Abuse in Aging Populations

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Introduction

As of 2021, older adults represent 19% of the total Canadian population, with the number of individuals older than 65 exceeding that of younger people under 15 years of age [1]. With increasing age, older adults often engage less in community activities, raising the risk that instances of abuse will remain undetected [1]. Globally, it is estimated that 15.7% of individuals over the age of 60 have experienced some form of elder abuse (EA), also referred to as elder maltreatment or elder mistreatment [2, 3]. Within Canada, approximately 8% of adults 65 and older report experiencing EA [2, 4, 5].

Regional disparities in reported cases are notable. In 2015, the highest rates of police-reported family violence against older adults were recorded in Canada's territories, with Saskatchewan, Manitoba, and Alberta exhibiting the highest rates among the provinces [6]. Furthermore, the 2019 Canadian General Social Survey (GSS) reported a 29% increase in police-reported violence against older adults aged 65 to 89 between 2014 and 2019, with a national rate of 227 older adult victims per 100, 000 population [4].

Despite these concerning trends, EA remains substantially under-reported. Contributing factors include older adults' reluctance to disclose personal issues, inconsistent reporting mechanisms, limitations in assessment tool inclusivity, transportation challenges, and barriers related to digital literacy and access [1, 2, 4, 7]. Cultural variability in defining and perceiving abuse can also create barriers to reporting, especially when education and literacy regarding EA may not be encouraged by the community or when available resources lack cultural sensitivity. In addition, Canadian legislation does not mandate the reporting of EA in most circumstances, except when reporting is required by an individual's professional responsibilities or employment in long-term care or retirement facilities [8]. Notably, the Criminal Code of Canada does not define EA as a specific offence, and such incidents are typically prosecuted under other criminal provisions [4].

Definition of Elder Abuse

While there is no universally accepted definition of EA in Canada, the Canadian federal policy definition of mistreatment of older persons states that the mistreatment of older adults as single or repeat events within a relationship of trust where an "act, word, attitude, or lack of appropriate action causes risks causing negative consequences for an older person" [9]. This definition, while overlapping with other types of definitions, is intended to create cultural change and generate public awareness about the mistreatment of older adults [9]. Further, at least one key organization or agency in every Canadian jurisdiction, except Nunavut, has developed a definition of EA containing a description of EA as well as the types of abuse. Consequently, definitions for scientific and legal purposes are still varied [9].

Commonly, in the absence of a national standard, the World Health Organization (WHO) definition is widely adopted by researchers and EA organizations to describe abuse faced by older adults. WHO defines EA as "a single or repeated act, or lack of appropriate action, occurring within any relationship where this is an expectation of trust, which causes harm or distress to an older person" [10].

The lack of definitional consistency extends beyond terminology. Research on EA also varies in terms of age thresholds, with no agreed-upon minimum age for inclusion. These variations, combined with interpretations of abuse among service providers, researchers, and older adults, further complicate efforts to identify, measure, and respond to EA. Cultural differences in how abusive behaviours are perceived and reported add another layer of complexity, making standardized assessment and intervention particularly challenging [6, 10].

Ageism

Ageism refers to prejudice, discrimination, and stereotypes directed at individuals based solely on their age [11]. It begins in childhood through learned cues and over time, is reinforced, manifesting in various forms such as institutionally, interpersonally, or internally [11]. Ageism is associated with a wide range of negative outcomes, including reduced life expectancy, poorer physical and mental

health, delayed recovery from illness or disability, cognitive decline, and an overall decrease in quality of life [11].

Beyond health complications, ageism is linked to increased poverty and financial insecurity, social isolation, loneliness, restricted sexual expression, and a heightened risk of violence and abuse against older adults [11]. Certain factors can increase individuals' vulnerability to ageism, such as advanced age, dependency on care, limited healthy life expectancy, and employment in specific professions or occupational sectors [11].

Ageism Against Older Adults

Globally, it is estimated that one in two individuals hold ageist attitudes towards older adults [11]. The social construction of aging is shaped by two dominant and conflicting stereotypes. One portrays older adults as youthful, employable, and socially contributive, while the other depicts them as burdensome, aggressive, or even abusive towards caregivers [12]. These reductive narratives oversimplify the complex and varied experiences of aging, reinforcing a harmful binary of benevolence versus hostility. Benevolent ageism refers to the protection and adoption of well-meaning behaviours towards older adults based on the assumption that age identifies need [13]. As a result, many older adults experience a loss of dignity and autonomy [13]. Comparatively, hostile ageism refers to negative attitudes and discrimination towards older adults, manifesting as contempt or neglect [13].

Research indicates that individuals more likely to express ageist views toward older adults are often younger, male, have lower levels of education, and demonstrate higher levels of death anxiety [11]. Additionally, older adults who internalize ageism may adopt stereotypes, such as believing they are too old to pursue postsecondary education, which in turn reinforces ageism at interpersonal and systemic levels. Understanding these patterns is essential for developing targeted strategies to mitigate ageism within healthcare systems, workplaces, and broader social environments.

The Implications of Intersectionality

EA does not occur in isolation and is often shaped by the intersection of multiple forms of discrimination, such as ageism, ableism, sexism, and racism [11]. These intersecting oppressions compound the marginalization of older adults and can significantly intensify the negative impact on health, safety, and overall wellbeing [11]. Acknowledging these intersections is essential for developing a more comprehensive understanding of EA that reflects the complex realities of diverse identity markers and lived experiences.

Structural systems rooted in capitalism, colonialism, toxic masculinity, and patriarchal norms serve to reinforce existing power imbalances and social hierarchies [14]. In such systems, bodies that reflect masculine power and youthful vitality are often privileged, while those that do not conform to these ideals are rendered 'others' and marginalized [14]. This exclusion, often referred to as the violence of exclusion, disproportionately impacts women, racialized communities, and older adults, increasing their vulnerability to various forms of abuse, including physical and sexual violence [14].

Importantly, rigid cultural narrative around masculinity and youth also negatively impact men as well, forming barriers to disclosing abuse and accessing help [14]. Stigma and societal expectations may act as barriers, especially for older men experiencing physical or sexual abuse [14].

Canadian data demonstrates these gendered and structural disparities. In 2019, 58% of police-reported EA victims of family violence were women, a rate approximately 26% higher than that of men [1, 6]. In terms of perpetrators of EA, older women are most frequently victimized by a spouse (28%), an extended family member (28%), or an adult child (27%) [1, 6]. In contrast, older men were more likely to experience victimization by an extended family member or adult child, each accounting for 34% of reported cases [1]. Between 2008 and 2018, 198 older adults were killed by a family member, with women comprising 62% of all older

adult victims of family-related homicide [6]. Additionally, rates of violence were consistently higher in rural areas than in urban settings for both older adult women and men [6].

Regarding Indigenous populations, unique demographic and structural factors shape the experience of aging and vulnerability. Although Indigenous populations are aging at a slower overall rate due to declining birth rates and improved life expectancy, dependence and age-related health challenges often emerge earlier, typically around age 55, nearly a decade sooner than in non-Indigenous populations [15, 16]. Indigenous older adults also face elevated rates of EA, influenced by both the historical and contemporary impacts of colonization [10, 16]. However, there remains a lack of detailed data specifically capturing experiences of EA within Indigenous contexts, representing a significant gap in current research [10, 16].

Types of Abuse

EA encompasses a broad spectrum of harmful actions and behaviours directed toward older adults. Among this population, individuals aged 75 and older are identified as the most vulnerable to abuse [17]. In their examination of EA research in Canada, Walsh and Yon highlight that older adults conceptualize abuse within three broad themes [17]. These include neglect, the violation of human, legal, and medical rights, as well as the deprivation of choices, decisions, status, finances, and respect [17].

Physical

Physical abuse refers to the infliction of pain or injury that may result in bruises, welts, cuts, and wounds [3]. More severe indicators of physical EA can include broken bones, sprains, burns, dislocated joints, head or spinal injuries, and delayed or repeated emergency room visits, often without adequate information [18]. Common forms of physical abuse involve, but are not limited to, hitting, slapping, kicking, shoving, and the improper use of physical restraints [18].

Among all types of EA, physical abuse is of the most common forms of police-reported family violence against older adults, most often committed by family members. In Canada, level one assault (i.e. assault without a weapon or bodily harm) accounts for approximately 55% of reported cases [1]. The actions most often reported are pushing or hitting (61%), followed by threats of violence (21%) [1]. Weapons were present in 18% of documented violent encounters [1].

Psychological & Emotional

Psychological and emotional abuse are deliberate actions that cause mental pain, fear, or distress to an older adult [18]. Signs of psychological and emotional abuse include depression, social withdrawal, avoidance of eye contact, disrupted eating or sleeping patterns, isolation, low self-esteem, anxiety, and fearfulness [3, 18]. This form of abuse may manifest as verbal assault, threats of abuse, harassment, intimidation, name calling, belittling, withholding affection, and a general lack of acknowledgement [3, 18]. It may also involve more subtle or coercive behaviors such as restricting access to loved ones, communication, or resources [3, 18].

Psychological and emotional abuse is one of the most frequently occurring forms of EA in Canada. According to 2019 data, psychological and emotional abuse was reported more often than financial abuse [4]. Notably, adult children of the older adult are often more emotionally abusive and neglectful, in comparison to spouses who are more likely to commit physical and sexual abuse [14].

Financial & Material

Financial and material abuse is the unauthorized or improper use, control, or withholding of an older adult's financial resources or assets, typically to the detriment of the individual and for the benefit of the perpetrator [3, 18]. This form of elder abuse can both be overt or covert, making detection particularly challenging to recognize. Signs of financial and material EA may include redirected financial documents (i.e. cancelled cheques or bank statements sent to unauthorized individuals), overpayment for goods and services, sudden changes to legal documents (i.e. power of attorney or wills), and unexplained alternations to

bank accounts [18]. Additional red flags include unpaid bills, missing belongings or property, confusion regarding financial status, and unexplained spending [18].

Older adults can experience financial and material abuse through scams and fraudulent activities [4]. These often involve the unauthorized use of personal information to obtain money, goods, or services; fraudulently applying for benefits; or deceiving individuals to relinquish assets through in person, online, or telephone-based schemes [4].

According to the 2019 GSS, over 14% of older adults were victims of fraud within the preceding five years [4]. Furthermore, approximately 2% of older adults indicated experiencing financial or emotional abuse at the hands of a family member or caregiver between 2013 to 2019 [3].

Sexual

Sexual abuse of older adults includes any nonconsensual sexual contact or activity, particularly in instances where the individual lacks the capacity to provide informed consent due to cognitive impairment, coercion, or physical intimidation [3]. The indicators of sexual abuse can include unexplained pelvic injuries, difficulties walking or sitting, the presence of new sexually transmitted infections, bruising on the inner thighs and breasts, and bleeding from the genitals [18]. It is important to note that physical and sexual abuse statistics are often reported together due to underreporting of sexual abuse in older adults, similar categorization in criminal codes, shared dynamics of the abuse (i.e. bodily harm), and privacy protection.

According to data from 2019, 1.5% of older adults reported physical or sexual abuse by an intimate partner [14, 19]. The prevalence was notably higher among women aged sixty-five to seventy-four, with 2.2% reporting such abuse, compared to 1.1% of men in the same age group [19]. Overall, older women are approximately three times more likely than men to experience physical or sexual abuse [14].

Neglect

Neglect is the failure by caregivers to provide the necessities of required for health and wellbeing [3]. Similarly, self-neglect occurs when an older adult is unable or unwilling to meet their own essential needs, such as food or medical care [3]. In the context of EA, the two types of neglect highlighted in the literature include physical neglect and emotional neglect [7].

Physical neglect involves the omission to essential care needs, such as adequate nutrition, hydration, shelter, hygiene, and access to medical treatment or assistive devices [7]. Emotional neglect encompasses the failure to offer companionship, emotional support, or opportunities for meaningful engagement in social activities [7].

Signs of elder neglect may include dehydration, malnutrition, unclean or inadequate clothing, overmedication, poor personal hygiene, weight loss, untreated infections or injuries, as well as dangerous or unsanitary living conditions [3, 7, 18]. Other signs include feelings of loneliness, depression, and social isolation [7].

The placement of older adults in care can also be considered a form of neglect or psychological/emotional abuse due to the separation of the individual from loved ones and their communities [20]. Fears of abandonment, inadequate care, and loss of stability or safety can harm older adults by creating anxiety about having support withheld. Further, some older adults view placement in continuing care settings as a threat to their dignity and autonomy due to the loss of independence, the stigma surrounding continuing care homes, and reduced privacy [20].

Additional Considerations

It is important to note that a longtime trusting relationship does not need to be established for EA to occur, such as in cases of scams or fraud where interactions can occur between strangers [20]. Furthermore, while there is a consensus on what qualifies as EA, some aspects of abuse go unnoticed. This includes experiences of government neglect, concerns regarding immigration/citizenship status, perceived disobedience, filial obligations, gender issues, digital or technological abuse, and spiritual abuse [2, 21].

Outcomes of EA

EA can have profound and enduring consequences for the health, wellbeing, and overall quality of life of older adults [3]. Victimization is associated with a range of adverse outcomes, including poor physical and mental health, increased use of emergency services, higher rates of hospitalization, and premature admission into continuing care facilities [5, 8, 21]. Psychological consequences are significant and may include accelerated cognitive decline, chronic stress, and post-traumatic stress disorder [5, 7]. Beyond the psychological and physical toll, financial devastation, anxiety, depression, social isolation, and diminished opportunities for meaningful social interaction are common among victims. Additional effects encompass issues related to denial or self-blame, reduced self-esteem, and elevated risks of cardiovascular events such as stroke and heart attack, as well as inappropriate medication use [1, 5, 7, 22].

Alarmingly, research indicates that older adults who experience elder abuse are three times more likely to die within one year compared to their non-abused counterparts, underscoring the critical need for early identification and intervention [8, 22].

Cost

The financial burden of addressing family violence and abuse in Canada is substantial, with estimated costs reaching approximately $6 billion annually. Of this total amount, $385 million is allocated to social programs, $408 million to health and medical services, $577 million to labour and employment, $872 million to criminal justice, $1.5 billion to health and well-being services, and $2.3 billion to social services and education [23]. Within the healthcare sector specifically, elder abuse-related services account for at least $500 million in direct medical expenses each year. Additionally, an estimated $225 million is attributed to the intangible costs of pain and suffering resulting from abuse [15, 23].

Comparatively, the United States Centers for Disease Control and Prevention estimated that EA injuries result in approximately US$5.3 billion healthcare expenses annually [8].

Barriers to Reporting

Barriers to reporting or seeking help can be grouped into three main categories: those related to the individual, those centered on the perpetrator or family dynamics, and those influenced by community or cultural factors [10].

Individual

For older adults who have experienced EA, numerous personal factors can inhibit disclosure or help-seeking. These barriers often stem from a combination of emotional, psychological, and situational challenges. Additionally, cognitive decline can hinder reporting by impacting memory and communication.

Common individual-level barriers include dependency on the abuser, fear of retaliation, shame, learned helplessness, and feelings of powerlessness [10, 21]. Many victims may hesitate to report abuse due to concerns about their well-being, the risk of losing a critical relationship, or a reluctance to disrupt family dynamics. Some internalize blame, rationalize the abuse, or excuse the perpetrator's behavior, particularly when the abuser is a spouse or family member [2, 10]. Additional barriers include language barriers, difficulty identifying or naming the abuse, limited awareness of the severity of the abuse, and the tendency to normalize or downplay harmful behaviour, often referring to the abuse as 'disrespect' [2, 10]. Cultural or personal beliefs in fate or destiny may further discourage action [10].

Older adults may also experience guilt, feeling that others are suffering more severely, or choose silence due to the emotional toll of recounting traumatic events, a lack of physical evidence, or fears of not being believed [2, 10]. Furthermore, distrust in services and difficulties accessing appropriate resources represent critical structural barriers to intervention [10].

For immigrant older adults who have been sponsored by their families, another layer of complexity is added as social exclusion is heightened. Canada's immigration and family reunification policies often require sponsors to assume financial responsibility for up to ten years, which can lead to heightened

dependence and social exclusion [2]. In such cases, the older adult may fear being a burden or risking their immigration status by disclosing abuse. The fear of jeopardizing sponsorship, housing stability, or eventual citizenship can act as powerful deterrents to reporting [2, 20].

Perpetrator and Family

Family dynamics and the behavior of perpetrators can create substantial obstacles that prevent older adults from reporting abuse or accessing support services. Perpetrators or family members can create significant barriers to service access by restricting older adults' communication and independence and by actively discouraging them from seeking help. Additional barriers to reporting may stem from the nature of the family relationship, concerns for the perpetrator's wellbeing, fear of law enforcement involvement, self-blame, shame, embarrassment, and beliefs that the abuse is inevitable [10].

In some cases, these barriers are further complicated by patterns of intergenerational abuse, originating with a spouse and continuing through to children and grandchildren [20]. Families may also struggle to recognize certain behaviours as abusive, such as withholding money, ignoring the older adult's requests, or installing additional locks, especially when caregiving for individuals with dementia or memory loss [20].

Community and Culture

EA is a cultural construct, and its understanding can vary greatly across different communities and cultures [10]. For instance, many older adult immigrants interpret EA through the lens of their cultural norms, religious beliefs, values, experiences prior to immigration [2]. Communities that place a strong emphasis on traditions, family honour, and respect may deter older adults from reporting EA out of fear of bringing shame to the family, or out of fear of retaliation [7]. Therefore, barriers to reporting are often shaped by differences in terminology, definitions, and perceptions of what constitutes abuse [10].

Furthermore, factors such as prevailing social and traditional norms, limited public awareness, lack of knowledge about available resources, restricted service ability,

transportation challenges, low levels of professionalism, and a lack of cultural sensitivity within services can discourage communities from reporting instances of EA [2, 10].

Risk Factors of Elder Abuse

Risk factors are the conditions or behaviours that increase the likelihood of a person experiencing harm or negative outcomes. Static risk factors, variables that are mostly historical, and dynamic risk factors can be effective indicators of vulnerability to harm, as well as targeting intervention [22]. Since the COVID-19 pandemic, EA has increased, as well as other stressors such as alcohol use, social isolation, and negative impacts on caregiver health [10].

Interpersonal Risk

Interpersonal risk serves as a central organizing principle that can contribute to the likelihood of elder abuse [2, 14]. Older adults are more vulnerable in personal relationships with caregivers, family members, or partners who have developed "'default individualism", which is the assumption that individuals are solely responsible for their circumstances and often ignores the influence of broader social, structural, or systemic factors [14]. Consequently, relationships can become more tenuous, leading to various forms of abuse, violence, inequalities, and power imbalances in relation to a trusted other [5, 14]. Characteristics of the older adult, the perpetrator, the relationship, as well as the environment must be considered when considering EA risk factors [21].

Victims

Victims of EA are affected by a wide variety of risk factors, ranging from individual-level issues to broader social, relational, and system factors.

Physical and cognitive impairments, challenges with the activities of daily life, shared living arrangements, cultural beliefs and values, Indigenous identity, gender, adverse childhood experiences, and prior victimization before the age of 60 have all been identified as risk factors of EA [2, 3, 5, 10, 14, 17]. Additional risks include

difficulties in past relationships, marriage, and divorce [2, 14]. Older adults are also more vulnerable to EA when experiencing social isolation, ethnic and racial marginalization, poverty, housing insecurity, personality disorders, substance abuse, poor coping strategies, or a lack of financial and psychosocial independence [2, 5, 10, 14, 21].

Broader structural issues, such as barriers to accessing support services and immigration policies, as well as societal challenges, like the opioid crisis, also contribute to older adult victimization [2, 5, 14, 17, 21].

Lastly, the erosion of traditional roles and respect within immediate and extended family structures, combined with a lack of community "elder-specific" health and social services, may increase the vulnerability of Indigenous older adults to EA [16].

Perpetrators

Perpetrators also face a range of contributing factors that span from individual to societal levels. Perpetrators of are often financially dependent on the victim, may have physical, mental, and cognitive vulnerabilities, and frequently experience housing instability, poverty, and social isolation [2, 5, 10]. Many also exhibit poor coping strategies, have histories of being victims of violence themselves, and have difficulty managing interpersonal relationships [2, 5, 10, 22].

Perpetrators with more chronic health conditions and physical symptoms have also been found to be more likely to commit acts of EA [22]. Mental health concerns are common among EA perpetrators, with reported rates ranging from 14% to 25%, and depression being the most prevalent diagnosis [22]. These mental health challenges often increase the perpetrator's dependence on the older adult, leading to unrealistic expectations of an older adults' capabilities as well as impairing emotional regulation [22].

Substance abuse is considered one of the strongest predictors of EA [22]. Multiple studies have found that older adults are at a higher risk of experiencing abuse when their caregivers have substance use problems [22]. Hypotheses explaining this link include increased dependency on the older adult, the need to steal to

support the addiction, impaired judgement due to intoxication in relation to care decisions, and stress related to the addiction [22].

In some cases, the perpetrator's own trauma plays a role. Learned caregiving norms and childhood experiences of victimization or neglect may increase the likelihood of perpetrating abuse in childhood [22]. Exposure to family or domestic violence may impair the perpetrator's problem-solving abilities, making them more prone to using aggression under stress [22]. While there is limited evidence supporting the idea that perpetrators abuse their older parents out of revenge for childhood abuse, research suggests that child abuse is more likely to emerge in those dynamics than EA [22].

Social attitudes, such as ageism and negative perceptions of aging are also significant risk factors. A lack of empathy or diminished value placed on older adults can lead to caregivers resisting their caregiving roles [22]. The reluctance can deter caregivers from building the skills needed to respond to behaviours, often resulting in frustration, aggression, and antisocial conduct [22].

Addressing Elder Abuse Factors

To address the factors associated with EA, preventative strategies focused on policy reform, transition-period programming, and community support have been identified as essential [5]. For example, community-focused healthcare, interdisciplinary collaboration, and redesigning spaces to reduce violence are suggested [14]. Older adults are more comfortable reporting instances of EA when services and amenities are close by and accessible, thus limiting the reliance on the abuser [14]. Awareness groups, such as the Alberta Elder Abuse Awareness Council, play a key role in generating awareness about EA, as well as providing resources and education [23]. These groups enhance an older adult's autonomy, empowering them to develop strategies and enhance their decision-making in relation to EA [21].

Higher levels of resilience, social support, and embeddedness in a social network are also protective factors in lowering the risk of EA [5]. For example, regular church attendance lowered the risk of physical and sexual assault in older adults,

highlighting that social networks and community involvement reduced individualism and the likelihood of victimization due to isolation [13]. Groups or support programs can also alleviate risk factors [2]. Interventions focused on caregiver support to prevent abuse and money management for older adults can aid decreasing in EA [2]. Additionally, accessible helplines and emergency shelters, as well as services created by multidisciplinary teams are essential in assisting with reporting and managing experiences of EA [2].

One example of a validated screening tool for elder abuse is the Elder Abuse Suspicion Index (EASI), developed by an interdisciplinary team at McGill University. Designed specifically for use in primary care settings, EASI assists family physicians in identifying potential victims of EA and determining whether further investigation is warranted [24]. EASI is administered to individuals 65 years and older and is comprised of six questions, taking around two to five minutes to complete [24]. Unlike other traditional screening tools, the physician's decision-making and diagnostic strategies are respected [23]. The tool is intended to raise clinical suspicion of EA and physicians can then choose to either further explore concerns themselves or, with the patient's consent, refer the case to a specialized professional, such as a social worker, law enforcement officer, or elder care advocate [24]

Criticisms

Critiques of current EA awareness and intervention strategies highlight how the professionalization of the issue has often excluded older adults from the conversation entirely [12]. Efforts tend to prioritize protection over participation, focusing heavily on raising awareness and identifying problems rather than empowering older adults or promoting their active involvement [12]. Despite the need, the implementation of universal programs addressing EA has yet to materialize [12].

Another key concern is the inconsistency among screening tools used to identify EA. This lack of standardization makes it difficult to compare prevalence, understand risk factors, and develop effective prevention and intervention strategies [3]. Additionally, most screening tools are only designed to detect EA, not

to assess the risk or severity of harm [21]. As a result, practitioners are often left to rely on unstructured professional judgement to determine the likelihood of abuse [22]. This approach can be unreliable and lacks transparency, raising ethical concerns due to the absence of clear accountability in decision-making processes [22].

To strengthen the EA response effort, the integration of harm reduction principles and improved access to timely assessments are recommended. These measures would support the development of tailored intervention plans that better address the diverse needs and circumstances of older adults facing abuse [21].

Elder Abuse in Continuing Care

With a rapidly aging population, continuing care sites are essential in supporting individuals with ongoing personal care needs. These services bridge health and social supports, ensuring that people of all ages, specifically older adults, receive essential care. As the demand for continuing care grows, so does the importance of recognizing and preventing EA, ensuring that the care environment is not only supportive, but safe, respectful, and free from harm.

Overall, Canadian survey data does not capture the continuing care population, and severe cognitive limitations preclude older adults from providing consent and participating [19]. Police-reported data and academic studies are often the best resources to highlight rates of EA in continuing care [19]. For example, in a study examining 781 reports of abuse in 385 Ontario continuing care homes, 441 of incidents involved staff-to-resident abuse [25]. The most common type of abuse was physical (37%), followed by verbal (24%) and emotional (21%) [25].

Factors contributing to EA in continuing care include staff shortages and burnout, lack of training and resources, as well as isolation of residents and limited oversight [26]. Further, issues arise in the documentation and reporting of abuse due to a lack of training and awareness of protocol, lack of trust, need for cultural and leadership changes, and a missing quality and safety framework [25].

Within Alberta, the Protection for Persons in Care (PPC) Act promotes the prevention and reporting of abuse against adults receiving care or support from the service providers named or identified in the act [27]. Examples of service providers include hospitals, continuing care homes, and support services funded by provincial or regional health authorities [27]. The act also provides a definition for what is or is not considered abuse, and outlines two types of serious harm, which are bodily and emotional [27].

Gaps in Literature & Implications

Older adults are often excluded from healthcare research and data collection efforts, leading to a significant gap in literature [11]. This gap affects awareness, service development, and policymaking, particularly in the area of EA. Research on EA has lagged considerably behind other forms of violence, such as child abuse and intimate partner violence [21]. In 2003, it was estimated to be 10 to 30 years behind [22]. In terms of data collection, Canada's only nationwide survey focused specifically on EA was conducted in 1989, underscoring the urgent need for more targeted research in this area [17].

The absence of standardized definitions for abuse and EA contributes to a significant data gap, as interpretations vary and categorizing behaviours becomes challenging [3, 20]. Additionally, areas of abuse such as spiritual, systemic, and medical are not currently captured [17]. Existing definitions were developed without the input from older adults, resulting in perspectives that may not fully reflect their lived experiences [20]. Ambiguity around the boundaries of EA, compounded by ageism, further complicates the development of assessment tools for identifying and reporting abuse, conducting research, and reducing stigma and misunderstanding [17]. Likewise, the lack of standardized assessments makes the measurement of EA particularly difficult and the development of interventions and programs directionless [7]. Assessment tools are often not culturally sensitive as well, meaning interventions do not meet the needs of many older adults [7].

Data collection in care settings is another gap in the literature. Due to each province and territory developing different reporting requirements for incidences

of EA occurring in long-term care homes, there is a lack of reporting occurring in private settings [3]. Consequently, a portion of the older adult population is hidden, making the accuracy of EA awareness and data impossible. As older adults in continuing care are often more dependent due to the complexity of their care, the increase for abuse and neglect makes it essential to understand and address these risks through research. Further, legislation, such as the PPC Act, applies only to the services provided by the regulations, meaning private care arrangement may not be covered. Placing timelines on requirements to abuse, such as no later than two years from the date of abuse, or using language, such as "serious" harm, creates ambiguity around what is considered serious. Finally, the limitation of only considering two types of abuse, bodily and emotional, does not fully capture the depth and complexity of EA.

Another key data gap is the missing information on Indigenous elders, LGBTQIA+, the unhoused, persons with disabilities, and marginalized groups [17, 20]. The inclusion of diverse group perspectives is not often considered in society, leading to differences within cultural groups not being widely known [20]. In fact, most EA data is reported without identifying markers being noted, meaning specific information about under-represented and marginalized populations rarely exists or is updated [2]. For example, older adult immigrants make up 28% of the Canadian population over 60, with EA also being common in minority populations [2, 3]. The culturally specific elements of EA are essential to designing prevention and intervention strategies targeted to culturally specific contexts [3]. For Indigenous populations, EA research is minimal, with the literature not clearly outlining rates or types of abuse faced by older adults.

Recommendations for Future Studies

A primary recommendation for advancing elder abuse research is the development of a standardized definition of EA, along with reliable and consistent measurement tools [17]. Without uniform definitions, studies remain difficult to compare, and

prevalence rates are often inconsistent or underreported. A standardized definition would ensure uniformity in understanding and reporting, as well as acknowledge the types of abuse to be considered EA. Standardized assessment tools would enable more accurate identification, reporting, and tracking of abuse across different contexts and populations.

Future studies must adopt culturally inclusive frameworks that recognize diverse understandings of family, aging, and abuse. Cultural values such as family loyalty, filial piety, and the role of older adults within communities can shape how abuse is perceived, reported, and experienced [2, 7]. Research should explore how language, religion, and customs influence experiences of EA, and avoid oversimplified racial or ethnic categorizations. Importantly, individuals from the same racial or cultural background may still have vastly different experiences, highlighting the need for nuanced, culturally sensitive approaches [2, 7].

There is a critical need for Indigenous-led research that addresses EA within Indigenous communities, considering risk and protective factors specific to Indigenous populations [15, 16]. This includes examining how colonial legacies, systemic discrimination, poverty, chronic illness, and food insecurity contribute to experiences of abuse [15]. Rather than assuming higher risk is inherent to Indigeneity, research should focus on structural inequalities and community-specific contexts to inform culturally appropriate interventions [16].

Older adults with cognitive impairments are often excluded from EA studies due to challenges with informed consent and data collection [2]. However, this population may be at greater risk of experiencing abuse and have decreased ability to report it. Future research should prioritize ethical and methodological strategies to include geriatric populations, ensuring their experiences are included in policy and practice.

Most current EA studies rely on cross-sectional and self-reported data, which limits the ability to understand abuse over time and within complex relational or systemic contexts [3, 7]. Future research should focus on longitudinal designs to track abuse trajectories, explore subtypes of abuse, and identify perpetrator characteristics in various settings. A topic of necessary exploration is the relationship between survivors of domestic violence who have experienced traumatic brain injuries (TBIs)

and their risk of cognitive decline in older adulthood. Given the nature of cognitive decline and EA, understanding the relationship to traumatic brain injuries is key to understand cumulative impact of TBIs over time, the risk of increased vulnerabilities, as well as healthcare needs. Incorporating legal documentation, financial records, and medical histories can also provide a clearer picture of abuse patterns and help identify individuals at greater risk, such as those with pre-existing mental health conditions.

Another area requiring further exploration is the economic burden of elder abuse. Studies should investigate how different forms of abuse impact healthcare, mental health services, and long-term support systems [7]. Understanding which types of abuse lead to the greatest service utilization can help policymakers allocate resources more effectively and recognize the societal-level costs of inaction. While most research focuses on victims, there is a need for deeper exploration into the motivations and characteristics of perpetrators. Integrating insights from domestic violence research could shed light on the dynamics within abusive relationships, especially in family or caregiving contexts [7]. This line of inquiry could inform more effective interventions and prevention strategies that address both sides of the abuse dynamic.

Finally, future research should examine risk and protective factors for EA in both community and care setting environments, with particular attention to gendered dynamics and broader social factors beyond individual characteristics [18]. Such research would support the development of more targeted policies and programs aimed at reducing risk and strengthening protective mechanisms within vulnerable populations.

Conclusion

Elder abuse remains a pervasive yet underrecognized issue affecting older adults across diverse settings and communities. Despite its serious consequences, including physical harm, psychological trauma, social isolation, and increased mortality, it continues to be overlooked in research, policy, and practice. The lack of standardized definitions, culturally inclusive frameworks, and methodologically

rigorous studies have contributed to significant gaps in understanding the true scope and nature of elder abuse. The lack of mandatory reporting in most provinces, combined with the absence of EA as a distinct offense in the Criminal Code of Canada, further complicates the identification and prosecution of abuse. With older adults increasingly at risk of isolation, particularly as they disengage from community life, it is crucial to enhance surveillance, improve reporting mechanisms, and develop culturally informed prevention strategies. Addressing these issues through comprehensive policy reform, education, and continued research is essential to protecting the rights and well-being of Canada's aging population.

To effectively address this complex issue, future efforts must prioritize the voices and experiences of older adults, particularly those from marginalized populations. There is a pressing need for comprehensive, interdisciplinary, and culturally sensitive research that can inform prevention, early detection, and intervention strategies. Ultimately, recognizing EA as a public health, human rights, and social justice concern is essential to ensuring that all older adults can live with dignity, safety, and respect.

Implications for The Brenda Strafford Foundation

Combatting EA is necessary within continuing care to ensure the wellbeing, safety, and quality of life for all residents. It is essential for The Brenda Strafford Foundation to consider prevention and protection, support programs, and collaboration in relation to EA.

Making screening and assessment tools accessible, alongside proper training is on reporting procedures and recognizing different forms of abuse, is essential to creating an environment where residents and staff feel safe to disclose concerns. Support programs for residents and families that promote resident autonomy can reduce misunderstandings within the relationship and strengthen resident confidence, while wellness initiatives for both staff and family caregivers help prevent burnout and compassion fatigue. Collaboration with researchers and

advocacy groups is also key developing best practices, training initiatives, and resident-centred approaches. Examining intersections of aging, such as cultural differences, offers valuable perspectives on EA. Additionally, integrating interventions and technologies into continuing care settings, such as monitoring systems or anonymous reporting apps, may aid in reporting accuracy and strengthen protections within continuing care settings.

References

[1] Conroy, S. (n.d.). Family violence against seniors. Elder Advocates Society of Alberta. https://elderadvocates.ca/family-violence-against-seniors/

[2] Mehdi, F., Dahlke, S., & Hunter, K. F. (2023). Developing a comprehensive understanding of older person abuse in Canadian immigrant communities: An integrative review. *Canadian Journal of Nursing Research*, *55*(2), 139–152. https://doi.org/10.1177/08445621221112429

[3] Dong, X. Q. (2015). Elder abuse: Systematic review and implications for practice. *Journal of the American Geriatrics Society (JAGS), 63*(6), 1214–1238. https://doi.org/10.1111/jgs.13454

[4] Canadian Centre for Justice and Community Safety Statistics. (2021, May 21). Brief: Statistical landscape of senior abuse in Canada. Statistics Canada. https://www.ourcommons.ca/Content/Committee/432/JUST/Brief/BR11355142/br-external/StatisticsCanada-e.pdf

[5] Burnes, D., Pillemer, K., Rosen, T., Lachs, M. S., & McDonald, L. (2022). Elder abuse prevalence and risk factors: Findings from the Canadian longitudinal study on aging. *Nature Aging, 2*(9), 784–795. https://doi.org/10.1038/s43587-022-00280-2

[6] Government of Canada. (2024, July 31). Fact sheet: Family violence. https://www.canada.ca/en/women-gender-equality/gender-based-violence/family-violence.html

[7] Folorunsho, S., & Okyere, M. (2025). The impact of neglect, physical, and financial abuse on mental health among older adults: A systematic review. *Aging & Mental Health, 29*(4), 567–577. https://doi.org/10.1080/13607863.2024.2436468

[8] Atkinson, E., & Roberto, K. A. (2024). Global approaches to primary, secondary, and tertiary elder abuse prevention: A scoping review. *Trauma, Violence & Abuse, 25*(1), 150–165. https://doi.org/10.1177/15248380221145735

[9] Beaulieu, M. & St-Martin. K. (2023). Mistreatment of older persons: Federal policy definition – explanation document. Government of Canada.

https://www.canada.ca/content/dam/canada/employment-social-development/corporate/reports/seniors-aging/mistreatment-older-persons/FederalPolicyDefinition-MistreatmentOfOlderPersons.pdf

[10] Walsh, C. A., Dukart, A., Roger, K., & Goodridge, D. (2024). Disclosure and reporting of abuse against older adults: Perspectives of older adults with abuse histories and service providers in Alberta, Canada. *Journal of Gerontological Social Work, 67*(4), 444–473. https://doi-org.ezproxy.lib.ucalgary.ca/10.1080/01634372.2024.2339990

[11] World Health Organization. (2021, March 18). Global report on ageism: Executive summary. https://iris.who.int/bitstream/handle/10665/340205/9789240020504-eng.pdf?sequence=1

[12] Harbison, J., Coughlan, S., Beaulieu, M., Karabanow, J., VanderPlaat, M., Wildeman, S., & Wexler, E. (2012). Understanding "elder abuse and neglect": A critique of assumptions underpinning responses to the mistreatment and neglect of older people. *Journal of Elder Abuse & Neglect, 24*(2), 88–103. https://doi-org.ezproxy.lib.ucalgary.ca/10.1080/08946566.2011.644086

[13]. FamCare. (n.d). Benevolent ageism… they treat me like I'm old and stupid. https://www.famcare.net/benevolent-ageism-they-treat-me-like-im-old-and-stupid/

[14] Brozowski, K., & Hall, D. R. (2010). Aging and risk: Physical and sexual abuse of elders in Canada. *Journal of Interpersonal Violence, 25(*7), 1183–1199. https://doi.org/10.1177/0886260509340546

[15] Carson, A. (n.d.). We cannot ignore the unique care needs and resiliencies of Indigenous elders and communities. Centre for Global Social Policy. https://cgsp-cpsm.ca/article/we-cannot-ignore-the-unique-care-needs-and-resiliencies-of-indigenous-elders-and-communities/

[16] Dumont-Smith, C. (2002). Aboriginal elder abuse in Canada. National Centre for Truth and Reconciliation. https://new.nctr.ca/wp-content/uploads/2021/01/ahfresearchelderabuse_eng.pdf

[17] Walsh, C. A., & Yon, Y. (2012). Developing an empirical profile for elder abuse research in Canada. Journal of Elder Abuse & Neglect, 24(2), 104–119. https://doi.org/10.1080/08946566.2011.644088

[18] Rivers, J. (n.d.). Types of elder abuse. Nursing Home Abuse Center. https://www.nursinghomeabusecenter.com/elder-abuse/types/

[19] Conroy, S. and Sutton, D. (2022, July 7). Violence against seniors and their perceptions of safety in Canada. Statistics Canada. https://www150.statcan.gc.ca/n1/pub/85-002-x/2022001/article/00011-eng.htm

[20] Ploeg, J., Lohfeld, L., & Walsh, C. A. (2013). What is "elder abuse"? Voices from the margin: The views of underrepresented Canadian older adults. Journal of Elder Abuse & Neglect, 25(5), 396–424. https://doi-org.ezproxy.lib.ucalgary.ca/10.1080/08946566.2013.780956

[21] Goodridge, D., Roger, K. S., Walsh, C. A., PausJenssen, E., Cewick, M., & Liepert, C. (2021). Service providers' use of harm reduction approaches in working with older adults experiencing abuse: a qualitative study. BMC Geriatrics, 21(1), Article 398. https://doi.org/10.1186/s12877-021-02328-1

[22] Storey, J. E. (2020). Risk factors for elder abuse and neglect: A review of the literature. Aggression and Violent Behavior, 50, Article 101339. https://doi.org/10.1016/j.avb.2019.101339

[23] Alberta Elder Abuse Awareness Council. [n.d.]. Stats on abuse in Canada. https://www.albertaelderabuse.ca/stats-on-abuse-in-canada/

[24] Canadian Network for the Prevention of Elder Abuse. (2013). EASI: Elder Abuse Suspicion Index. https://cnpea.ca/en/tools/practice-tools/220-easi-elder-abuse-suspicion-index

[25] Baumann, A., Crea-Arsenio, M., Smith, V., Antonipillai, V., & Idriss-Wheeler, D. (2024). Abuse in Canadian long-term care homes: A mixed methods study. *BMJ Open Quality*, *13*(2), e002639. https://doi.org/10.1136/bmjoq-2023-002639

[26] Kimball, D. (2025, January 15). Behind closed doors: Elder abuse in care homes. Seniors guide. https://www.seniorsguide.com/community-life/behind-closed-doors-elder-abuse-in-care-homes/

[27] Government of Alberta. (n.d.). About protection for persons in care. https://www.alberta.ca/about-protection-for-persons-in-care