? How has education prepared or influenced them in this area? What influences a Nurse Practitioner to report elder abuse? What assessment tools, if any, are used to measure abuse risk, potential, and occurrence? What forensic markers alert them? How often do they encounter suspected abuse and neglect? What are their reporting practices? What barriers exist to reporting suspected cases? What patterns of knowing influence a Nurse Practitioner to report elder abuse? Empirical research is urgently needed to answer these vital questions. There is much work yet to be done to progress our knowledge in this challenging field. This research study strives to provide initial answers to address this gap in nursing knowledge by asking the following questions: What are nurse
practitioners’ self-perceived barriers in the detection of elder abuse? What are nurse practitioners’ self-perceived strategies in the management of elder abuse? So many questions remain. This study is only the beginning.
III. Methodology

Introduction

The purpose of this study is to explore and quantify the self-perceived barriers and strategies for detecting and managing elder abuse. Specifically, this study was designed to explore the self-perception of Nurse Practitioners in this arena. Chapter one and two established the study’s problem statement, identified the research questions and presented a review of the literature. This chapter describes the methodology used for this study including a discussion on the research design, participant selection, inclusion criteria, procedure for the protection of human subjects, instrument review and the procedure for data collection and analysis.

Research Design

This study is an exploratory, descriptive survey design conducted using a mailed self-administered questionnaire that examined the self-perceptions of the barriers and strategies for detecting and managing elder abuse by nurse practitioners. The researcher explored the dimension of elder abuse detection and management practices of nurse practitioners. An exploratory design was chosen as by definition, exploratory research is a study which explores a phenomenon’s dimension (Polit & Hungler, 1999). The nature of the research questions guided the chosen methodology.

Surveys are designed to determine what proportion of a predefined population has a particular attribute or opinion (Salant & Dillman, 1994). A mailed survey is the ideal form of data collection for this study as it provides the design advantage of economy of design and rapid turnaround in data collection (Creswell, 2003). A survey provides the opportunity to identify attributes of a large population from the use of a small group of individuals (Salant & Dillman,
Mailed surveys provide a sense of privacy, as it is easier for participants to answer personal questions in writing than in a face-to-face manner. They also provide anonymity and are less sensitive to biases introduced by interviewers. It is recognized that the greatest weakness of mailed surveys stems from sensitivity to non-coverage error as samples are often drawn from often incomplete and out of date lists. In addition, some individuals are less likely to respond to questionnaires than others, which can present as a non-response error. Furthermore, the researcher cannot control whether mailed questionnaires are completely filled out causing an item non-response. Lastly, the researcher has little control of what happens with the questionnaire after it is mailed and cannot ensure that it is properly received and completed by the individual to whom it is addressed (Salant & Dillman, 1994).

**Participant Selection**

The participants for this study were randomly selected from the American Academy of Nurse Practitioners (AANP) current membership mailing list of approximately 17,600 members. A preliminary power analysis was conducted. Sixty-two completed surveys were needed in order to minimize sampling error. Two hundred participants were selected in anticipation of a 40% response rate.

**Inclusion Criteria**

The inclusion criteria consisted of currently licensed Nurse Practitioners who care for the elderly population (identified as 60 years and older) and practice in the United States.

**Procedures for the Protection of Human Subjects**

Following the approval of this study by the dissertation committee, approval was received from the Duquesne University Institution Review Board in order to remain in compliance with procedures governing protection of human subjects (Appendix E). The AANP
provided a database of names and addresses of the academy members at a predetermined fee. Through an agreement with the AANP, a professional at the AANP who is contracted by AANP to provide accurate random samples from their database to researchers, chose a random sample of 200 currently licensed and employed nurse practitioners. Participation was strictly voluntary and subjects had the right to refuse. Materials were mailed to the prospective subjects. No monetary benefit for participation was offered. There was no reward for participation except for the personal satisfaction that is derived from contributing to nursing body of knowledge. Measures to protect confidentiality of the Nurse Practitioners subjects were strictly maintained and were described to all subjects at the onset of the study. Participants were instructed to return their completed questionnaire with no identifier. Published results of this study will be made available to interested participants. Data will be maintained in a secure location pending completion of this study and for potential future use. There are no foreseen risks to participation in this study.

Instrument

The questionnaire utilized was designed by Krueger and Patterson for the Research Subcommittee of the Elder Abuse and Self-Neglect Task Force of Hamilton-Wentworth utilizing a framework described by Dillman (Krueger & Patterson, 1997). The tool was pre-tested and revised and took two years to develop before original usage by the authors. Frequency counts and proportions were calculated and then ordered for responses that related to the potential barriers to and strategies for the detection and management of elder abuse by the physicians sampled. Fisher’s exact test was used when appropriate along with the Chi Square ($\chi^2$) test to determine statistical significance in the proportions of responses according to physician characteristics, year of graduation, sex, and attendance at continuing medical education and
whether the physician ever had seen abused elderly patients in his/her current practice. A
probability level of .05 was utilized to determine statistical significance. SPSS and Epi-Info was
used to calculate statistical components (Krueger & Patterson, 1997). Permission from Dr. Paul
Krueger has been obtained (Appendix E). The Krueger and Patterson tool was utilized
unchanged except the word “nursing” replaces the word “medical” in order to properly address
the target population of this survey.

Procedures for Data Collection

The following survey procedures were utilized for this study:

1. Participants were randomly selected by the American Academy of Nurse Practitioners from the American Academy of Nurse Practitioner Data Base.
2. All selected participants were mailed a personalized, advance notice letter informing them that they have been selected for the survey and they would be receiving a questionnaire within one week (Appendix B).
3. Approximately one week later, all participants were mailed a personalized cover letter (Appendix C) with further detail regarding the survey, the survey questionnaire (Appendix A), and a stamped addressed envelope. The participants were informed in the cover letter that their return of the questionnaire constituted their consent.
4. De-identification of the data: Participants were instructed to return their questionnaire with no identifier. Their return envelope did not include a return address. In this way, there is no chance that any participant could be identified. The return of the questionnaire to the researcher constituted consent.
5. Four to eight days after the questionnaire was mailed, all participants were mailed a follow-up postcard thanking those who responded and requesting response from those that did not (Appendix D).

6. Data was maintained in a secure location during the completion of this study and for potential future use.

Procedures for Data Analysis

Statistical analysis was conducted utilizing the Statistical Package for the Social Sciences (SPSS) version 14.0. Data from each questionnaire was entered into a database by the researcher for data analysis. Two survey instruments with missing data were rejected. Statistical analysis includes descriptive statistics and Spearman rank correlation was used to determine whether statistically significant relationships are present between elder abuse awareness and nurse practitioner characteristics (such as year of graduation, attendance at continuing education experiences and whether the nurse practitioner has seen abused elder patients in current practice). Qualitative data collected in the open-ended questions on the questionnaire was utilized for descriptive purposes. A probability level of .05 was utilized to determine statistical significance. Measures to protect confidentiality of the Nurse Practitioner subjects were strictly maintained.
IV. Results

Overview

This chapter describes the results of data analysis. The chapter begins with an overview of the methodology utilized, a description of the characteristics of the participants, and is followed by a description of the results as they relate to the research questions.

Two hundred potential participants were randomly selected from the American Academy of Nurse Practitioners (AANP) membership database. Each potential participant was mailed an advanced notification letter (Appendix B), followed one week later by the survey questionnaire (Appendix A) with a cover letter (Appendix C). A reminder postcard (Appendix D) was mailed one week after the questionnaire was mailed in order to maximize the response rate. All participants were assured of complete confidentiality. One hundred and nine survey questionnaires were returned (54.5% response rate). Nineteen respondents indicated that they did not see elderly patients in their current practice and were thus ineligible. In addition, two participant’s survey questionnaires contained missing data and were excluded from data analysis. A preliminary power analysis determined that a sample size of 62 was needed. This study resulted in 88 eligible survey participants. Therefore, the sample size was adequate to obtain significant power (and avoid committing a Type II error). All statistical analyses were computed at a significant level of $p < .05$. Data from each survey questionnaire was entered into a database for data analysis using SPSS (v. 14.0) by the researcher. Data was analyzed descriptively examining frequencies, ranges, and distribution of variables.

Analysis of Participant Characteristics

The total sample of eligible nurse practitioners (N=88) reveals the following participant characteristics. Seventy-eight participants were female (88.6%) and ten participants (11.4%)
were male. Eleven (12.5%) classified their type of practice as a solo practice, twenty-seven (30.7%) as a group practice with other nurse practitioners, thirty-five (39.8%) as a multidisciplinary group practice and fifteen (17%) identified as other. Those identified as other types of practice included: prison, urgent care facility, infirmary, rural health clinic private MD practice, acute care hospital and specialty practice settings. The majority of respondents, sixty-seven (76.1%), reported that their primary method or reimbursement was through a salaried position, while eight reported fee for service reimbursement (9.1%) and fifteen reported other means of reimbursement (15%). Two participants reported a combination of salary and fee for service reimbursement, two were owners of their clinic, three worked in the Veterans Administration system, one received reimbursement through productivity, one through insurance reimbursement, one was paid hourly and one via a combination of salary and bonuses.

The total years since graduating as an NP ranged from one to thirty-two, with a mean number of years at 8.66, a median of 8, and a mode of 9. The majority of respondents, seventy-five (85.2%) received their master’s degree in nursing, ten respondents noted a master degree other than nursing (11.4%), eighteen reported earning a post master’s degree as an NP (20.5%) and two respondents were doctorally prepared in nursing (2.3%)

Analysis of Self-Perceived Barriers to the Detection of Elder Abuse

Research Question #1: What are the self-perceived barriers to the detection of elder abuse by nurse practitioners? Nurse practitioners were asked to rate the importance of fourteen potential barriers to the detection of elder abuse using a 5-point Likert scale (not at all important, not very important, neutral, fairly important, and very important). The barriers that were perceived to be fairly or very important by the majority of respondents include: families/patients’ resistance to intervention once elder abuse is identified, families/patients’
denial of elder abuse, fear of reprisal by the abuser towards the elder, lack of professional
protocol related to responding to elder abuse, lack of knowledge about where to call for help,
lack of professional protocol related to assessing elder abuse, lack of knowledge about where to
call for help, lack of professional protocol related to assessing elder abuse, lack of clear
guidelines about confidentiality in elder abuse situations, difficulty in determining what
constitutes elder abuse, and the lack of knowledge about the prevalence of elder abuse. Table 1
lists the barriers that were noted to be fairly or very important by the responding nurse
practitioners.

Table 1

*Nurse Practitioner Self-Perceived Barriers to the Detection of Elder Abuse* (N=88)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Potential Barrier</th>
<th>%</th>
<th>(No.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Families/patients’ resistance to intervention once elder abuse is identified</td>
<td>76.1%</td>
<td>(67)</td>
</tr>
<tr>
<td>2</td>
<td>Families/patients’ denial of elder abuse</td>
<td>73.9%</td>
<td>(65)</td>
</tr>
<tr>
<td>3</td>
<td>Fear of reprisal by the abuser towards the elder</td>
<td>71.6%</td>
<td>(63)</td>
</tr>
<tr>
<td>4</td>
<td>Lack of professional protocol related to responding to elder abuse</td>
<td>70.5%</td>
<td>(62)</td>
</tr>
<tr>
<td>5</td>
<td>Lack of knowledge about where to call for help</td>
<td>67.1%</td>
<td>(59)</td>
</tr>
<tr>
<td>6</td>
<td>Lack of professional protocol related to assessing elder abuse</td>
<td>67.1%</td>
<td>(59)</td>
</tr>
<tr>
<td>7</td>
<td>Lack of clear guidelines about confidentiality in elder abuse situations</td>
<td>65.9%</td>
<td>(58)</td>
</tr>
<tr>
<td>8</td>
<td>Difficulty in determining what constitutes elder abuse</td>
<td>59.1%</td>
<td>(54)</td>
</tr>
<tr>
<td>9</td>
<td>Lack of knowledge about the prevalence of elder abuse</td>
<td>56.8%</td>
<td>(50)</td>
</tr>
<tr>
<td>10</td>
<td>The amount of time involved in assessment, referral, and follow-up</td>
<td>46.6%</td>
<td>(41)</td>
</tr>
<tr>
<td>11</td>
<td>Language/cultural barriers</td>
<td>44.3%</td>
<td>(39)</td>
</tr>
<tr>
<td>12</td>
<td>Fear of damaged relationships with patient / family</td>
<td>44.3%</td>
<td>(39)</td>
</tr>
<tr>
<td>13</td>
<td>Recent changes in legislation</td>
<td>38.6%</td>
<td>(34)</td>
</tr>
<tr>
<td>14</td>
<td>Fear of legal consequences (court appearances, defamation, suits)</td>
<td>36.4%</td>
<td>(32)</td>
</tr>
</tbody>
</table>
Nine (10.2%) respondents offered other potential barriers to the detection of elder abuse in response to an optional open-ended question on the survey. These include: alien/immigration status, fear of intervention, disruption of the elder’s independence, elder’s perception of abuse and the abuser’s perception of the abuse, untreated mental illness, dependence on others, lack of hotline information and elder financial dependence. Of special interest, three nurse practitioners identified the lack of response from local agencies as a major barrier.

Analysis of Self-Perceived Strategies for the Management of Elder Abuse

Research Question #2: What are the self-perceived strategies for the management of elder abuse by nurse practitioners? Nurse practitioners were asked to rate the likelihood of their using 11 potential strategies to assist in the management of elder abuse using a 5-point Likert scale (not at all likely, not very likely, neutral, fairly likely, and very likely). The strategies that were noted to be fairly or very likely to be used by more than 50% of the responding nurse practitioners include: one agency to call regarding cases of elder abuse (97.7%), a list of resource people to advise on elder abuse (92.0%), a directory of services for seniors (88.6%), an elder abuse resource package for your practice (83.0%), professional guidelines or protocols for detection and management of elder abuse (76.1%), general continuing education on elder abuse (73.9%), elder abuse education provided in your practice (72.7%), a central accessible library of elder abuse resources (56.8%), an elder abuse newsletter containing relevant articles and resources (54.5%). Table 2 lists the strategies that were noted to be fairly or very likely to be used by the responding nurse practitioners.
Table 2

*Nurse Practitioner Self-Perceived Strategies for the Management of Elder Abuse* (N=88)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Potential Strategy</th>
<th>%</th>
<th>(No.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>One agency to call regarding cases of elder abuse</td>
<td>97.7%</td>
<td>(86)</td>
</tr>
<tr>
<td>2</td>
<td>A list of resource people to advise on elder abuse</td>
<td>92.0%</td>
<td>(81)</td>
</tr>
<tr>
<td>3</td>
<td>A directory of services for seniors</td>
<td>88.6%</td>
<td>(78)</td>
</tr>
<tr>
<td>4</td>
<td>An elder abuse resource package for your practice</td>
<td>83.0%</td>
<td>(73)</td>
</tr>
<tr>
<td>5</td>
<td>Professional guidelines or protocols for detection and management of elder abuse</td>
<td>76.1%</td>
<td>(67)</td>
</tr>
<tr>
<td>6</td>
<td>General continuing education on elder abuse</td>
<td>73.9%</td>
<td>(65)</td>
</tr>
<tr>
<td>7</td>
<td>Elder abuse education provided in your practice</td>
<td>72.7%</td>
<td>(64)</td>
</tr>
<tr>
<td>8</td>
<td>A central accessible library of elder abuse resources</td>
<td>56.8%</td>
<td>(50)</td>
</tr>
<tr>
<td>9</td>
<td>An elder abuse newsletter containing relevant articles and resources</td>
<td>54.5%</td>
<td>(48)</td>
</tr>
<tr>
<td>10</td>
<td>Change in fee structure to reimburse amount of time needed to manage elder abuse cases</td>
<td>50.0%</td>
<td>(44)</td>
</tr>
<tr>
<td>11</td>
<td>Guaranteed reimbursement for any time spent on legal matters</td>
<td>44.3%</td>
<td>(39)</td>
</tr>
</tbody>
</table>

Six (6.8%) respondents offered other potential strategies for the management of elder abuse in response to an optional open-ended question on the survey. These included patient education material in the form of literature and pamphlets on elder abuse prevention for distribution to patients and their families. One respondent suggested a designated location on an AARP (American Association of Retired Persons) website. Three respondents suggested an increased educational focus for nurse practitioners in this area, which would include mandatory educational reviews, case study presentations and a review of existing state agencies.

*Analysis of Variance of Self-Perception According to Individual Characteristics*

Research Question #3: In what ways do the self-perception of nurse practitioners vary according to individual characteristics such as year of graduation, attendance at continuing
education experiences, and experience with abused elder patients in current practice? A series of Spearman rank-order correlation coefficients were conducted in order to determine if a relationship existed between the following individual nurse practitioner characteristics:

- Attendance at continuing education experiences ($C^1$ = continuing education events, $C^2$ = in-service training)
- Years since graduation ($C^3$)
- Experience with suspected abused elder patients ($C^4$)

and the following variables of nurse practitioner self-perception:

- Level of concern for the potential of elder abuse in current practice ($S^1$)
- Level of confidence in assessing elder abuse ($S^2$)
- Level of knowledge of existing community services ($S^3$).

Spearman rank ordered correlation coefficient ($rho$) is a nonparametric procedure that is used to determine the strength of the relationship between two ranked variables (Cronk, 2006). In cases where both of the categorical variables had only two categories, the Chi-Square Test of Independence ($\chi^2$) was utilized to test whether two variables were independent of each other. SPSS (v.14) was utilized for data analysis. An alpha level of .05 was used for all statistical tests.

Continuing Education Experiences

A two-tailed test of significance indicated that there was a significant relationship between $C^1$ and $S^2$ ($rho=-.360, p=.001$). A chi-square test of independence was calculated comparing $C^1$ and a self-perceived fairly or very confident $S^2$. The relationship between these two variables was statistically significant ($\chi^2 = 12.538, p=.000$) indicating that those who attended continuing education events on average had an increased self-perceived level of confidence in assessing elder abuse in their practice. A significant relationship was also
identified between \( C^1 \) and \( S^3 \) \((\rho = -.392, p = .000)\). A chi-square test of independence was conducted comparing \( C^1 \) and a self-perceived *fairly or very confident* \( S^3 \) and found to be significant \((\chi^2 = 7.519, p = .006)\), indicating that those who attended continuing education events on average had an increased self-perceived level of knowledge of existing community services. However, a similar two-tailed test of significance failed to identify a relationship between \( C^1 \) and \( S^1 \) \((\rho = -.182, p = .093)\) which was attendance at continuing education events and a self-perceived level of concern for the potential for elder abuse in current practice.

Attendance at elder abuse detection and management in-service training \((C^2)\) was found to be significantly related to \( S^1 \) \((\rho = -.234, p = .028)\), \( S^2 \) \((\rho = -.318, p = .003)\) and \( S^3 \) \((\rho = -.370, p = .000)\). In addition, significant chi-square test of independence calculations were noted when comparing \( C^2 \) to a *fairly or very concerned* \( S^1 \) \((\chi^2 = 5.501, p = .019)\) and comparing \( C^2 \) with a self-perceived *fairly or very confident* \( S^3 \) \((\chi^2 = 11.857, p = .001)\) indicating that those who attended in-service training on average had an increased self-perceived level of concern for the potential of elder abuse in their current practice and an increased self-perceived level of knowledge of existing community services. However, attendance at in-service training \((C^2)\) was not found to be significantly related to self-perceived *fairly or very confident* \( S^2 \) \((\chi^2 = 3.416, p = .065)\) which was a self-perceived level of confidence in assessing elder abuse. Lastly, nurse practitioners were asked whether they read any journal articles that focused on elder abuse detection and management. No statistically significant relationship was found between the reading of journal articles and \( S^1 \), \( S^2 \), or \( S^3 \).

**Years Since Graduation**

No statistically significant relationship was found between years since graduation and \( S^1 \), \( S^2 \), or \( S^3 \).
Experience with Abused Elder Patients

A significant relationship was found between $C^4$ and $S^1$ ($\rho = -0.462$, $p = 0.000$). A chi-square test of independence was calculated comparing $C^4$ and a self-perceived *fairly* or *very confident* $S^1$ ($\chi^2 = 22.768$, $p = 0.000$) indicating that those who had experience with suspected abused elder patients on average had an increased level of concern for the potential of elder abuse in their current practice. However, a relationship was not established between $C^4$ and $S^2$ ($\rho = 0.017$, $p = 0.872$) or $S^3$ ($\rho = 0.036$, $p = 0.738$) which was between nurse practitioners that reported seeing elders who were suspect for abuse and a self-perceived confidence level of assessing elder abuse in practice or a self-perceived level of knowledge of existing community services.

Concern About the Potential for Elder Abuse

Nurse practitioners surveyed were asked how concerned they were about the potential of elder abuse in their practice. Forty-four respondents (50%) reported that they were fairly concerned and eight (9.1%) reported being very concerned about the potential for elder abuse in their practice. Whereas, eighteen (20.5%) indicated that they were not very concerned and two respondents (2.3%) were not concerned at all. Sixteen nurse practitioners (18.2%) indicated a neutral level of concern.

Number of Suspected Cases of Elder Abuse

Nurse practitioners were asked how often they saw older persons that they suspected were being abused. The majority of nurse practitioners, forty-seven (53.4%) reported that they saw suspected cases of elder abuse on a monthly bases, with four reporting seeing weekly suspected elder abuse cases. Thirty-seven participants (42%) reported not having seen any cases of elder abuse.
Confidence in Assessing Elder Abuse

Nurse practitioners were asked about their confidence in assessing elder abuse. The majority of nurse practitioners, forty-eight (54.5%), reported that they were fairly confident in their ability to assess elder abuse, with nine (10.2%) reporting that they were very confident. Whereas, sixteen (18.2%) reported that they were not very confident, fourteen (15.9%) were neutral, and one (1.1%) reported not being confident at all.

Nurse practitioners were asked whether their undergraduate nursing education provided adequate training in the detection and management of elder abuse. Forty respondents (45.5%) indicated that they disagreed with this statement with fifteen (17%) stating that they strongly disagreed. Twelve respondents (13.6%) were neutral while eighteen (20.5%) agreed and three (3.4%) strongly agreed. When asked whether their nurse practitioner education provided adequate training in the detection and management of elder abuse, thirty (34.1%) disagreed, seven (8%) strongly disagreed, eighteen (20.5%) were neutral, twenty-six agreed (29.5%), and seven (8%) strongly agreed.

Thirty-one respondents (35.2%) reported that they attended a continuing education event that focused on elder abuse since graduation and eighteen (20.5%) attended in-service elder abuse training. Sixty-seven nurse practitioners (76.1%) noted reading a journal article related to elder abuse detection and management and 38 (43.2%) had discussions with colleagues on this topic.

Knowledge of Existing Community Services

Nurse practitioners were asked about their confidence in the knowledge of existing community services. Thirty nurse practitioners (34.1%) reported that they were not very confident in their knowledge of existing community services, with seven (8%) reporting that they
were not very confident at all. Fourteen (15.9%) were neutral, twenty-eight were fairly confident, and nine (10.2%) reported being very confident in their knowledge of existing community services. Nurse practitioners were also asked to identify which services they would normally utilize in a potential elder abuse situation. Table 3 lists the services that were identified.

Table 3
*Normally Utilized Services in Potential Elder Abuse Situations (N=88)*

<table>
<thead>
<tr>
<th>Service</th>
<th>%</th>
<th>(No.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Work</td>
<td>89.8%</td>
<td>(79)</td>
</tr>
<tr>
<td>Police</td>
<td>60.2%</td>
<td>(53)</td>
</tr>
<tr>
<td>Nursing</td>
<td>59.1%</td>
<td>(52)</td>
</tr>
<tr>
<td>Specialized Geriatric Assessment</td>
<td>55.7%</td>
<td>(49)</td>
</tr>
<tr>
<td>Individual or Family Counseling</td>
<td>55.7%</td>
<td>(49)</td>
</tr>
<tr>
<td>Case Management Service</td>
<td>54.5%</td>
<td>(48)</td>
</tr>
<tr>
<td>Meals on Wheels</td>
<td>54.5%</td>
<td>(48)</td>
</tr>
<tr>
<td>Legal Services</td>
<td>53.4%</td>
<td>(47)</td>
</tr>
<tr>
<td>In-Home Respite</td>
<td>48.9%</td>
<td>(43)</td>
</tr>
<tr>
<td>Placement Coordination Assessment</td>
<td>46.6%</td>
<td>(41)</td>
</tr>
<tr>
<td>In-Home Caregiver Support</td>
<td>39.8%</td>
<td>(35)</td>
</tr>
<tr>
<td>Emergency Shelter</td>
<td>38.6%</td>
<td>(34)</td>
</tr>
<tr>
<td>Specialized Capacity/Competency Assessment</td>
<td>37.5%</td>
<td>(33)</td>
</tr>
<tr>
<td>Homemaking</td>
<td>35.2%</td>
<td>(31)</td>
</tr>
<tr>
<td>Nutrition</td>
<td>35.2%</td>
<td>(31)</td>
</tr>
<tr>
<td>Institutional Respite Care</td>
<td>34.1%</td>
<td>(30)</td>
</tr>
<tr>
<td>Day Program</td>
<td>33.0%</td>
<td>(29)</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>23.9%</td>
<td>(21)</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>18.2%</td>
<td>(16)</td>
</tr>
</tbody>
</table>
In addition, the nurse practitioners were asked what they would normally do in a situation where an abused individual would not accept help. Fifty nurse practitioners (56.8%) would seek advice, thirty-seven (42.0%) noted that they would refer for further assessment, eight (9.1%) reported that they did not know what they would do and eight (9.1%) identified other strategies (consider mental status, speak with family, clinical support, continue to encourage intervention and four respondents noted regular follow-up).

A chi-square test of independence was calculated comparing a self-perceived fairly or very confident level of knowledge of existing community services to assist abused elderly and a self-perceived fairly or very confident level of confidence in assessing elder abuse. A significant interaction was noted ($\chi^2 = 14.122, p=.007$), indicating that these two variables are not independent. Nurse Practitioners who were fairly or very confident in their knowledge of existing community services were also fairly or very confident in their ability to assess elder abuse.

Written Protocols

Nurse practitioners were asked whether they used a written protocol or whether they have a protocol for screening/assessing/intervening in situations where older patients are suspected of being abused. Seventy-eight nurse practitioners (88.6%) reported that they did not have or did not use written protocol, while ten participants (11.4%) reported yes that they had and used written protocols. Of those reporting that they did utilize a written protocol or that they had a protocol, two submitted copies of their protocols. One of the submitted copies was a protocol from the Social Services Department of a Medical Hospital emergency room policy. The policy reviews types of abuse and neglect and identifies the procedures to be utilized, which include: report the case to Adult Protective Services, Crisis Intervention Services, and the distribution of
state assistance telephone numbers. The second participant’s submitted procedure copy outlines the signs and symptoms of abuse in general and refers to child and adult violence victims. The policy reviews the state definitions for various forms of abuse and identifies state health department reporting agencies.

The remaining eight respondents who identified the use of protocols submitted written descriptions of the protocols that they utilized. Three stated that they contact the Department of Health Services in their location or the police. Three identified that they make a referral to the Social Service Department of the hospital where they are employed. One participant arranges for home care nursing assessment and one identifies the use of a screening question on the patient’s intake assessment that asks whether the elder has ever experienced or is currently experiencing an abusive situation.

Additional Comments

Nurse practitioners were asked whether they would like to add any additional comments, thirteen respondents (14.8%) offered additional comments. A summary of the additional comments follows:

- “Great topic!! Such an under served population and a problem that is clearly not adequately assessed or evaluated. Best of luck to you!”
- “Thank you for choosing such an important area for your research! As an NP I feel I had little/-no preparation to deal with elder abuse-and many MDs that I encounter ‘don’t want to deal with it’-so they just ignore it.”
- “Good luck with your research and your doctorate. An online or email version of a survey such as this would be great-if you have the available technology.”
• “I work in a primary care setting but I see acute/overflow. So, chances of my running into a situation of elder abuse is low.”

• “Good Luck” noted on 4 comment pages.

• “Have rarely suspected abuse despite caring for large geriatric population. Have found target of abuse not usually receptive to intervention. Same sort of problem as with spouse abuse. Long history of pattern. Resistant to change, even positive change. Two recent cases where elder was previously abused by spouse, now by children. Very difficult to change behaviors that have been ongoing for over 50 years.”

• “Great project! I look forward to your completion and all the rich data. Elder abuse needs to be ‘cared for’ as the baby boomers move forward.”

• “You have touched on such an important area! In my practice, the elder abuse issues related to overt things, like physical abuse, are easy-you assess and treat the problem, then usually refer to social services. My challenges come from elders who have significant physical / mental health needs who are kept home because the family “needs their check”, or seniors who haven’t done any planning (no durable power of attorney, etc) and a change in their health status occurs requiring someone to act on their behalf. Our hospital social service has little to offer except referral to attorneys. It gets frustrating!”

• “I understand that this is a problem, however, in the three years that I have spent in cardiology I have seen maybe one or two potential elderly abuse cases.”

• “A protocol that addressed neglectful self-care would be helpful in practice.”

• “Valuable, important survey”
V. Discussion

This chapter begins with an overview of the theoretical framework utilized in this study, Carper’s Fundamental Patterns of Knowing. The chapter is then divided into the four patterns of knowing as outlined by Carper (1978): empirical pattern of knowing, aesthetical pattern of knowing, personal knowledge pattern of knowing, and the ethical pattern of knowing. Study results are discussed according to the four patterns of knowing in order to facilitate discussion. This discussion will elaborate on the results of data collection and will relate results with the review of the literature identified in Chapter II.

*Carper’s Fundamental Patterns of Knowing*

A body of knowledge has patterns, forms, and structure, which help to describe ways of thinking about a phenomenon (Carper, 1978). This study sought to identify self-perceived barriers to the detection of elder abuse and the self-perceived strategies for the management of elder abuse. In essence, it sought to identify the nurse practitioner’s body of knowledge and describe the ways of thinking about the phenomenon of elder abuse detection and management. Carper (1978) identified four fundamental patterns of knowing: empirics, aesthetics, personal knowledge, and ethics. Each pattern of knowing is required for achieving mastery in a given discipline and one pattern alone is not sufficient to understand a given phenomenon. Although each of these patterns of knowing is separate in distinctive characteristics, they are in fact, interrelated and interdependent, and need to be understood as a whole. Nursing depends on empirical knowledge, the esthetic perception of human experiences, the individuality of personal knowledge, and the ability to choose when confronted with particular moral judgment (Carper, 1978).
Carper’s patterns provide a guiding framework for understanding the ways that nurse practitioners know about the barriers to the detection of elder abuse and the ways that they know about the strategies for the management of elder abuse. Understanding the four fundamental patterns of knowing about elder abuse detection and management increases the awareness of the complexity of this phenomenon while recognizing that each pattern is incomplete without the input of the other patterns. The results of data collection are discussed in the following sections grouped within the domains of each pattern of knowing in order to organize the data and present a framework for discussion.

Empirical Pattern of Knowing

Empirics refers to the science of nursing where emphasis is on the generation of theory and on systematic research which is controlled by factual evidence (Carper, 1978). Factual knowledge is knowledge that can be taught and learned. Numerous questions addressed the empirical dimension of knowing.

In the first such question, participants were asked whether their undergraduate and their nurse practitioner education provided them adequate training in the detection and management of elder abuse. Educational programs generate factual knowledge and are in the domain of the empirical pattern of knowledge. The majority of respondents did not feel that their undergraduate nursing program adequately prepared them to detect and manage elder abuse. When asked whether their nurse practitioner education provided adequate training in the detection and management of elder abuse, the training adequacy was perceived as improved. However, many felt that the empirical knowledge provided to them in their training was inadequate for practice. What implication does this have to undergraduate and graduate nursing education and to nursing practice? Furthermore, what implication does this have on elder abuse
detection? Year of graduation did not significantly affect the level of concern for the potential of elder abuse in current practice, level of confidence in assessing elder abuse, or the level of knowledge of existing community services.

A review of the literature revealed that studies and data that specifically identify elder abuse course content in curriculums are scarce. The National Aging Resource Center on Elder Abuse (NARCEA, 1992) investigated the degree to which elder abuse course content was a part of higher education curricula in aging. It was reported that only slightly over one-quarter of all courses offered within the undergraduate instructional units included content on aging, while approximately one-third of all courses offered within the graduate instructional units included content on aging and an extremely small number included course content on elder abuse. Approximately 95% of both undergraduate and graduate curriculums do not require courses with primary content in elder abuse, however 76% of undergraduate curriculums and 68% of graduate curriculums include elective courses in the area of elder abuse as a segment or component of the course content. An exhaustive search of the literature failed to reveal information regarding the educational preparedness of nurses or nurse practitioners in the area of elder abuse. This is an identified area in need for further study and review as it can hold major implications to future nursing empirical body of knowledge.

In addition, nurse practitioners were asked whether they had attended any continuing education, in-service training, or read any journal articles that focused on elder abuse. Data analysis identified a significant relationship between attendance at continuing education events that focus on elder abuse and a self-perceived heightened level of confidence of assessing elder abuse in practice, in addition to a heightened level of self-perceived knowledge of existing community services to assist abused elders. Similarly, attendance at elder abuse detection and
management in-service training was significantly related to a self-perceived heightened level of confidence of assessing elder abuse in practice in addition to a heightened level of self-perceived knowledge of existing community services to assist abused elders. Of special note, a significant relationship was identified between in-service training and a heightened perception of concern for the potential for elder abuse in practice. The finding from this study suggests that attendance at continuing education programs and in-service training impact upon the nurse practitioners awareness to the elder abuse phenomenon and as such, has the potential to impact upon elder abuse detection as a whole. A majority of nurse practitioners stated that they read a journal article related to elder abuse detection and management. However, the reading of journal articles did not statistically affect the level of concern for the potential of elder abuse in practice or the confidence level in assessing elder abuse. Prior research supports this finding. A randomized controlled trial that utilized nurses, care assistants, and social workers compared the effectiveness of attending an education course to printed educational material in improving management of elder abuse (Richardson et al., 2002). The main findings of this study included a lack of knowledge of good management in dealing with elder abuse and that educational course work was superior to printed material in increasing elder abuse knowledge and interventional management.

Nurse practitioners identified general continuing education on elder abuse, elder abuse education provided in their practice, a central accessible library of elder abuse resources, and an elder abuse newsletter containing relevant articles and resources as potentially useful strategies in the management of elder abuse. The implementation of these strategies may hold promise in increasing awareness and thus impact upon the diagnosis and management of elder abuse.
Secondly, nurse practitioners were asked to rate the importance of fourteen potential barriers to the detection of elder abuse. In the original Krueger and Patterson study (1997) physicians were also asked to rate the importance of these potential barriers to the detection of elder abuse. The rank order of potential barriers differed somewhat between the responses of Krueger and Patterson’s physician respondents and the nurse practitioner respondents in this study. However, all of the nine barriers that were felt to be *fairly* or *very important* by more than half of the responding physicians were exactly the same as those identified as *fairly* or *very important* by more than half of the responding nurse practitioners in this study.

Thirdly, nurse practitioners were asked to rate the likelihood of their using eleven potential strategies to assist in the management of elder abuse. In the original Krueger and Patterson study (1997) physicians also responded to this question. The rank order of potential strategies differed very slightly between the responses of the physician respondents and the nurse practitioner respondents of this study. All of the first five ranked self-perceived strategies that were felt to be *fairly* or *very important* by more than half of the responding physicians were exactly the same as those identified as *fairly* or *very important* by more than half of the responding nurse practitioners. The remaining six strategies were also fairly closely ranked with one exception. Nurse practitioners ranked the potential strategy of guaranteed reimbursement for any time spent on legal matters last with only 44.3% of respondents identifying this strategy as *fairly* or *very important*. In the Krueger and Patterson study (1997) this strategy was ranked sixth and reported that 71.3% of the physician respondents perceived this strategy as *fairly* or *very important*.

Four of the fourteen nurse practitioner identified potential barriers to the detection of elder abuse (lack of professional protocol related to responding to elder abuse, lack of knowledge
about where to call for help, lack of professional protocol related to assessing elder abuse, and lack of knowledge about the prevalence of elder abuse) and nine of the eleven identified potential strategies for the management of elder abuse (one agency to call regarding cases of elder abuse, a list of resource people to advise on elder abuse, a directory of services for seniors, an elder abuse resource package for your practice, professional guidelines or protocols for detection and management of elder abuse, general continuing education on elder abuse, elder abuse education provided in your practice, a central accessible library of elder abuse resources and an elder abuse newsletter containing relevant articles and resources) in order to address the empirical pattern of elder abuse knowing.

Professional protocols offer nurse practitioners a systematic and scientific plan for action in order to meet a standard of care. As such, protocols provide factual knowledge that speaks to the empiric dimension of knowing. The use of professional protocols for the detection or management of elder abuse was addressed in a number of survey questions. The issues of whether nurse practitioners in this study used a written protocol or whether they had a protocol for screening/assessing/intervening in situations where older patients are suspected of being abused yielded interesting results. The majority of respondents reported that they did not have or did not use a written protocol for elder abuse in their practice and that this lack of professional protocol was a potential barrier to the detection of elder abuse. Only ten respondents in this study identified the use of a written protocol or having a protocol for screening/assessing/intervening in situations where elders were suspected of being abused. Protocols shared by the respondents generally identified reporting the suspicion to the Social Services Department or Adult Protective Services with little mention of the screening criteria to be used. Out of those ten respondents who identified the use of a written protocol not one
participant identified the use of a specific screening tool. As presented in Chapter II, a review of the literature identifies numerous screening tools such as: the Indicators of Abuse Screen (IOA), the Elder Assessment Instrument (EAI), the Hwalek-Sengstock Elder Abuse Screening Test (HSEAST) and the Caregiver Abuse Screen (CASE). If the majority of nurse practitioners do not use a protocol for screening, assessing, or intervening when situations where abuse is suspected, how then do they make that diagnosis or determination? This is another identified area for further investigation.

The majority of responding nurse practitioners perceived a lack of knowledge about where to call for help as a potential barrier to elder abuse detection. Almost all of the respondents identified the potential strategy of one agency to call regarding cases of elder abuse as the highest ranked potential strategy in the management of elder abuse and a list of resource people to advise on elder abuse as the second ranked potential strategy. The identification of one agency to call regarding cases of elder abuse was also the highest ranked potential strategy in the Krueger and Patterson study (1997). Nurse Practitioners identified numerous services that they would normally use in potential elder abuse situations with the majority identifying Social Work services as a primary source of support. As the majority of Nurse Practitioners did not identify the use of written protocols, it is unclear as to who is the first point of contact. Does the nurse practitioner notify social work in their facility and consider this action in compliance with mandatory reporting requirements if they are practicing in a mandatory reporting state? Or is this action in addition to a report submitted by the nurse practitioner to an official agency such as Adult Protective Services (APS)? Findings suggest that the establishment of a streamlined intervention that requires contacting one agency would be helpful to practice and to the
management of elder abuse. A need for elder abuse clinical resource information has been established.

Lastly, the majority of nurse practitioners who responded to this study identified difficulty in determining what constitutes elder abuse and identified the lack of knowledge about the prevalence of elder abuse as potential barriers to the detection of elder abuse. As discussed in the review of the literature, the elder abuse definition controversy and the lack of elder abuse statistical data is well established (Kleinschmidt, 1997; Lachs & Pillemer, 1995; National Center on Elder Abuse, 1998). Different definitions exist in the literature as to how to define elder abuse, including variation in the age that defines an elder. It has been suggested that increasing awareness will increase the number of cases screened for potential abuse (Rosenblatt et al., 1996). The literature review also revealed that official reporting agencies such as Adult Protection Services (APS) are alerted to the most visible cases of abuse and neglect and that large numbers of incidents remain unidentified and unreported (National Center on Elder Abuse, 1998). The majority of respondents as well as the literature reviewed identified this as a potential barrier to detection. This reinforces the need for clear detection guidelines.

Aesthetical Pattern of Knowing

The art of nursing identified as aesthetics places emphasis on expressiveness, subjective acquaintance, individual perceptions, and empathy (Munhall, 2001). The aesthetic art of knowing addresses care that is based upon perceptive assessment and involves analysis, understanding and interpretation of the elder’s subjective experience (Kingsley, 2002). Participants were asked to identify their self-perceptions to the potential barriers and strategies of managing elder abuse. In essence, the entire questionnaire addressed the participant’s aesthetical perception of elder abuse.
The majority of respondents felt difficulty in determining what constitutes elder abuse as a potential barrier to its detection. This speaks to the totality of aesthetic use of elder abuse knowing or lack there in. The aesthetic component of knowing goes beyond identification and description to a wider perception (Kingsley, 2002). Aesthetic knowing addresses the comprehension and perception of an event and can assist in the development of a deeper understanding of a given phenomenon. It is through an increased awareness and the experiences of patient’s various abuse situations that a corresponding and frequently intuitive recognition develops. This intuitive recognition then becomes an important aspect of clinical judgment and aids in the development of creative clinical interventions (Kingsley, 2002). A majority of respondents did not have a working definition of what elder abuse was. Yet, the self-perception of knowing about elder abuse goes beyond having a working definition. It speaks of a much more comprehensive aspect of the event. An exhaustive literature review failed to identify research or data about the aesthetic pattern of knowing about elder abuse. A major gap in the literature exists in this regard. This study sought to open the door to discoveries in this aesthetic dimension of knowing.

Personal Knowledge Pattern of Knowing

Personal knowing is concerned with interpersonal relationships of nurses and the expressions of the quality and authenticity of the interactions between each patient and each nurse (Fawcett et al., 2001). This personal knowing extends not just to others, but also to relations with oneself as one strives to know the self. It is a state of being that cannot be described or experienced, it can only be actualized (Carper, 1978).

Two questions on the survey questionnaire specifically addressed the issue of personal knowledge of elder abuse. The first asked how often nurse practitioners saw older persons that
they suspected were being abused. This question identifies personal experiences and speaks to the personal domain of knowing about elder abuse. A majority of nurse practitioners reported that they saw suspected cases of elder abuse on a monthly basis and four participants reported seeing weekly suspected elder abuse cases. The second question that addressed personal knowledge asked about nurse practitioners confidence in assessing elder abuse. This question asks the nurse practitioner to reflect and identify a self-perceived level of personal confidence in elder abuse assessment skills. A majority of nurse practitioners expressed a positive level of confidence in their elder abuse assessment ability. This is substantially higher than the level of confidence reported by physicians in the Krueger and Patterson study (1997).

Self-perception can be viewed as an assessment of personal knowledge. The majority of nurses expressed a heightened level of confidence in their assessment ability. What are the factors that influence this heightened self-perceived level of assessment? Is this self-perception a true value of assessment ability? In contrast, what are the factors that influence the nurse practitioners to a self-perceived lower level of assessment ability? Krueger and Patterson (1997) identified a lower level of confidence among physicians. What factors account for this difference in perception level among professional domains?

The mode of inquiry in the personal pattern of knowing can be achieved through thinking and reflecting (Fawcett et al., 2001). Participation necessitated the need for responding nurse practitioners to think and reflect upon their personal knowledge in regards to the topic of elder abuse. According to Kingsley (2002), each nurse needs to reflect on how and why they know what they know and then integrate this knowledge into actual clinical practice. Reflection and awareness into the nurse’s individual personal knowing affects how nurses think about
themselves and their personal encounters with their patients. In essence, participation can be viewed as an intervention that may influence future elder abuse encounters.

Ethical Pattern of Knowing

Ethics is the component of moral knowledge in nursing (Carper, 1978). This encompasses descriptions of moral obligations, moral and non-moral values, and desired ends (Fawcett et al., 2001). The ethical pattern of knowing focuses on matters of what should be done and represents standards, codes and values (Schmidt, Nelson, & Godfrey, 2003). It goes beyond simply knowing the norms or ethical code of a discipline as it includes deliberate voluntary actions, which are subject to the judgment of right and wrong (Fawcett et al., 2001). The ethical pattern of knowing also addresses the willingness to accept responsibility for professional actions in the face of complex or difficult moral choices and decisions (Kingsley, 2002). Elder abuse laws are intended to protect vulnerable citizens and to punish violators, yet conflict may exist that raises doubts among clinical professionals about appropriateness and feasibility of reporting (Hirsch et al., 1999). Nurse practitioners voiced some of these conflicts.

The first three ranked responses of nurse practitioners to self-perceived barriers to the detection of elder abuse addressed the moral component of knowing, that of ethics. Families / patients’ resistance to intervention once elder abuse is identified is the first ranked potential barrier in this study. This is closely followed by the second ranked response in this category that of families / patients’ denial of elder abuse. Followed by fear of reprisal by the abuser towards the elder. These identified ethical barriers present a moral dilemma, as the consequences of one’s actions may be difficult to predict (Fawcett et al., 2001). In addition, a majority of respondents identified the lack of clear guidelines about confidentiality in elder abuse situations.
as a potential barrier to the detection of elder abuse. This data holds major implications for further inquiry into the ethical component of knowing elder abuse.

Nurse practitioners were also asked what they would normally do in a situation where an abused individual would not accept help. Most responded that they would seek further advice and would refer for further evaluation. Yet, some did not know what they would do which would present them with an ethical dilemma.

Nurse practitioners surveyed were asked how concerned they were about the potential of abuse in their practice. The majority of nurse practitioners expressed concern about the potential of elder abuse in their practice. In contrast, the Krueger and Patterson study (1997) indicated that fewer than half of the physicians reported that they were fairly or very concerned about the potential for elder abuse in their practice. The self-perception of an ethical component of knowing, that of concern for the potential of abuse in practice, is one that also presents an interesting avenue for future study. The majority of nurses expressed a heightened level of concern. What are the factors that influence this heightened level? In contrast, what are the factors that influence some nurse practitioners to a low level of concern? Why do nurse practitioners perceive a higher level of concern for the potential of elder abuse in their practice as opposed to physicians in the Krueger and Patterson study? Data analysis identified a significant relationship between nurse practitioners that reported seeing elders who were suspect for abuse and a self-perceived heightened concern for the potential for elder abuse in their current practice. This too, is an interesting area for further study.

Lastly, two areas of special interest and concern to this researcher came from comments noted on four of the respondents’ questionnaires when asked if they would like to add any additional comments. One respondent stated, “As an NP I feel I had little/no preparation to deal
with elder abuse and many MDs that I encounter ‘don’t want to deal with it’, so they just ignore it’. As a researcher, I found this statement rather haunting. It would be of great personal interest to explore the components of this statement further.

Three nurse practitioners identified the lack of response from local agencies as a major barrier to elder abuse detection. It would be very interesting to learn of the specific events that led to these statements, especially since it was expressed by three responding nurse practitioners.

Carper’s Fundamental Patterns of Knowing provided the framework for organization of the collected data and presented a framework for discussion. In the final chapter, Carper’s Fundamental Patterns of Knowing will provide the organizational framework for discussion regarding the nursing implications of this study and recommendations for future research.
VI. Summary and Recommendations

This chapter begins with a summary review and is followed by a discussion of implication for nursing practice and recommendations for nursing research. Carper’s Fundamental Patterns of Knowing (1978) provides the organizational framework for discussion. Study implications and recommendations are discussed within the four patterns of knowing. An outline of the study limitations and a concluding statement complete the dissertation.

Summary

Elder abuse is a serious and growing phenomenon, yet it is one of the most under-diagnosed and under-reported problems in the United States. Nurse Practitioners are uniquely positioned to identify, diagnose, and report elder abuse. However, an extensive review of the literature failed to identify research or data that explored nurse practitioners experience in the phenomenon of elder abuse. Quantitative methodology underpinned by the theoretical framework of Carper’s Fundamental Patterns of Knowing was utilized to explore the issue of elder abuse detection and management.

The purpose of this study was to assess the knowledge of nurse practitioners related to the detection and management of elder abuse in order to identify areas of needed education for nurse practitioners so that they might better serve elders who may be victims of abuse or neglect. Three research questions were explored: What are the self-perceived barriers to the detection of elder abuse by nurse practitioners? What are the self-perceived strategies for the management of elder abuse by nurse practitioners? In what ways do the self-perception of nurse practitioners vary according to individual characteristics such as year of graduation, attendance at continuing education, and experience with abused elder patients in current practice?
Two hundred potential participants were randomly selected from the AANP membership database. One hundred and nine survey questionnaires were returned for a 54.5% response rate. This study resulted in 88 eligible survey participants.

Nurse practitioners were asked to rate the importance of fourteen potential barriers to the detection of elder abuse. The barriers that were perceived to be fairly or very important by the majority of respondents include:

- Families/patients’ resistance to intervention once elder abuse is identified, families/patients’ denial of elder abuse
- Fear of reprisal by the abuser towards the elder
- Lack of professional protocol related to responding to elder abuse
- Lack of knowledge about where to call for help
- Lack of professional protocol related to assessing elder abuse
- Lack of clear guidelines about confidentiality in elder abuse situations
- Difficulty in determining what constitutes elder abuse
- Lack of knowledge about the prevalence of elder abuse.

Nurse practitioners were also asked to rate the likelihood of their using eleven potential strategies to assist in the management of elder abuse. The strategies that were noted to be fairly or very likely to be used by the majority of the responding nurse practitioners include:

- One agency to call regarding cases of elder abuse
- A list of resource people to advise on elder abuse
- A directory of services for seniors
- An elder abuse resource package for practice
- Professional guidelines or protocols for detection and management of elder abuse
• General continuing education on elder abuse
• Elder abuse education provided in practice
• A central accessible library of elder abuse resources
• An elder abuse newsletter containing relevant articles and resources.

A series of Spearman rank-order correlations and when appropriate, a chi-square test of independence was calculated \( \chi^2 \) in order to determine if a relationship existed between the following individual nurse practitioner characteristics: attendance at continuing education experiences, years since graduation, experience with suspected abused elder patients and the following variables of nurse practitioner self-perception: level of concern for the potential of elder abuse in current practice, level of confidence in assessing elder abuse, and the level of knowledge of existing community services.

A significant relationship was noted between the following:

• Attendance at continuing education events that focused on elder abuse and a self-perceived heightened confidence level of assessing elder abuse in practice (indicating that those who attended continuing education events on average had an increased self-perceived level of confidence in assessing elder abuse in their practice)

• Attendance at continuing education events and a self-perceived heightened level of knowledge of existing community services to assist abused elderly (indicating that those who attended continuing education events on average had an increased self-perceived level of knowledge of existing community services)

• Attendance at elder abuse detection and management in-service training and a self-perceived heightened level of concern for the potential for elder abuse in...
current practice (indicating that those who attended in-service training on average had an increased self-perceived level of concern for the potential of elder abuse in their current practice)

- Attendance at elder abuse detection and management in-service training and a self-perceived heightened confidence level of knowledge of existing community services to assist abused elderly (indicating that those who attended in-service training on average had an increased self-perceived level of knowledge of existing community services)

- Attendance at in-service training and a self-perceived confidence level of assessing elder abuse in practice

- Nurse practitioners that reported seeing elders who were suspect for abuse and a self-perceived heightened level of concern for the potential for elder abuse in current practice (indicating that those who had experience with suspected abused elder patients on average had an increased level of concern for the potential of elder abuse in their current practice)

A significant relationship was not identified between:

- Attendance at continuing education events and a self-perceived heightened level of awareness of the potential for elder abuse in current practice

- Nurse practitioners that reported seeing elders suspect for abuse and a self-perceived heightened confidence level of assessing elder abuse in practice or a fairly or very confident level of knowledge of existing community services

- Years since graduation did not present statistical significance between any of the variables tested.
The majority of responding nurse practitioners reported that they saw suspected cases of elder abuse on a monthly or weekly basis and the majority reported that they were confident in their ability to assess elder abuse. A large majority, reported that they did not have or did not use a written protocol for screening, assessing, or intervening in situations where elders were suspected of being abused. When asked to identify the level of concern about the potential for elder abuse in their practice, the majority of nurse practitioners reported that they were fairly or very concerned. The majority of nurse practitioners (62%) did not feel that their undergraduate nursing program adequately prepared them to detect and manage elder abuse compared to the 42.1% of respondents that felt that their nurse practitioner program adequately prepared them. Lastly, many respondents identified a personal lack of knowledge regarding existing community services available to aide in the management of elder abuse.

Implication for Nursing Practice

The findings of this study have major implications for nursing education and practice. Carper’s Patterns of Knowing provides a guiding framework for discussion about the findings of this study and an understanding of the ways that nurse practitioners know about the barriers to the detection of elder abuse and the ways that they know about the strategies for the management of elder abuse. As such, it also provides a framework for discussion of the implications of this study for nursing practice.

Empirics. Empirics refers to the science of nursing where emphasis is on the generation of theory and on systematic research which is controlled by factual evidence (Carper, 1978). Factual knowledge is knowledge that can be taught and learned. This study holds major implications for nursing education and practice under this domain.
Analysis revealed that many respondents did not perceive that their undergraduate nurse program and their nurse practitioner program adequately prepared them to detect and manage elder abuse. Data analysis identified a significant relationship between attendance at continuing education events that focus on elder abuse and a self-perceived heightened level of confidence of assessing elder abuse in practice and a heightened level of self-perceived knowledge of existing community services to assist abused elders. This new information potentially holds promise for further generation of empirical nursing knowledge.

In addition, the lack of knowledge or access to professional protocols and clear guidelines was perceived as a potential barrier for the detection and management of elder abuse. A majority of nurse practitioners identified difficulty in determining what constitutes elder abuse and a lack of knowledge in the prevalence of elder abuse as potential barriers to detection. Clearly, there is a knowledge deficit in the basic understanding of the elder abuse phenomenon that holds major implication for nursing practice.

Educational program are tasked with the responsibility of generating factual knowledge and skill based on evidence based practice. Findings from this study should be utilized and incorporated into nursing and nurse practitioner curriculum to expand nursing empiric knowledge on the topic of elder abuse. In addition, findings from this study can be incorporated into discussions regarding the importance of development of screening tools, clearly written protocols and guidelines that nursing can utilize to assist in the early identification and management of elder abuse. The majority of respondents reported that professional guidelines or protocols for detection management of elder abuse would be useful in their practice. This study substantiates the need for the development of a clear definition of elder abuse. Lastly, this study
echoes the need for the development of a single agency to call for help when dealing with this vital area of nursing practice.

Aesthetics. Aesthetics places emphasis on expressiveness, subjective acquaintance, individual perceptions, and empathy (Munhall, 2001) and addresses the artful performance of manual and technical skills (Fawcett et al., 2001). To gain aesthetic understanding goes beyond identification and detection of a problem. It speaks of a wider perception and a comprehensive understanding of an event and an almost intuitive recognition. Aesthetic knowing opposes articulation and necessitates an abstract understanding. For example, nursing students in a baccalaureate program were instructed to implement an aesthetic project with one of their community based chronically ill clients (Michael, Candela, & Mitchell, 2002). Students asked their clients to express what their specific chronic illness means in their life through drawing, taking pictures, creating a poem, through song, or through the use of any other method that was comfortable for the client. Almost half of the students reported that their plan of care changed because of information identified during this project and many indicated that the client or the family benefited from this project by providing a venue for discussion of a difficult topic. This example of aesthetic knowing goes beyond simply describing what an illness means to a client. This form of expression provides a deeper understanding of how these clients perceive their own illness in ways that words can not articulate and may identify critical information that can impact the direction of nursing care (Michael et al., 2002).

Poetry in itself is a unique medium for human expression and has been utilized as an aesthetic expression in nursing (Hunter, 2002). Poetry increases the understanding of the importance of the arts and humanities and as such, it increases the comprehension of a patient’s and a nurse’s lived experience. It has been utilized in nursing education to augment nursing
theory and to enhance self-awareness and has also been utilized in nursing research. Poetry personifies humanity and can be utilized as a means to gain further meaning and knowledge about the lived experience (Hunter, 2002), in this case that of elder abuse.

A review of the literature failed to identify research that explored the relationship between aesthetic knowing and elder abuse. The art of elder abuse nursing is an area waiting to be explored. Findings from this study could potentially fuel the need for further exploration in this vital domain of knowing.

Personal Knowledge. Personal knowing is concerned with self-awareness and the therapeutic use of self to begin to know the elder in a different context. Self-awareness and reflection are important components of this actualization of knowledge. Participation necessitated the need to self-analyze and think about elder abuse. As such, participation can be viewed as an intervention that may influence future elder abuse encounters. Self-awareness and self-reflection holds implication to further the meaning of personal knowledge in the elder abuse arena. In doing so, it may also hold implication as a key component to elder abuse detection and management.

Ethics. Ethics focuses on matters of obligation or what should be done and addresses ethical problem solving skills. Ethics address such matters as legal issues, legislation, and standards of practice as well as aspects of knowing about what is right and what is wrong while maintaining a professional obligation. This study identified a number of ethical concerns in regards to the detection and management of elder abuse: resistance to intervention once elder abuse is identified, denial of abuse, and fear of reprisal by the abuser towards the elder. These findings potentially hold implication for nursing practice in that it identifies a major clinical
ethical dilemma that may impact upon the management of elder abuse. Findings from this study can be utilized to further discussion about the ethical component of knowing elder abuse.

Recommendations for Nursing Research

Empirics. Empirical knowing refers to the science of nursing. The mode of inquiry is through empirical research. Findings generated many questions that can be investigated to further nursing research. The following specific areas for further inquiry under the empirical domain of knowing were identified: investigation of elder abuse educational preparedness of nurses and nurse practitioners, nursing and nurse practitioner elder abuse curriculum analysis, exploration of the relationship between continuing educational programs and elder abuse detection and management, development of clear elder abuse guidelines and protocols, and further investigation of elder abuse screening tools. Findings from this study substantiate the need for further investigation into the development of clear and streamlined protocols and the need to have one agency to call to report and use as a clinical resource.

Aesthetics. Exploration of the aesthetic component of knowing elder abuse is fertile ground for nursing research. This is a potentially rich area for research and holds major potential for a holistic understanding of the elder abuse phenomenon. Several potential areas for further research include: understanding the lived experience of elder abuse from the perspective of the victim and the clinician, investigation of the intuitive aspects of elder abuse detection, and methods of elder abuse self-awareness and self-reflection.

Personal Knowledge. Findings from this study revealed that the majority of responding nurse practitioners reported a heightened level of confidence in their assessment ability. It would be beneficial to explore this issue further. What are the factors that influence this heightened self-perceived level of assessment? Is this self-perception a true value of their assessment?
ability? What are the factors that influence nurse practitioners to a self-perceived lower level of assessment ability?

_Ethics._ Perhaps the greatest challenge in elder abuse research is in the ethical pattern of knowing domain. Nurse practitioners identified a number of ethical concerns regarding elder abuse detection and management. Resistance to intervention once elder abuse is identified, denial of abuse, and fear of reprisal by the abuser towards the elder were identified as potential major barriers to elder abuse detection. Research is needed to further investigate these areas of concern. A special interest and concern for this researcher developed from comments noted on four of the respondents’ questionnaire when asked if they would like to add additional comments. One respondent identified that many medical doctors whom this nurse practitioner encountered did not want to deal with the problem of elder abuse and ignored the situation and another three respondents identified the lack or response from local agencies as a major barrier to elder abuse detection. These statements are concerning and warrant further investigation in hopes of unlocking some major barriers to early detection and intervention.

_Limitations of the Study_

There are some recognized limitations to this study. First, the study was limited to nurse practitioners from one nurse practitioner organization, the AANP. Therefore, the results of the study may not be generalized to a larger population. Second, surveys may be adversely affected by recall bias. Lastly, survey data is based on the participant’s subjective responses and may be inaccurate due to question misunderstanding, placebo affect, question structure and / or inaccurate responses.
Conclusion

Approximately two million Americans aged 65 and older are the victims of abuse or mistreatment by someone on whom they depend for their care or protection. Elder abuse is a serious and growing phenomenon, yet it is one of the most under-diagnosed and under-reported problems in the United States. Research is urgently needed to further explore the dimensions of this public and health concern. The findings of this study provided initial answers and identified areas for further inquiry in order to help bridge a major gap in nursing knowledge. Many questions still remain. This study is only the beginning.
Appendix
Appendix A. Study Questionnaire

Barriers and Strategies to the Detection and Management of Elder Abuse

Nurse Practitioners are in a unique position to recognize situations of elder abuse and to access community services. In order to determine what issues are important to Nurse Practitioners, kindly complete this confidential survey. For the purpose of this survey, elderly is defined as “60 years of age or older” and elder abuse is “any action or inaction by a person in a position of trust – a friend, family member, neighbor or paid caregiver – which causes harm (physical, psychological, financial, neglect) to an older person”. This questionnaire is being mailed to you as your name is among a select few who were randomly drawn from a list of practicing American Academy of Nurse Practitioners.

It is anticipated that completion of this survey will require approximately 10 – 20 minutes of your valuable time. Thank you for your participation.
SECTION 1: ASSESSMENT OF ELDER ABUSE

For each of the following questions, please circle the number of your response as appropriate.

Q1. Do you see elderly patients (60 years of age or older) in your current practice setting? (Circle number)
   1. Yes
   2. No........>

Q2. How concerned are you about the potential for elder abuse in your practice? (Circle number)
   1. Not at all concerned
   2. Not very concerned
   3. Neutral
   4. Fairly concerned
   5. Very concerned

Q3. In your current practice, how often do you see older patients that you suspect are being abused? (Elder abuse is defined as “any action or inaction by a person in a position of trust – a friend, family member, neighbor or paid caregiver – which causes harm (physical, psychological, financial, neglect) to an older person”) (Circle number)
   1. Daily
   2. Almost daily
   3. Weekly
   4. Monthly
   5. Have not seen any suspected cases of elder abuse

Q4. How confident are you in assessing the existence of elder abuse in your practice? (Circle number)
   1. Not at all confident
   2. Not very confident
   3. Neutral
   4. Fairly confident
   5. Very confident

Q5. How confident are you about your knowledge of existing community services to assist abused elderly patients? (Circle number)
   1. Not at all confident
   2. Not very confident
   3. Neutral
   4. Fairly confident
   5. Very confident
Q6. Do you currently use a written protocol or have a protocol for screening/assessing/intervening in situations where older patients are suspected of being abused? (Circle number)

1. No
2. Yes………> If yes, please describe protocol below or enclose a copy of the protocol you normally use.
### SECTION 2: POTENTIAL BARRIERS

**Q7. The following table lists potential barriers to assisting older adults experiencing abuse.** For EACH of the potential barriers, please circle the number which indicates your assessment of the importance of the barrier in your practice.

<table>
<thead>
<tr>
<th>Potential Barrier to Assisting Older Adults Experiencing Abuse</th>
<th>Importance of Barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all Important</td>
</tr>
<tr>
<td>Recent changes in legislation.</td>
<td>1</td>
</tr>
<tr>
<td>Lack of professional protocol related to assessing elder abuse.</td>
<td>1</td>
</tr>
<tr>
<td>Lack of professional protocol related to responding to elder abuse.</td>
<td>1</td>
</tr>
<tr>
<td>Lack of clear guidelines about confidentiality in elder abuse situations.</td>
<td>1</td>
</tr>
<tr>
<td>Lack of knowledge about where to call for help.</td>
<td>1</td>
</tr>
<tr>
<td>Lack of knowledge about the prevalence of elder abuse.</td>
<td>1</td>
</tr>
<tr>
<td>Difficulty in determining what constitutes elder abuse.</td>
<td>1</td>
</tr>
<tr>
<td>Fear of legal consequences (court appearances, defamation suits).</td>
<td>1</td>
</tr>
<tr>
<td>Fear of damaged relationships with patient/family.</td>
<td>1</td>
</tr>
<tr>
<td>Fear of reprisal by the abuser towards the elder.</td>
<td>1</td>
</tr>
<tr>
<td>The amount of time involved in assessment, referral and follow-up.</td>
<td>1</td>
</tr>
<tr>
<td>Language/cultural barriers.</td>
<td>1</td>
</tr>
<tr>
<td>Families’/patients’ denial of elder abuse.</td>
<td>1</td>
</tr>
<tr>
<td>Families’/patients’ resistance to intervention once elder abuse is identified.</td>
<td>1</td>
</tr>
</tbody>
</table>
Other barriers to assisting older adults experiencing abuse. (Specify)

1. _________________________ 1 2 3 4 5
2. _________________________ 1 2 3 4 5
3. _________________________ 1 2 3 4 5

SECTION 3: AVAILABLE SERVICES

For each of the following questions, please circle as many response options as appropriate.

Q8. If you identified a situation of elder abuse in your practice, which of the following services would you normally use? (Circle all that apply in each of the service groups)

**Assessment Services:** (Circle all that apply)
1. Specialized geriatric assessment
2. Specialized capacity/competency assessment
3. Other (Specify) _______________________________________

**Personal Services:** (Circle all that apply)
1. Homemaking
2. Nursing
3. Occupational therapy
4. Physiotherapy
5. Social work
6. Nutrition
7. Meals on Wheels
8. Day program
9. In-home caregiver support counseling
10. In-home respite care
11. Individual or family counseling
12. Case management services
13. Other (Specify) _______________________________________

**Relocation Services:** (Circle all that apply)
1. Placement coordination assessment
2. Emergency shelter
3. Institutional respite care
4. Other (Specify) _______________________________________
**Other Services:** (Circle all that apply)
1. Police
2. Legal services
3. Other (Specify) ________________________________

Q9. **What do you normally do if an older person experiencing abuse DOES NOT agree to accept help?** (Circle all that apply)

1. Take no further action
2. Refer for further assessment
3. Don’t know
4. Seek advice (Specify sources(s) ) __________________________

________________________

5. Other (Specify) __________________________
**SECTION 4: POTENTIAL STRATEGIES**

**Q10. The following table lists a number of strategies that may be helpful in dealing with elder abuse.** (For EACH of the strategies, please circle the number that corresponds to how likely you are to use that strategy in your practice.)

<table>
<thead>
<tr>
<th>Potential Strategy</th>
<th>Likelihood of Using Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all Likely</td>
</tr>
<tr>
<td>Professional guidelines or protocols for detection and management of elder abuse.</td>
<td>1</td>
</tr>
<tr>
<td>Change in fee structure to reimburse amount of time needed to manage elder abuse cases.</td>
<td>1</td>
</tr>
<tr>
<td>Guaranteed reimbursement for any time spent on legal matters.</td>
<td>1</td>
</tr>
<tr>
<td>A central, accessible library of elder abuse resources.</td>
<td>1</td>
</tr>
<tr>
<td>A directory of services for seniors.</td>
<td>1</td>
</tr>
<tr>
<td>One agency to call regarding cases of elder abuse.</td>
<td>1</td>
</tr>
<tr>
<td>An elder abuse resource package for your practice.</td>
<td>1</td>
</tr>
<tr>
<td>A list of resource people to advise on elder abuse.</td>
<td>1</td>
</tr>
<tr>
<td>Elder abuse education provided in your practice.</td>
<td>1</td>
</tr>
<tr>
<td>General continuing education on elder abuse.</td>
<td>1</td>
</tr>
<tr>
<td>An elder abuse newsletter containing relevant articles and resources.</td>
<td>1</td>
</tr>
<tr>
<td>Other. (Specify)</td>
<td>1</td>
</tr>
<tr>
<td>1.</td>
<td>1</td>
</tr>
<tr>
<td>2.</td>
<td>1</td>
</tr>
<tr>
<td>3.</td>
<td>1</td>
</tr>
</tbody>
</table>
SECTION 5: TRAINING IN ELDER ABUSE DETECTION AND MANAGEMENT

For each of the following questions, please circle the number of your response as appropriate.

Q11. Your undergraduate nursing education provided adequate training in the detection and management of elder abuse. (Circle number)

1. Agree strongly
2. Agree
3. Neutral
4. Disagree
5. Disagree strongly

Q12. Your nurse practitioner education provided adequate training in the detection and management of elder abuse. (Circle number)

1. Agree strongly
2. Agree
3. Neutral
4. Disagree
5. Disagree strongly

Q13. Since graduation, have you attended any continuing education events which have focused on elder abuse? (Circle response number)

1. Yes
2. No
3. Uncertain

Q14. How else have you obtained information related to elder abuse detection and management? (Circle all that apply)

1. Reading journal articles
2. Discussions with colleagues
3. In-service training
4. No other ways
5. Other (Specify)  ____________________________________
SECTION 6: DEMOGRAPHIC / PRACTICE INFORMATION

The final section of the survey is needed so that we may combine your answers with those of others like yourself. Please circle the number of your response as appropriate.

Q15. Which of the following best describes your type of practice?  (Circle number)

1. Solo practice
2. Group practice (with other nurse practitioners)
3. Multidisciplinary group practice
4. Other (Specify)  ____________________________________

Q16. Which of the following best describes your method of reimbursement?  (Circle number)

1. Salaried position
2. Fee for service
3. Other (Specify)  ____________________________________

Q17. Year graduated from undergraduate nursing program.  (Enter year)

____________

Q18. Year graduated from nurse practitioner program.  (Enter year)

____________

Q19. Level of undergraduate and postgraduate education.  (Circle all that apply)

1. Undergraduate degree other than nursing
2. Undergraduate degree in nursing
3. Masters degree other than nursing
4. Masters degree in nursing
5. Post-Master degree (Specify)  ____________________________________
6. Doctorate degree other than nursing
7. Doctorate degree in nursing
8. Other (Specify)  ____________________________________

Q20. Your gender.  (Circle number)

1. Male
2. Female
If there is anything else that you would like to comment on, please feel free to write in the space below. **Thank you** for the time and effort you have taken to complete the survey. Please return your completed questionnaire in the enclosed postage paid envelope as soon as possible.
Appendix B. Advanced Notice Letter

Dear Fellow Nurse Practitioner,

I am a doctoral nursing student in the Ph.D. program at Duquesne University and I am conducting a research study on the barriers to the detection and management of elder abuse. Within the next few days, you will receive a request to complete a brief questionnaire. I am inviting you to participate in this research project.

I am a Nurse Practitioner and have several years experience in primary care. I am sensitive to the complexity of working with the elderly population and hope you will participate in a study that will add to our knowledge associated with their care.

I would greatly appreciate your taking the time (approximately 10 – 20 minutes) necessary to complete and return your questionnaire. Your participation is voluntary and your return of the questionnaire will constitute your consent. No identity will be associated with your responses.

Thank you in advance for your help.

Sincerely,

Catherine Pearsall, PhDc, FNP
Doctoral Nursing Student
Duquesne University
Appendix C. Cover Letter

Date

Dear Fellow Nurse Practitioner:

I am a doctoral nursing student in the Ph.D. program at Duquesne University and I am conducting a research study on barriers to the detection and management of elder abuse. This questionnaire is being mailed to you as your name is among a select few who were randomly drawn from a list of practicing nurse practitioners from the American Academy of Nurse Practitioners.

I am a Nurse Practitioner and have several years experience in primary care. I am sensitive to the complexity of working with the elderly population and hope you will participate in a study that will add to our knowledge associated with their care.

I would greatly appreciate your taking the time (approximately 10 – 20 minutes) necessary to complete and return your questionnaire. Your participation is voluntary and your return of the questionnaire will constitute your consent. In order that the results of the study truly represent our nurse practitioner community, it is important that each question be completed and returned in the stamped envelope provided.

You may be assured of complete confidentiality. Please do not include your name anywhere on the questionnaire and do not include a return address on your response. No identity will be associated with your responses.

I welcome any further discussion on my research study and would be happy to answer any questions you may have about this study.

Thank you very much for your assistance and I look forward to receiving your response.

Sincerely,

Catherine Pearsall, PhDc, FNP
Doctoral Nursing Student
Duquesne University
Appendix D. Follow-up Post Card

Last week, a questionnaire seeking your opinion about the **barriers and strategies to the detection and management of elder abuse** was mailed to you. Your name was drawn randomly from a list of practicing Nurse Practitioners.

If you have already completed and returned the questionnaire, please accept my sincere thanks. If not, please do so today. I am especially grateful for your help, as I believe that your response will be very useful in expanding Nurse Practitioner knowledge in the area of Elder Abuse.

If you did not receive a questionnaire, or if it was misplaced, kindly call me collect at (631) 734-7084 or email cpanp1@optonline.net and I will make sure a copy is mailed to you today.

Catherine Pearsall, PhDc, FNP, ANPC
Doctoral Nursing Student
Duquesne University
Appendix E. Permission from Paul Krueger

From: Paul Krueger  
To: Catherine Pearsall  
Sent: Sunday, January 30, 2005 1:30 PM  
Subject: Re: Elder Abuse Study Question

Catherine Pearsall wrote:

Dear Paul, We last made contact this past summer regarding my dissertation efforts in the area of Elder Abuse. I have completed my literature review and am currently completing my proposal draft. After careful review, your questionnaire would be ideal for use in my study. You were kind to have provided me with a hard copy of the questionnaire. I am requesting formal approval to use your questionnaire in my study. I most certainly will appropriately site the source in my dissertation. I anxiously await your response and am most grateful for your time. Respectfully, Catherine Pearsall

Hi Catherine,

You are more than welcome to use the questionnaire.

Best wishes with your dissertation!

Paul
Appendix F. Duquesne University Institutional Review Board Letter of Approval
Dr. Paul Richer  
Chair, Institutional Review Board  
Phone (412) 396-6326 Fax (412) 396-5176  
e-mail: richer@duq.edu

November 9, 2005

Ms. Catherine Pearsall
425 Fawn Lane
Cutchogue NY 11935

Re: “Detection and management of elder abuse: nurse practitioner self-perceptions of barriers and strategies” Protocol #05/106

Dear Ms. Pearsall:

Thank you for submitting your research proposal.

Based upon the recommendation of IRB member, Dr. Joan Masters, along with my own review, I have determined that your research proposal is consistent with the requirements of the appropriate sections of the 45-Code of Federal Regulations-46, known as the federal Common Rule. The intended research poses no greater than minimal risk to human subjects. Consequently, under rules 46.101 and 46.110, your proposed research is approved on an expedited basis.

This approval must be renewed in one year as part of the IRB’s continuing review. You will need to submit a progress report to the IRB in response to a questionnaire that we will send. In addition, if you are still utilizing your consent form, you will need to have it approved for another year’s use.

If, prior to the annual review, you propose any changes in your procedure or consent process, you must inform the IRB Chair of those changes and wait for approval before implementing them. In addition, if any procedural complications or adverse effects on subjects are discovered before the annual review, they immediately must be reported to the IRB Chair before proceeding with the study.

When the study is complete, please provide us with a summary, approximately one page. Often the completed study’s Abstract suffices. Please keep a copy of your research records, other than those you have agreed to destroy for confidentiality, over a period of five years after the study’s completion.
Thank you for contributing to Duquesne's research endeavors.

If you have any questions, feel free to contact me at any time.

Sincerely yours,

[Signature]

Paul Richer, Ph.D.
Chair, IRB

C: Dr. Joan Masters
   Dr. Kathleen Sekula
   IRB Records
References


Burgess, Prentky, & Dowdell. (2000). Sexual predators in nursing homes. *Journal of Psychosocial Nursing & Mental Health Services, 38*(8), 26-.


NARCEA. (1992). Elder abuse and neglect content in higher education programs on aging. In United States Administration on Aging (Ed.):Clearinghouse on abuse and neglect of the elderly.


