Elder Mistreatment & Interpersonal Relationships

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Contents

Introduction

Abuse against older adults is a significant and often under-recognized dimension of interpersonal violence in Canada, intersecting with both domestic violence (DV) and intimate partner violence (IPV). Abuse against older adults can also be known as elder abuse, elder maltreatment, and elder mistreatment (EM), with elder abuse being the most used of the three terms [1]. Yet, it is critical to note that the term "mistreatment" has increased in use over the years as it is found to be more inclusive, including violence and neglect, and is not limited to harsh physical events [1]. Whereas "abuse" has strong connotations of assault robbery, extortion, and other legal implications, "mistreatment" allows individuals to avoid reluctance when addressing and acknowledging harmful behaviours [1]. For the purposes of this report, EM will be used going forward.

As of 2025, it is estimated that EM impacts between 4-10% of older adults in Canada, but only one in five incidents of EM is brought to the attention of those who can help [2]. In parallel, statistics on IPV demonstrate that among individuals who have ever been in a relationship, 44% of Canadian women and girls aged 15 and older have reported experiencing psychological, physical, or sexual abuse by an intimate partner over their lifetime [3, 4]. Within the older adult population, the relationship between EM and IPV emerges in several ways. Approximately 7% of older adults in 2019 reported emotional or financial abuse by an intimate partner in the prior five years [5]. Additionally, older women are twice as likely to be victimized by an intimate partner in comparison to older men (16% vs. 7%) [5]. They also tend to sustain more severe injuries and are likely to have more reported cases of spousal and family violence [6].

These statistics underscore how EM cannot be understood in isolation, but rather as part of a continuum of violence dynamics, which include IPV, DV, and intergenerational or familial harm. Within the Canadian context, aging demographics, increasing dependency, cognitive or physical impairments, and power imbalances in intimate or household relationships all contribute to the risks of violence. Acknowledging this overlap is essential for policy,

prevention, and intervention efforts that respond to EM as family, DV, and IPV concerns.

Terminology

As discussed with Dr. Rose Joudi, an ethnocultural diversity and aging educator in Alberta, it is inappropriate to categorize DV, IPV, and EM together as current supports and cultural understandings of EM do not target the older adult population adequately [personal communication, September 18, 2025]. Further, the experiences of older women are often considered EM rather than DV or IPV due to the prevalence of the medical model when working with older adults [7]. The focus on frailty and daily living needs removes the realities of gender, power, and need for services, such as shelter, crisis intervention, and safety planning, and implies that individuals working in the EM field are only trained to deal with aging and age-related health issues [7]. This model reflects ageist and paternalistic attitudes, overlooking the reality that the violence involved is harmful by focusing solely on issues of health and aging [7].

What is Elder Mistreatment?

Within Canada, no universal definition of EM exists, although 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 or risks causing negative consequences for an older person" [1]. This definition is intended to promote cultural change and generate public awareness about the mistreatment of older adults by expanding the types of abuse included, such as various harmful behaviour and neglect experienced by individuals [1].

Due to inconsistent definitions, the understanding across researchers, service providers, and older adults differs and creates complications in identifying, measuring, and responding to mistreatment.

What is Domestic Violence?

Domestic violence is “a broader term that encompasses a range of abusive behaviours within the context of a domestic or family relationship” [8]. This violence can occur between family members, household members, intimate partners, or individuals living together and can happen anywhere, in private or public [8, 9]. Most often, this violence will go undetected if occurring in the home [9]. Older adult women may experience DV later in life because of new relationships or past strained ones [10]. The impact of DV can include effects of long-term trauma (i.e. depression, anxiety, and other mental health issues), increased morbidity and mortality, and long-term consequences on family relationships and services [10].

What is Family Violence?

According to Statistics Canada, family violence is defined as “violence committed by spouses, parents, children, siblings, and extended family members” [11]. Since 2018, incidents of family violence against older adults in Canada have risen by 49%, including a 4% increase since 2023 [11]. Of the 7,622 older adult victims of police-reported family violence in 2024, 34% of individuals were victimized by a family member [11]. Additionally, six in 10 victims were women [11]. Most often, older adults are victimized by their child (36%), by their spouse (28%), by another type of family member (25%), or by a sibling (11%).

What is Intimate Partner Violence?

Similar to EM, definitions of IPV are inconsistent and often leave older women out of violence discourse as definitions of IPV are focused on individuals of childbearing age [12, 13]. Further, research regarding the relationship between older adults and IPV does not use consistent age ranges, meaning the age in which someone is considered “older” depends on the researcher [12]. Through analysis of several sources, the following definitions of IPV were discovered:

Table 1: Definitions of IPV

Organization	Definition
GBV Learning Network	"Physical, sexual, or financial abuse, or stalking by an individual with whom one has a close personal relationship with, that may be characterized by identity as a couple, ongoing physical and sexual contact, and emotional connectedness (e.g. a current or former spouse, boyfriend or girlfriend, dating partner, or sexual partner)" [12].
Stand to End Rape	Any form of violence or abuse that occurs between individuals in an intimate relationship. This can include, physical, sexual, emotional, or psychological harm inflicted by a current or former boyfriend, girlfriend, dating partner, or cohabitating parter [8].
World Health Organization	"Behaviour within an intimate relationship that causes or has the potential to cause physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviours" [4].
Statistics Canada	"Violence committed by current and former legally married spouses, common-law partners, dating partners and other intimate partners" and includes those who may or may not live together [11, 14].
Royal Canadian Mounted Police	"Broadly, harm caused by an intimate partner, which takes many forms but is

	often the result of an attempt to gain or asset power or control over a partner" [14].

In comparison to EM, DV, and family violence, IPV emphasizes the significance of relationship context and focuses specifically on violence occurring within intimate partnerships, regardless of martial status or legal recognition [8]. It is essential to note that terms such as "spousal violence", "dating violence", or DV should not be used interchangeably with IPV, as these labels either exclude certain forms of IPV by narrowing the scope to specific relationship types, or conflate IPV with other forms of violence occurring in domestic settings, such as child mistreatment [14]. Furthermore, while definitions of EM and IPV share similarities – such as acknowledging that violence can take multiple and co-occurring forms, need not be physical, and can be perpetuated by someone known to the victim – IPV definitions fail to acknowledge the presence and continuity of violence across the life course [13].

IPV & Older Adults

IPV is the most prevalent form of gender-based violence, with women at higher risk of victimization and cases commonly involving a female victim and a spouse or partner as the perpetrator [4, 15]. In terms of older adults, the relationship between EM and IPV has not been excessively studied despite older women who have survived violent relationships dying sooner and having poorer neurological and physical health [16, 17]. Further, older adults experiencing prolonged mistreatment experience lifelong isolation that limits their access to socially protective relationships [16]. As of 2022, IPV against adults 65 years and older has increased by 42% since 2014 [18]. Women aged 55 and older are also more likely to experience IPV in comparison to men in the same age group [18].

IPV is often categorized into two types in relation to older adults, which are "IPV grown old" and "late onset IPV" [19]. "IPV grown old" can be described as the abusive behaviours that have always been prevalent throughout the relationship, whereas "late onset IPV" begins in late adulthood and is thought to be related to retirement, as this life transition tends to

bring on new roles and changes for couples, such as disabilities, sexual changes, cognitive impairment, and social isolation. [15, 19, 17, 20]. Further, as perpetrators themselves get older, the tactics of mistreatment change, where the frequency of physical violence reduces but economic coercion, psychological abuse, and verbal threats increase [13]. Caregiving stress has been indicated as an explanation for abusive behaviour but cannot be used as an excuse, as the behaviour is meant to gain and maintain power and control over victims [12, 20, 21].

Areas of Consideration

By examining the intersection of EM, DV, and IPV, several areas of consideration emerge. These include the ideological gulf that exists between aging and violence sectors, barriers to services that further prevent older adults from receiving appropriate protection and care, and the current tools and assessment frameworks that exist to identify and respond to mistreatment.

Ideological Gulf

Collaboration between IPV, DV, and EM services is minimal due to territorial barriers imposed by authoritative bodies and rigid age-based service restrictions [7]. Although IPV and DV affect individuals across the lifespan, violence against older women often goes unrecognized because the IPV/DV sector tends to focus on younger women [22]. As a result, harm experienced by older adults is frequently encompassed under EM, emphasizing age over the gendered and power-based dynamics at play that shape these experiences. This often leaves older women's victimization invisible in IPV and DV discourse [10, 13, 22, 23].

This disconnect has been described as an "ideological gulf" between professionals working in DV and IPV and those in aging care sectors, arising from different conceptual frameworks and a failure to acknowledge the distinctions between the different types of violence [10, 19]. Within this divide, DV is framed as a gendered abuse of power, yet in later life it is often reclassified as a subset of EM, obscuring the nature of harm and limited appropriate intervention [10]. In a clinical context, abuse within intimate relationships is rarely identified or assessed, resulting in missed or overlooked injuries and unaddressed

trauma [10, 13, 19, 21, 23]. Moreover, sexual violence does not disappear with older age, yet the recognition that that older women can be victims is recent and often misunderstood [19, 23]. Misconceptions that older adults are asexual or physically incapable of experiencing or reporting sexual violence contribute to this invisibility. Finally, the terms "battered women" and "abused older adults" fail to acknowledge that an intimate partner may be the perpetrator, even though, in many cases, the perpetrator is a spouse, partner, or acquaintance rather than a caregiver, as is commonly assumed within EM frameworks [21, 23].

Cultural Attitudes

Linked to the ideological gulf are cultural understandings of EM. Predominant definitions of EM are constructed through a Western lens which may not align with the experiences or interpretations of diverse cultural groups [21]. For example, East Asian women residing in North America may view abusive behaviours from older partners as enduring but excusable personality traits rather than as violence [21]. Perpetrators may be labelled as "hot-tempered" or "frustrated men" with their behaviours considered as personality clashes, disputes, or marital conflicts rather than abuse [21]. Furthermore, despite broader cultural shifts surrounding marriage, relationship norms, and gender roles, it cannot be assumed that older women have internalized these changes within their own relationships [13].

Barriers that prevent older adults from leaving IPV and DV situations often reflect deeply rooted cultural and structural factors, including traditional values discouraging divorce or separation, religion and spirituality, financial or physical dependence, limited awareness of available resources, and language barriers that restrict access to support services [21].

Shelter Access

Older adults who seek support through the DV or IPV system often encounter difficulties as their needs and circumstances do not align with the design or focus of existing services [20]. Consequently, it is uncommon for older adults to access or utilize DV shelter services [20]. In Canada, there are over 500 emergency and transitional shelters, yet only 13 (2.5%) are specifically designated for older adults, and just eight offer full or partial accessibility for individuals

with disabilities [24]. Moreover, these shelters are only located in Alberta, British Columbia, Manitoba, Ontario, and Newfoundland, leaving large regions of the country without accessible or age-appropriate options [24].

Older Women Living with Disabilities

Older women living with disabilities face heightened vulnerability to both IPV and EM due to compounding risk factors [17]. As of 2018, victimization for older women with disabilities was 15.3%, compared to 13.8% for older women without disabilities [22]. While the difference was small and may not be statistically significant, the trend aligns with broader evidence of heightened vulnerability among women with disabilities. This increased vulnerability is often linked to reduced access to community resources and greater financial dependence on partners, exacerbated by smaller social networks resulting from the death of peers, geographic separation from family, or intentional isolation by perpetrators [22].

Access to safe and accessible housing poses another significant barrier. Securing appropriate shelter is particularly difficult for older women with disabilities, who face both physical accessibility issues and limited program capacity [17]. In a 2014 Ontario survey on shelter staff serving South Asian communities, 80% reported denying services to women with disabilities, citing inaccessibility and insufficient accommodations [22]. Within the same survey, 50% of staff reported turning away older women due to an inability to provide primary or medical care and a lack of accessible facilities [22].

Additional barriers to accessing shelters for older women include higher noise levels, difficulty completing required chores or activities due to physical or cognitive impairments, time-limited stays, staff untrained in gerontology, and challenges related to mobility, medical appointments, and transportation [22]. Furthermore, self-perceptions, such as believing they are “too old” to seek help or fearing disbelief, can further discourage older women from accessing services [23]. Shelter staff may also hold narrow conceptions of who constitutes an older abused woman, often envisioning someone who is independent and self-advocating, thereby overlooking frail or dependent women who are equally at risk of mistreatment [7].

Recommendations for The Brenda Strafford Foundation

Effective strategies to address EM, IPV, and DV must prioritize healthy aging, with an emphasis on optimizing older adults' health, independence, and social engagement [15]. Organizations should adopt an intersectional approach that recognizes how diverse experiences, risk factors, and barriers shape vulnerability and access to support [17]. To enhance responsiveness, services must be integrated across sectors rather than siloed. Multidisciplinary EM teams that bring together expertise from healthcare, social services, and criminal justice can provide coordinated and rapid responses to complex cases [15].

The Brenda Strafford Foundation (BSF) is uniquely positioned to engage in work to strengthen efforts to prevent and respond to EM, IPV, and DV. BSF's integrated approach – spanning from continuing care, international health, DV services, and research and innovation – provides a distinct lens through which to understand and address the complex intersections of age, vulnerability, and violence. This multidisciplinary foundation allows BSF to bridge practice, policy, and research to position the organization as a leader in developing and implementing holistic, evidence-informed strategies that promote safety and well-being across the life course.

In considering how to position the foundation within the EM, IPV, and DV space, it is essential to identify the most strategic and impactful role for BSF to play. This may include acting as a research leader, a convenor, a capacity builder, or an innovator. Each potential role carries implications for partnerships, resource investment, and scope of influence. Ultimately, BSF's engagement in this work should reinforce its overarching goal of promoting safety, dignity, and well-being for older adults across care and community settings.

For BSF, there are several recommendations to strengthen efforts to prevent and respond to EM, IPV, and DV. These include training and learning initiatives, partnerships and advocacy, and research and innovation projects.

Training and Learning Activities

Staff training could focus on the patterns of power and control in later life, the types of dependency that can occur, and the definitional distinctions between EM, IPV, and DV. Training modules should also emphasize creating a safe environment for disclosure, fostering trusting professional relationships, asking direct questions, recognizing signs of mistreatment, and screening for co-occurring issues [25]. Similar modules and programs, as well as appropriate resources, could be created for residents and families to increase awareness about EM, IPV, and DV [12]. Further, creating a module about healthy relationships is crucial to ensure individuals recognize the signs of fulfilling partnerships, know how to make informed decisions about their personal lives, and how to recognize the warning signs of unhealthy relationships [21].

When asking questions, staff should first ensure that the individual is alone and away from caregivers and family members to promote safety and confidentiality [26]. Questions may range from generic (i.e. “What have you done lately?”) to mistreatment-specific (i.e. “Are you concerned someone is taking your money, house, or belongings?”) [26].

A helpful framework for supporting older adults facing EM, IPV, or DV is the acronym, LABOR [26].

L – Look and listen for signs of abuse

A – Ask direct questions

B – Believe what the victim tells you

O – Offer hope and support

R – Refer to protective services and contact authorities if the individual is in immediate danger

Regarding individuals living with dementia or cognitive impairments and who are not their own decision maker, standard screening and assessment tools may not be as reliable. However, shifting to observation, context-based assessment, and collateral information may be ways to gather information about experiences of IPV, DV, and EM. For example, assessing for signs, patterns, and environmental indicators such as unexplained injuries, sudden behavioural changes, or financial inconsistencies may be signs of mistreatment [2, 3]. Tools, like the Indicators of Abuse checklist developed by The National Initiative for the Care of the Elderly, can be used by staff summarize high-risk abuse signs for both the caregiver (i.e. "is financially dependent") and the care-receiver (i.e. "has suspicious falls or injuries") [27].

Partnerships and Advocacy

Building and maintaining strategic partnerships is critical for systemic impact. BSF could strengthen connections with the Canadian Network for the Prevention of Elder Abuse (CNPEA) and the Gender-Based Violence (GBV) Learning Network to enhance collaboration, knowledge sharing, and service accessibility for older adults [21]. Broader advocacy and public education efforts, including awareness campaigns, policy recommendations, and amplifying survivor voices, are essential for destigmatizing EM, IPV, and DV. Highlighting national observances such as World Elder Abuse Awareness Day and Family Violence Prevention Month provides opportunities to engage the public and promote awareness.

Research and Innovation Projects

On the research and innovation front, an initial investigation into BSF's population would need to be conducted to determine the prevalence of EM, IPV, and DV cases and confirm that this is a "problem worth solving" within BSF. This problem discovery journey could help the foundation decide what role to play in this sector. From there, exploration into culturally specific anthropological tools for understanding experiences of harm among culturally diverse older adults may be beneficial [21]. For example, the Korean traditional healing practice of han-puri allows individuals to use storytelling to identify feelings of sorrow and despair (han) and envision ways to cope with painful events [21].

Research could also focus on developing peer-support and peer-advocacy groups, as well as safety planning models tailored to continuing care settings [21]. Creating communities of practice that integrate expertise in aging, IPV, DV, and research can foster collaboration and innovation. Lastly, exploring safe disclosure tools, technology-assisted safety planning, and integrated safety features within existing care platforms represents an important opportunity for innovation that directly supports older adults' safety and well-being.

Conclusion

Addressing EM, IPV, and DV among older adults requires a coordinated, intersectional, and age-inclusive approach. The overlapping nature of these forms of violence highlights the need for stronger collaboration across health, social, and justice sectors, as well as improved cultural understanding and accessibility in services. For organizations like BSF, advancing this work through training, partnerships, advocacy, and research is essential to ensure that older adults can live safely, maintain autonomy, and access the supports they need. Ultimately, recognizing and responding to violence in later life is not only a matter of protection but also a critical component of promoting dignity, equality, and healthy aging.

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