Ethical and Psychosocial Issues Raised by the Practice in Cases of Mistreatment of Older Adults

Marie Beaulieu, PhD
Nancy Leclerc, Social Worker, MA

SUMMARY. Intervention regarding older adult mistreatment raises many questions for practitioners. They have to interact with the victim, the abuser, and, in many cases, with both of them at the same time. In such cases, five themes emerge from the literature review on psycho-social and ethical issues in practice: practitioners’ pre-construction and axiological frameworks, victims’ capacity, confidentiality versus collaboration between practitioners or between agencies, social and family responsibilities and the balance between competing values in practice. Practitioners are well placed to offer a critical reflection on their practice and on ways of improving it. The goal of our qualitative study is to iden-
tify issues and ethical dilemmas in elderly mistreatment situations as represented in the discourses of practitioners in reference to interventions in their psychosocial practice. Sixteen practitioners from the public and community (non-profit organization) sectors were interviewed using a practice history approach. This paper presents the main ethical and psychosocial issues raised by practitioners and some ideas to improve the practice. It is motivated by the crucial question haunting the practitioners' minds: "How far should we go?" [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.haworthpress.com> © 2006 by The Haworth Press, Inc. All rights reserved.]

KEYWORDS. Mistreatment of older adults, intervention, ethical issues, psychosocial issues, values, practice improvement

INTRODUCTION

The nations of the world must create an environment in which ageing is accepted as a natural part of the life cycle, where anti-ageing attitudes are discouraged, where older people are given the right to live in dignity—free of abuse and exploitation—and are given opportunities to participate fully in educational, cultural, spiritual, and economic activities. (Randal & German, 1999, p. 143)

Research on mistreatment of older adults began in the 1970s. It has been decelerated by definitional, methodological, and theoretical problems. In fact, much research on the topic has been produced, yet it appears to be very difficult to obtain probing data on this issue; mistreatment tends to be kept more or less hidden. In the United States of America, programs administered by the Federal government on elder abuse are non-existent (Fulmer, 1991), and each state has its own protection laws (Bergeron, 2001). In Canada, legislation and practice vary according to provinces and territories (Beaulieu, Gordon, & Spencer, 2003). In Québec, where this study was conducted, protection laws for mistreated older adults do not exist, aside from a disposition on exploitation in the Provincial Charter of Rights. It was only in the early 1980s that abuse and neglect began to be considered as a social problem (Beaulieu, 1992) or as a social dilemma (Spencer, 1998).

The seriousness and widespread problem of elder abuse affects approximately 700,000 to 1.2 million older adults on an annual basis in the United States of America. Reported figures are similar for Great Britain and Canada via sample surveys (Fulmer, 1998). In fact, two Canadian population studies
have estimated that 4 to 7% of older adults living in the community are abused by persons they trust (Podnieks & Pillemer, 1990; Pottie Bunge, 2000). According to these statistics, material and financial exploitation is the most frequent form of abuse. Researchers agree that these statistics represent an underestimation of the magnitude of the problem. Many cases of elder abuse are not reported (nine out of ten) and there is considerable underreporting by clinical professionals possibly due to inappropriate screening instruments (Fulmer, 2002).

Clinical practitioners (psychosocial and medical) are at the forefront for detecting elder abuse. Yet, they are often lacking the appropriate tools for the identification of abuse (accepted definition of elder abuse, nature and parameters of the problem) and intervention in such cases (limited knowledge base on elder abuse, lack of community support). They struggle with their own values, beliefs, and biases with regards to violence and the ageing family (Bookin & Dunkle, 1985). Individuals may be influenced by societal values conveyed around them, such as ageism or other beliefs on violence, family relationships, and so-on, whether they are practitioners or a member of an abuser-abused dyad.

Efficient action concerning mistreatment rests on the collaboration between professionals and services (Wolf & Pillemer, 1988; Spencer, 1998; Bergeron, 2001). This sense of renewal leads to a personal ethical self-reflection. Ethical positions may vary in accordance with professions and services. Not only is knowledge about violence and neglect important, but also experience and the willingness to consider each case as a unique intervention.

The purpose of this paper is to present the viewpoints of psychosocial practitioners on issues raised in their practice when working with cases of older adult mistreatment. They have plenty to share regarding values and actions, as well as psychosocial and ethical issues related to the practice. Based on their experience and on account of their focal position, they are well situated to recommend elements to enhance the guidelines and improve the practice. This article is divided as follows: review of the literature with regards to ethical and psychosocial issues raised by intervention in cases of older adult mistreatment, methodology, results and discussion, and conclusion. Our text is punctuated with quotes that illustrate the profundity of practitioners’ concerns.

LITERATURE REVIEW

It is important that we continue to listen, learn, and be diligent in our efforts to tackle new challenges in ethical conduct. (Villani, 1994, p. 1)
Our literature review focuses on ethical and psychosocial issues related to practice with mistreated older adults. Therefore, it does not cover areas that are well documented such as victim characteristics, abuser characteristics, dynamics of abuse, legislation issues, impacts of abuse, social costs of abuse, different explanation theories, etc. One of the main issues when working in the field of older adult mistreatment is finding a common definition that everyone can agree upon. Many researchers and practitioners have proposed various definitions. At last, in 2002, The World Health Organization defined elder abuse by encompassing concerns of policy makers, practitioners and, more importantly, older adults themselves: “Elder abuse is a single or repeated act, or lack of appropriate action, occurring within a relationship where there is an expectation of trust, which causes harm or distress to an older person. It can be of various forms: physical, psychological/emotional, sexual, financial, or simply reflect intentional or unintentional neglect” (World Health Organization, 2002).

Our literature review has brought us to understand that even if many authors talk about psychosocial and ethical issues raised by the practice in cases of older adult mistreatment, very few are proposing results stemming from empirical research on ethical concerns. It appears that ethics is frequently treated as a reflexive account rather than as a subject-matter worthy of “serious” research.

Five themes emerge from the literature review. It is presented by an arrangement of ideas in a crescendo fashion. The first element, which is the reflection of one’s own knowledge and one’s own representations, is usually accessible to each and everyone. However, the last element, which involves an in-depth personal reflection on a person’s way of doing and seeing things, is not within everyone’s reach. The themes are (1) pre-construction and axiological framework, (2) victim’s capacity, (3) confidentiality versus collaboration between professionals and services, (4) social or family responsibility, and (5) balance between competing values: autonomy, beneficence, non-maleficeance, and justice.

(1) Pre-Construction and Axiological Framework

In view of the fact that intervening in cases of older adult mistreatment raises confronting questions for practitioners on ageing, violence, personal relationships, and values, it is important for them to take the time to clarify their own position prior to being in contact with the victim or the abuser. Practitioners should perform an ethical self-reflection and question the values that they are putting forth when they intervene. Each older adult has his or her own values to be taken into consideration. Practitioners should not only be aware of them but should also honour them given that they are the most salient guidelines
in the intervention process. This perspective may be idealistic, nevertheless, all practitioners should at least acknowledge and act in accordance with the values of older adults (Asch, 1993; Browdie, 1993; Dresser, 1993).

The representation practitioners have of the dynamics of mistreatment concerning older adults, along with their expertise in the field, determine their practice as well as their perception of the effectiveness of the interventions. A lack of knowledge or experience can lead to inactivity or a sense of pity for the elderly person (Saveman et al., 1997). In some cases, practitioners adopt a more neutral position, waiting for the situation to evolve instead of being proactive. In such cases, practitioners’ inaction may generate emotions of distress within them. The complexity of the mistreatment situation creates feelings of failure, guilt or ineffectiveness (Saveman, 1992). The latter can provoke counter-transference; for instance, the practitioner will not agree to intervene as a result of the client’s refusal, when in fact it is the practitioner’s attitude during the intervention that brings the client to retreat (Bergeron, 1999).

(2) The Victims’ Capacity

One of the first elements a practitioner ought to evaluate is the capacity for abused older adults to make their own decisions regarding their situation. In other words, mistreatment of older adults raises the question of autonomy. Practitioners must keep in mind that simply questioning the cognitive autonomy of the older adult or his/her capability is already an intrusion in one’s lives. Ideally, they should avoid thinking that since they are intervening with an older person, he/she may be incapable. Should we not adopt a presumption of aptitude rather than one of inaptitude in our work with the elderly? In fact, knowing that cognitive losses increase with age, practitioners must stay alert but continue to act without condemning every older adult at first sight (Browdie, 1993; Mixson, 1995; Anetzberger et al., 1997; Landau, 1998; Simmons & O’Brien, 1999).

In cases where older persons are completely capable and autonomous, practitioners presuppose that they are able to give informed consent to a particular proposal, and, therefore, their refusal of certain services is more easily accepted. This does not mean that their refusal must lead to a complete cessation in services offered (Gilbert, 1986; Matlaw & Mayer, 1988; Landau, 1988; Asch, 1993; Dresser, 1993; Browdie, 1993; Heisler & Quinn, 1995; Holstein, 1995; Anetzberger et al., 1997; Spencer, 1998; Simmons & O’Brien, 1999). On the contrary, there is meaning in investing in such a relationship. Perhaps older persons do not see a reason for services at a certain point in time, but with time, they will be better informed and feel more comfortable asking for help.
When the older adult is clearly incapable, a declaration of inaptitude can be requested as well as the establishment of protective supervision (advisor, tutorship or curatorship to persons of full age). These cases generally pose less problems for psychosocial practitioners working in the public system or in community organizations in view of the fact that elders are then taken in charge by specialised proceedings. Once again, authors emphasize the importance of minimal intrusion in the life of older persons (Mixon, 1995; Thomas, 1997; Marin et al., 1995; Heisler, 1995).

Situations that generate the most doubt and awkwardness for practitioners are cases where they question the older person's capacity to come to a decision. In fact, this occurs in cases where the person has partial aptitude. It seems that this is common in interventions with mistreated older adults; moreover, we may wonder if this partial aptitude is not a direct consequence of the abuse. Therefore, a close follow-up and periodical evaluations of psychological and physical capacities are necessary. Yet, practitioners cannot lose view of the fact that an incapability to verbally communicate is not equivalent to an incapability to decide (Matlaw & Mayer, 1986; Kane, 1993; Dresser, 1993; Asch, 1993; Marin et al., 1995; Heisler, 1995; Mixson, 1995; Sonntag, 1995; Heisler & Quinn, 1995; Spencer, 1998; Landau, 1998; Bergeron, 1999).

(3) Confidentiality versus Collaboration Between Practitioners and Agencies

Effective actions pertaining to mistreatment rest on the collaboration and cooperation between practitioners and agencies (Spencer, 1998; Bergeron, 2001; Wolf & Pillemer, 1988). The sharing of information between professionals is crucial, given that interventions in situations of mistreatment can hardly be undertaken by a sole practitioner. Confidentiality constitutes a current dilemma in case management, particularly in situations that require the collaboration of practitioners of the same organization or of several different organizations. We enquire: in what cases do we need the consent of the client to communicate information (Kane et al., 1993)? The evaluation of the risk, as well as the restriction on the disclosure of information, is of paramount importance. Inversely, as emphasized by Spencer (1998), the principle of confidentiality, which is not absolute in any professional code, should not serve to legitimate inaction. Furthermore, we recognize ethical viewpoints as shifting, conditional on the profession and/or service. It is important to bear in mind that the ethical practice is composed of listening, searching for compromises fastened in the client’s history, and adopting a vision that goes beyond the client’s refusal. Some difficulties result from a lack of time and non-existent resources for proper follow-ups (Johnson, 1995; Holstein, 1995; Marin et al.,
Health, public security, and social services organizations, which as a rule collaborate together, can offer a tighter safety net to abused older adults. It is important to prioritize collaboration in order to avoid authority interventions, which place simultaneously the client and services at risk. Mediation could be a solution, yet it is not always appropriate (Spencer, 1998).

(4) Social or Family Responsibilities?

Intervening with mistreated older adults introduces itself in a range of conditions, from social responses to social problems. Yet, concretely, who holds responsibility for the dependent elderly: families or the state? (Spencer, 1998). If families are responsible, what means are they given? If the state is responsible, why are we not more critical regarding health and social services offered to the elderly? What margin of action do practitioners have in their own organization? How can they exercise their professional autonomy and express their clinical judgement? (Beaulieu & Giasson, 2005). In order to be considered within their organization, shouldn’t practitioners serve simultaneously the needs of the client and those of the system? The absence of resources, as well as the lack of time to devote to each case, permits practitioners to pass responsibility to each other. This creates tensions for everyone, including the abused older adult, who is oriented in several directions (Matlaw & Mayer, 1986; Browdie, 1993; Spencer, 1998). The availability of resources constitutes a factor for intervention quality in addition to client well-being. Is there not reason to worry with regards to non-existent resources in organizations as well as employment of either barely or not trained professionals to specifically intervene in issues of older adult mistreatment? The lack of resources in home-care services encourages practitioners to resort to inappropriate or unsafe solutions (Sonntag, 1995). In keeping with Bergeron (1999) and Asch (1993), there is reason to wonder: what is the purpose of laws without sufficient resources?

As emphasized by Sonntag (1995), in several countries, the responsibility of services offered to dependent older persons is handed over to the families, which is first and foremost a moral circumstance rather than a legal one. When families give treatment and services, practitioners owe it to them to properly evaluate available resources in order to avoid caregiving becoming a burden (Kane et al., 1993; Asch, 1993; Dresser, 1993). What are the primary interests of family members when they solicit the state for services to help their elderly family member? Do they want, as Mixson (1995) points out, to assure safety for their kin rather than respect their autonomy? Or, do they wish to allow their older relative to continue to live autonomously by reducing constraints?
(5) The Balance Between Competing Values in Practice

Frequently, questions arising from the practice are tinted by an implicit ethical reflection, which challenge practitioners and force them to position their intervention more solidly. They cover all dimensions of action, starting from the moment the problem is recorded, transiting from the decision to act or not, to the impacts of actions or lack of actions in the life of all the implicated parties: victim, abuser, and practitioner. The first question concerns the importance of taking or not taking action. Let’s keep in mind that detecting and reporting may counter autonomy. Practitioners must understand the reasons to detect and evaluate a particular situation ensuring that the victim’s profile requires it. Due to limited services, we have to remember that detection without possible action leads to discouragement for everyone (Gilbert, 1986; Saveman, 1992; Landau, 1998; Spencer, 1998). In contexts where protection laws for mistreated older adults exist, is it likely that the consequences stemming from the declaration of the abuse be worse than the informal accountability assumed by others? Or, then again, that the declaration be inappropriate or useless (Gilbert, 1986; Matlaw & Mayer, 1986; Kane et al., 1993; Anetzberger et al., 1997; Landau, 1998). Prior to making a complaint, the practitioner should evaluate the situation and the risks by emphasizing the involvement of some kind of non-intrusive protection for the victim (Matlaw & Mayer, 1986; Willbach, 1989; Anetzberger et al., 1997; Spencer, 1998). If there are only suspicions of mistreatment, it is preferable to avoid advancing further in the detection and denouncing process, but rather, to continue to offer a pro-active support to the victim (Saveman et al., 1992; Spencer, 1998).

Concerning intervention with older adult victims, what is the most important? Their physical or socio-affective needs? (Asch, 1993; Dresser, 1993; Spencer, 1998). It is certainly important to evaluate to what extent our service system is able to protect the victim. Unfortunately, numerous errors can potentially produce harmful consequences for the elderly (Landau, 1998).

Despite the fact that less documentation exists, practitioners greatly question themselves as regards to their actions with people who abuse or neglect older persons. It is suggested that persons who mistreat be given the possibility of obtaining a follow-up with a practitioner not involved with the victim (Marin et al., 1995). In some cases, a clear message must be sent to aggressors regarding their responsibility for their actions, by means of justice and compensation (Heisler & Quinn, 1995; Spencer, 1998). In fact, only a handful of lawsuits pertaining to older adult mistreatment actually make it to court in Québec. We can only deplore the fact that little or nothing has been written on effective accompaniment programs for persons who mistreat older adults.
In a perspective of ethical reflection, we can only emphasize the importance given to practitioners' actions or lack of actions. Ethical judgement is required to unmistakably identify the violent act or negligent behaviour in order to prevent confusion or neutrality from surfacing (Willbach, 1989; Saveman et al., 1996; Spencer, 1998). Beneficence, without consideration for the autonomy of older persons, can lead them to feel distressed even when their mental functions are reduced (Simmons & O'Brien, 1999).

Finally, in a context where several researchers are pleading for the development of clearer policies and better specified laws in the matter of mistreatment, it is important to remember that our theoretical models which allow us to understand and explain older adult mistreatment are still at the early babbling stages. Prudence is in order in light of the fact that our elaborated theories, stemming from incomplete knowledge, lead to inappropriate laws and practices (Bergeron, 2001).

**METHODOLOGY**

The value of research, after all, depends not on some platonic measure of worth but on its value for appropriate audience. (Strauss, 1987, p. 301)

(1) Data Collection

The data analyzed come from a study pertaining to ethical issues of psychosocial intervention in situations of elder abuse.\(^3\) The collection of data was conducted by using a qualitative approach. As Gubrium and Holstein say, we are part of the group of those “qualitative researchers interested in the social accomplishment of meaning and order” (2000, p. 487). Recruitment took place in two regions in Québec, Canada. The sample is composed of sixteen practitioners, eight from Québec City (4 from the community sector, 4 from the public sector) and eight from the Bas-Saint-Laurent (same disposition).\(^5\)

For the purpose of the study, we retained two selection criteria: participants have worked for at least five years as psychosocial practitioners with an elderly clientele and possess significant intervention experience in situations of older adult mistreatment. Participants were recruited by means of the snowball technique, and we did not meet any practitioners from the same organization. We interviewed fourteen women and two men, with a work experience ranging from five years to approximately thirty years.
Practitioners were asked to describe their professional practice experiences in relation to their interventions with a clientele of abused older adults and their abusers. It was the same research professional, using a semi-structured approach, who conducted each interview. The interview protocol was divided in four sections: (1) perceptions concerning older adults in general and abused older adults in particular; (2) a description surrounding interventions (examples included problems, issues, and personal experiences); (3) a depiction of the rapport between intervention and society (examples included own values, and establishment of beliefs); and (4) a clarification of personal incentive for the chosen field and other personal questions. Practitioners were asked to express themselves with regards to their practice by using actual cases. This approach facilitated the emergence of ethical dilemmas. Data from interview transcripts were analyzed using N’Vivo, according to the mixed approach by Huberman and Miles (1991); that is, by combining inductive and thematic analysis.

For validation purposes, each practitioner received a written verbatim copy of his interview and was given the opportunity to comment on it, even to “correct” it, or minimally nuance it, prior to the analysis. The primary researcher and a group of research assistants carried out the thematic analysis performed according to the mixed approach (Huberman & Miles, 1991).

For the purpose of this article, we translated several quotes from the original French data. It gives a sense of the richness of our material.

(2) The Approach by Principle in Ethical Intervention Research

The approach by principle was originally developed by bioethics, a discipline created to respond to issues and scientific developments as well as technical dilemmas in the health services field. At the outset, it was applied to clinical intervention and research; now it is starting to be used in the public and community health sectors. In this respect, our project is original. Beauchamp and Childress (1979, 2001) in Principles of Biomedical Ethics, present a method, which consists of a reflection as well as the resolution of ethical dilemmas, structured around four principles: respect of autonomy, beneficence, non-malefeasance, and justice. In this approach, values are not in competition with one another; rather they complement each other. As a result, the decision to act in one way or another reflects a balance between values.

As illustrated in Figure 1, each value is not only theoretical, it is also transformed and adapted in order to guide the application. In our analysis, we account for these values. Even though we had introduced specific questions on ethical issues of the practice, we rapidly realized that the practitioners were
much more comfortable naming ethical reflections and dilemmas in an implicit manner.

RESULTS AND DISCUSSION

One of the key issues in social work in the future may be how professionals work with clients in this area to acknowledge their individuality and adulthood when there is public pressure to protect and pity. (Manthorpe, 1994, p. 88)

(1) Psychosocial Intervention

Intervention in situations of mistreatment of older adults can be described on a practice continuum. On one end of the continuum, we find negative autonomy, and at the other end, extreme measures, and finally, in the centre, accompaniment measures (see Figure 2). The choice of one type of practice over another depends on the evolution of three variables: the loss of autonomy of the older person, the dangerousness of the situation and the collaboration between the three parties (victim, abuser, and practitioner). These conditions can vary slowly or rapidly (an increasing dementia or a stroke; the departure of a caregiver; an increased number of violent or neglectful events). Changes or deterioration in any one of these variables influence the intervention process in place. Therefore, there is room for questioning the fragility of the clinical relationship.

Negative autonomy occurs when a person refuses the proposals of the practitioner. The latter chooses to withdraw from the file and accepts the refusal of the client. Intervention then comes to an end. It is abandonment of the victim rather than concrete intervention.

Accompaniment is the ideal condition. Decisions are made in a gradual fashion depending on the case and the relationship between the practitioner

<table>
<thead>
<tr>
<th>Values</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respect of the person’s autonomy</td>
<td>Establish conditions for a decisional process that respects the person’s autonomy</td>
</tr>
<tr>
<td>Beneficence/non-malfeasance</td>
<td>Minimise disadvantages and maximise benefits in relation to intervention goals</td>
</tr>
<tr>
<td>Justice</td>
<td>Respond to needs without discrimination and with impartiality</td>
</tr>
</tbody>
</table>
and the client, and occasionally, the relationship between the practitioner and the abuser.

Extreme measures are taken when practitioners are forced to make important decisions in a short period of time. These decisions are sometimes made without either the absolute consent of the older adult victim nor the complete collaboration of the abuser.

In their remarks, practitioners consider themselves quite preoccupied by the respect of autonomy of older persons and are concerned by their protection (therefore, beneficence) rather than non-maleficans or justice. In fact, it appears that these two previous values are relegated to second and third place. The following quote illustrates this balance between values and the type of feelings generated in practitioners:

What is important, my priority, it is the respect of the client, what he wants to do. But, it is not evident though. What he wants to do and what he should do, are two things. We can never decide for them unless they are really in danger for themselves or for others, that the person be dangerous for herself or for others and those that live with her never realize to what point... like someone with Alzheimer’s that would not realize that she is really subjected to mistreatments. Therefore, we have a great deal of worry because we do not have much power to intervene, when the person says no, we get going again, we are empty-handed but we are
conscious of the danger, we are conscious of the probability of death. But my greatest fear is to find myself with someone who gets killed.

(2) **Values at Play in Psychosocial Intervention**

I think that one of the values is respect with regards to the person, and once we have that respect for the person, it will inspire all interventions we may have . . .

What emerges from participants’ accounts is respect as a meta-value that transcends all actions. This respect of the person guides the construction of values that stimulate the practice, whether it is negative autonomy, accompaniment or extreme measures.

When the refusal of services by victims is entirely respected without any attempt to pursue the intervention, it is considered negative autonomy. With the hopes of not influencing the victim in their choice, the practitioner is exiting a situation that contains a certain level of risk, which may degenerate over time. This practice of abandonment or the lack of recognition of mistreatment raises some questions, as mentioned by a practitioner:

In fact, what I want to say is that with regards to statistics it is practically at 10% . . . It is not normal that there are practitioners that never make any statistical references. It is not possible that in their caseload of sixty, seventy files, that they do not have situations of abuse. Sometimes I tell myself, is it because they do not work with them or that they do not dare see them, they don’t touch that, or, they work with them but they don’t tell me. In any case, I think there are certain people that are more sensitive to that.

On the other hand, rather than completely respecting the person’s autonomy, the practitioner is sometimes required to resort to extreme measures. The older adult in this instance is no longer fully autonomous and, therefore, is unable to care for him/herself and is incapable of defending his or her interests. The practitioner is caught between doing what is right for the older adult victim (beneficence) and preventing any harm to be experienced (malfaeasance) by remaining vigilant with regards to the person’s autonomy. This protection issue is often presented as a solution of last resort.

When all the strategies, intervention plans that we can imagine of which I was making reference to earlier (were tried), and we arrive in extreme situations where there is in fact a person who is abused, mistreated, who risks her life sometimes or whose capabilities are lessened and we tell
ourselves, now, the only possibility, for example, is a home for the elderly. Ultimately, we must move towards protective supervision.

In accompaniment, the practitioner will ascertain that the person’s autonomy is respected and remain vigilant regarding beneficence. Therefore, autonomy will be favoured but the practitioner will also encourage the victim to become active in the situation. He will continue to monitor the situation and will suggest some actions that are more focused on protecting the victim, but only when those actions are necessary.

As we have seen in the literature review pertaining to the pre-construction and axiological framework, practitioners are aware that their experience, their knowledge of ageing, as well as their own values, tint intervention. The following quote is an example of it:

I began working at 22-years-old at the CLSC, I had a caseload of 90 elderly persons... I don’t know if I said it, but I surely thought that I was working for the elderly... That changed a lot and my desire to want to change (the clientele) for every year in the beginning, maybe the first 5, 6 years, I was not comfortable with the older clientele. We worked with death, illness, so that’s it. I had chosen a profession where we are in the problems, that’s for sure, except I was not comfortable. The palliative care, the elderly, Alzheimer, tinkle, pooh, I did not always feel like talking about that. It’s confronting, we see ourselves growing old. I was 22-years-old, so, no... it took me a long time to become comfortable. I would say that it has not been that long, because I had the opportunity to change clientele and I didn’t do it. Therefore, it shows that now I am comfortable with that clientele, very comfortable. But, at a young age, 22-years-old, we do not have first-hand experience, and we do not have the same vision of the elderly also.

(3) The Psychosocial Practice

We have to, of course, when it is necessary, protect them as much as possible. But not baby them, especially. They are ageing adults and they also have a part of responsibility with regards to their life. That, for me, is quite important. But, it is certain that in situations where there is an illness settling in, it is certain that they are more vulnerable and they need other people, that for me is clear.

In their practice, when practitioners wish to completely respect the older adult victim’s refusal of services, they will close the file. Henceforth, there will not be any type of follow-up in the case. This is negative autonomy, and there are no practical interventions!
In cases of accompaniment, practitioners will prefer to intervene in a proactive manner. They will remain vigilant with regards to the situation that poses a risk. As a result, a number of these risks can be managed and certain crises anticipated. Consequently, the practitioner is able to generate unique protection scenarios adapted to the situation of the victim. The greatest challenge is creating a durable relationship, maintaining contact, and, most importantly, developing a relationship of confidence with the mistreated older adult. Victims are encouraged to take certain actions (empowerment), are given suggestions to compensate for their changing level of autonomy, and are accompanied in the distancing process between themselves and the situation of violence. Throughout this development, the victim gains greater self-knowledge. As well, the intention of the practitioner is to preserve or improve the victim’s quality of life (such as respecting life habits, values, and culture) as well as enhance and extend his/her social support network, which also includes working with the victim’s abuser. Practitioners act as advocates for the victim’s rights, and their role is to influence, convince, modify beliefs, raise awareness, and so on. They call upon community organizations for partnership and are supported by interdisciplinary teams. The following situation illustrates an accompaniment in progress:

Little by little, we created this connection with this woman . . . at some point, after a certain amount of time, after creating a bond, well, I opened up to this woman, about worries that I had in relation to risk, in relation to the presence of that man. Clearly we do not arrive in the first interview with that . . . People don’t want to change things. The idea is to remain available, namely we say: “Listen, I respect that, that you do not want to, but if ever you change your mind, I am always there.” The idea is not to close the door.

Finally, when practitioners resort to extreme measures, they are faced with some degree of urgency. They must protect the victim to the best of their knowledge, respect their mandate, and apply, when necessary, protective supervision. There are certain legal recourses that the practitioner can suggest to either the victim or his/her family, which they can choose, such as: divorce, protective supervision, Curator, court order (the only measure to force long-term care), accompaniment with legal procedures, assistance to lodge a complaint, and so on. In the event of great danger, poor collaboration on the part of the family as well as severe loss in the autonomy of the victim, the practitioner must resort to the removal of the older adult victim from the environment.

As we noticed in the literature review, practice is highly conditioned by the older person’s capability, which seems to be treated in two ways: (1) compre-
hension or autonomy of the victim in relation to what is happening, and (2) the recourse of applying a legal disposition when the person finds him/herself in a high risk situation as well as incapable. For practitioners, the worst situation is when a person is under evaluation for protective supervision. Due to long delays, the person continues to live in a situation of risk whereas no one can adequately assure her safety.

(4) Issues Raised in Psychosocial Intervention (Figure 3)

4.1 Negative Autonomy

Relating to negative autonomy, the practitioner ceases to intervene in an elder abuse case when the client refuses any further services. The practitioner is comfortable with this situation when the person is autonomous, has the neces-

FIGURE 3. Issues Raised in Psychosocial Intervention

<table>
<thead>
<tr>
<th>Negative Autonomy</th>
<th>Accompaniment</th>
<th>Extreme measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Comfortable when person is autonomous, capacity, informed decision (but uneasiness when there is resistance from the victim and doubts on his cognitive autonomy) -Result from: organization of services (voluntary context), lack of time, overwork, and the growing number of clients -Limited definition of autonomy -Powerlessness of the practitioner, resignation, withdrawal, denial = end of the intervention -Lack of training, awareness-raising, and supervision of the practitioners</td>
<td>-Obtain the person’s consent -Time consuming intervention -Challenge = respect the person’s rhythm -Constant evaluation process (autonomy, dangerousness, vulnerability, cognitive losses, etc.), -Requires vigilance, tools/scale/guidelines, and time -Live with an at-risk situation (tolerate certain risks that are lower than the negative consequences of a radical intervention) -Some discomfort related to the respect of autonomy (questioning of certain decisions made by the victim) -Equilibration process</td>
<td>-Maximal vulnerability of the victim -Crisis, hospitalization, or other change -Pressures in the agency (supervisor, colleagues,) -Pressures from the victim’s entourage -Mandate, responsibility of the agency -Negative feelings (stressed, jammed, powerless, disappointment) -Professional autonomy level -Clinical support offered to the practitioner?</td>
</tr>
</tbody>
</table>

Abandonment of the older adult victim to himself | Acceptance and tolerance of an unsafe situation | Continue to act with the older adults instead of for the older adult in a context of decision-making for the client and not by the client
sary aptitude and makes an informed decision. However, uneasiness is felt when there is resistance from the older adult victim and there are doubts on his/her cognitive autonomy. This kind of situation causes some issues to be raised. When an older person victim resists services offered, should interventions be stopped? Certain questions arise: Does the older person completely understand the risks and consequences involved of this refusal? Are practitioners respecting the older person’s autonomy when they choose to close the case instead of trying other forms of intervention? Practitioners are faced with a particular reality. They work in a voluntary context, which means they must respect the person’s decisions and work around the fact that there are no legal measures to support actions that go beyond an older person’s wishes in a case of violence other than when there is impending danger for the victim. More often than not, the practitioner is overworked (due to a disproportional ratio between the number of practitioners and the number of clients) and lacks the required time to accomplish all the necessary actions in a case of abuse and/or neglect. Intervention may come to a halt due to the practitioner’s sense of powerlessness, which leads to relinquishment, withdrawal, and denial. Hence, a value conflict arises, for instance, by respecting a person’s autonomy, are we acting in his/her best interest? Respecting a person’s autonomy does not mean abandonment. Part of the responsibility of leaving the older person victim to fend for him/herself is due to the lack of any or sufficient training, awareness-raising, and proper supervision offered to practitioners faced with cases of elder abuse.

4.2 Accompaniment

These are extreme means where we really try to do everything and sometimes tolerate certain risks that we would rather not but that may be slighter than the intervention we could pose to protect the person.

Accompaniment is the ideal situation in which a practitioner and an older adult victim can discover themselves. In the event of mistreatment, the practitioner may not be comfortable with ceasing services on the sole basis that he/she must respect the victim’s autonomy. In intervention, it is crucial, if not absolute, to obtain consent from the older adult victim. Hence, the practitioner is faced with the challenge of respecting the person’s rhythm. To do so, he/she must be comfortable with small achievements, such as the place and time the practitioner is given by the older person as well as the few propositions the older person agrees to (as modest as they might be). In essence, it marks the beginning of a relationship between two beings that develops amidst respect, trust, tolerance, and commitment. This intervention approach requires vigi-
lance and time because periodic evaluations must be performed in order to en-
sure the autonomy of the person, evaluate the level of dangerousness of the
situation as well as the person's vulnerability, and finally, assess the person's
cognitive functions. Therefore, practitioners require adequate tools, evaluation
scales, guidelines, and time in order to feel secure and supported in the deci-
sion-making process. They must be able to work with an older person despite
the fact that the situation in which they find themselves has risk potential. While
several threats are out of the practitioners' control, they must exert tolerance in
regards to certain risks that are lesser than the negative consequences of a radical
intervention. The key qualities to possess in order to succeed in the accompa-
niement measure are acceptance and tolerance in precarious situations.

4.3 Extreme Measures

Wherever it is possible, I think we have to be very attentive at the outset,
to just be aware. Is the act or the objective we are aiming for to reassure
ourselves as interventionists or as a system, or is it really to bring more to
the person who has a loss of autonomy?

Extreme measures are undertaken when the older adult victim experiences
utmost vulnerability due, not only to the intensification of the mistreatment
situation, but also to a dramatic change in the situation, for instance a crisis or
a hospitalization. In such cases, practitioners are under extreme scrutiny. They
are pressured by their colleagues to solve the situation as quickly as possible and
by the victim's family members to have their wishes respected. Moreover, the
message sent by society is one of accountability for intervening in a situation of
mistreatment. In addition, practitioners must conform to their mandate and not
overstep its boundaries. This tremendous amount of pressure may lead the prac-
titioner to express negative feelings such as stress, powerlessness, disappoint-
ment, and the sentiment of being in a dead-end. All these conditions may set the
stage for ambiguous decision-making. Decisions must be made quickly, yet
practitioners need to find themselves in favourable conditions in order to do so.
Do practitioners have a sufficient level of professionalism as well as adequate
clinical support to make such vital decisions?

We can see, from what practitioners have said, that there have been some
changes in ways of working with older adults. These transformations stem
from ethical reflections. In the past, practitioners were more often in extreme
measures; today, they work in accompaniment. This change seems to be ex-
plained by a better comprehension of their duties and powers:
Another ethical problem: It is certain that when you arrive in intervention, we have to use the real words when we talk about negligence also. We must say what we do, we have to inform. I would say: when we are confronted in working in a situation of incapacity, we owe it to ourselves to inform the person, even if we know we are moving towards a declaration of incapacity. Maybe previously we informed less and we did it, and we protected the person, and we determined she was, between quotation marks, incapable. Yet, we do not have that role and we do not have that power. It is a court order that can determine the capacity of a person.

(5) **Suggestions to Improve Intervention (see Figure 4)**

I think there is a lack of training somewhere, the approach of violence against the elderly.

5.1 **Negative Autonomy**

Practitioners need to have adequate initial training in their field of study on the topic of violence and neglect. In the workplace, ongoing training is necessary to consolidate acquired knowledge to what is asked in day-to-day practice. Furthermore, practitioners should be aware of the services offered in the community and adequately harmonize the client’s needs to the appropriate services. Finally, practitioners have to receive support in the workplace; they

---

**FIGURE 4. Suggestions to Improve Intervention**

<table>
<thead>
<tr>
<th>Negative Autonomy</th>
<th>Accompaniment</th>
<th>Extreme measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate initial and ongoing training</td>
<td>Clinical supervision</td>
<td>Detection tools</td>
</tr>
<tr>
<td>Resources in the community</td>
<td>Possibilities for ethical discussions</td>
<td>A reinforced protective net</td>
</tr>
<tr>
<td>Offer support to practitioners</td>
<td>Interdisciplinary teams</td>
<td>Possibilities to practice ethical decision-making</td>
</tr>
<tr>
<td>Better application of the existing laws</td>
<td>Collaboration between organizations</td>
<td>(balancing the values of all parties)</td>
</tr>
<tr>
<td></td>
<td>Provincial or federal framework to guide the practice</td>
<td></td>
</tr>
<tr>
<td>Offering proper detection tools in the identification of elder abuse</td>
<td>Guidance in clarifying cases of elder abuse and developing best practice</td>
<td>Systematization of application procedures in cases of elder abuse and creation of an environment that pushes forward a meta-reflection on action</td>
</tr>
</tbody>
</table>
need a place to verbalize their impressions of a situation as well as express how they feel. Therefore, it is essential that, if practitioners are to move beyond respecting autonomy, they should have good detection tools to facilitate the identification of elder abuse and neglect. As can be noticed in the following quote, the first steps often go unnoticed but remain fundamental:

We especially try to raise the awareness of our work colleagues, all of the people that work with us: the nurses, the auxiliary workers. We make them aware, we do a lot of training, approaches to rapidly detect older adult abuse.

5.2 Accompaniment

At this stage, practitioners should have a good foundation derived from their initial training and the ongoing training as suggested in negative autonomy. Furthermore, sufficient clinical supervision on a regular basis ought to be prioritized as well as opportunities for discussions on ethical issues with the aim of helping practitioners perfect their practice. Better intervention competence suggests a greater synchronisation between needs and services. Practitioners find assistance and reinforcement in interdisciplinary team meetings as well as from collaboration between different organizations. Intervention could be improved by receiving greater support from the Provincial and Federal governments in guiding psychosocial practice by means of social policy.

In relation to the literature review, we observe that the question of collaboration between agencies not only raises issues about the level of accompaniment. In fact, there is reason to believe that economic and political imperatives can largely tint interventions, as the following citation reveals:

So I think there are situations that are very litigious that we have to carry alone . . . I am thinking specifically of, when we make a request for a long-term care facility, or when we have a situation where the person is waiting for the opening of protective supervision with the Curator. As long as the court judgement is not made, the person is not declared incapable. Therefore, the Curator, it is not them that will go to court to obtain the long-term care facility request, it is the CLSC. So who will pay for the lawyer’s fees? It is the CLSC. When we know that the person will be declared incapable, that the file is already sent to the Curator. There are financial and political issues.

The discourses of practitioners who find themselves in a situation of accompaniment are at times quite eloquent with regards to the distress not only of the victims but also of the abusers. They do not minimize the fact that some
persons who mistreat the elderly are dangerous or malicious people, but they also present the opposite side of the coin by proposing a reflection on social responsibilities that we have towards families. In this way, the following quote illustrates the reflection proposed in the literature review on the topic of family and social responsibilities in relation to mistreatment of older adults. What should be done when the informal carer is burdened?

She had said to the practitioners of the CLSC: Me, I am so tired, I don’t know how long I will last. And she had said: I am afraid of myself to some degree. That is why a social practitioner would go to her home. Because, starting from the moment where people say: “I am afraid of me,” it means: “I don’t know how I can react.”

5.3 Extreme Measures

When practitioners are faced with cases of extreme vulnerability, they not only require clinical support, interdisciplinary assistance, collaboration with other organizations and adequate social policies, but also require proper clinical tools that take into consideration all of these aspects. Good collaboration with the victim’s family is crucial in order to facilitate any necessary changes for the older adult victim. In the decision-making process, as time-consuming as it might be, the values of everyone ought to be considered and decisions should include all parties involved. When advancing towards extreme measures in cases of elder abuse, systematization is required in order to apply procedures effectively.

Many of the recommendations presented above point towards greater training development and adapted work tools. It does not consist necessarily of rigid protocols or procedures but rather of the production of material and adapted practical guides. As we have mentioned previously, few practitioners received the appropriate training on the topic of mistreatment of older adults. Questions are raised as a result of gaps in the practice. Certain practitioners even wonder why it is so difficult to transfer training experience from conjugal violence to mistreatment towards the elderly.

In matters of conjugal violence, we must meet the person... The conjugal therapy on abuse-violence-neglect... we believe a lot more in individual intervention. But if there is a will, if the notion of abuse is settled and there is a willingness towards a conjugal therapy, well, of course it will be more... In fact, it is what we tell one person and what we tell another, and the importance that if we suspect that there is abuse, if the couple wishes to have a follow-up in conjugal therapy, well, it is clear that it will not be the same practitioner that discovered the abuse. I think that on
this we have to question ourselves sometimes. In fact, we often say in conjugal intervention, it is rare that we will go for conjugal therapy in a situation of abuse-violence-neglect. But there has been conjugal therapy anyway after an abuse, we cannot hide that.

**CONCLUSION**

I would say that, in general, what bothers me a little with regards to violence, money laundering, is really really bad! But to beat an elderly person, that is less bad!

Whether it is in theory or in practice, issues related to intervention in situations of mistreatment of the elderly trigger many psychosocial and ethical questions. It is evident from the verbatim that one can not simply classify practitioners as being more or less in favour of autonomy or as being instantly in favour of protective supervision for the elderly. Of course, some practitioners deplore the fact that some of their colleges do not see anything or practice a form of negative autonomy, but the 16 practitioners interviewed showed a great deal of openness and discernment. In fact, the practice depends on numerous objective and subjective factors, the most important being the older person’s loss of autonomy, the dangerousness of the situation and the collaboration between parties (victim and abuser). It is possible for a case to move through the entire continuum. In the beginning, it may not be detected or followed-up (negative autonomy), then it may become added to a regular case-load (accompaniment), and lastly, it may require one or more directive interventions (extreme measures).

The results from our study allow us to validate among practice history and practitioners’ reflections with regards to their work, the collection of psychosocial issues and identification of ethics in the literature review. The original dimension of our work was to give central actors, the practitioners, full opportunity to speak. To our knowledge, we are also the first to propose a practice continuum inspired by an ethical reflection concerning action by identifying values in the practice: promoting the equilibrium between autonomy and beneficence/non-malfeasance. Furthermore, we are surprised to notice that practitioners do not speak about justice. In our opinion, justice should be more readily considered as a value if only to denounce moral vices or flaws in the application of legal procedures (particularly, protective supervision) or better yet, condemn the fact that other types of crime, such as money laundering, are more severely punished than mistreatment towards the elderly. Would it not be interesting to understand this modest preoccupation for equity?
Problems revealed by the practice are numerous and practitioners do not conceal their malaise, their worries, and even their incompetence or their limited power to intervene in certain cases. The reflection that arose from this study in order to expand and improve the practice, as rich and innovative as it is, does not permit us to be quite as affirmative as are Brownell and Wolden (2002), in their comparison of benefits and limits in social work centered approaches as well as criminal justice approaches, to effectively respond to different forms of violence and neglect.

Our work leads us to many research avenues. We now better know the ethical and psychosocial issues encountered by psychosocial practitioners when working with mistreated older adults in the community. What type of challenges are facing psychosocial practitioners working in emergency rooms, in nursing homes or long-term care settings? What are the challenges for other practitioners such as nurses, psychologists, and physicians? How could validated detection or intervention protocols influence the issues raised by the practice? As well, it would be interesting to perform a case study over several months in order to capture and understand the ethical and psychosocial dilemmas of all actors who are part of the situation (mistreated older adult, the abuser, other family members or people of trust, social worker, nurse, and physician). This would allow us to better understand the evolution of intervention and its impacts.

Many of the findings of this study could be transformed into useful training material. We must not only prepare our future practitioners to work with cases of mistreatment of older adults, but also train and support the practitioners in all agencies that work directly or indirectly with mistreated older adults. Other than what the rich content suggests such as, what mistreatment entails, how it is recognized, how to intervene with the victim, how to work with the abuser, what legal and social possibilities exist in offering support, and so on, we have to be prepared to teach practitioners how to develop the capacity to intervene in grey areas and in evolving situations that hold a high risk potential. Practitioners need to know and share their concerns facing the fact that there is never a precise answer to the question: "How far do we go?" We also have a certain amount of responsibility in encouraging all agencies to introduce some ethical dimensions to case discussions. It is worth pursuing ethical reflection; in other words: let's dialogue.

NOTES

1. This disposition says that “every aged person has a right to protection against any form of exploitation. Exploitation means taking advantage of the vulnerability or dependency of an elderly person to deprive that person of his or her rights, for example, by extorting money, inflicting abuse, withholding care that is required for health,
safety, or well-being, or attacking the person’s dignity” (Commission des droits de la personne et de la jeunesse, 1975, p. 7). It is important to acknowledge that this disposition has been in force since the mid ’70s but less than 10 cases were completely processed. It is then a very unusual solution to mistreatment of older adults.

2. These two studies were conducted by telephone with older adults living in the community. It excludes all the institutionalized adults, those with hearing problems or without telephone. More so, the main methodological limit to these studies is their incapacity to control the presence or not of the abuser nearby the older adult during the interview.

3. This research was funded by the Social Science Research Council of Canada, Grant: 410-2000-1541.

4. The P.I., Marie Beaulieu, wishes to recognize the contribution of Ghyslaine Lalande, Annie Lévesque, Josée Roy, Josée Mainville, Francine Caron, Mylène Giasson, and Nancy Leclerc at different stages of the 4 years project.

5. This project has received an ethical approval from the University of Québec in Rimouski and the University of Sherbrooke. All practitioners also signed a written consent form prior to the data collection.

6. The Figures 2 to 4 are a translation and adaptation of an initial figure published by Giasson and Beaulieu (2004). The authors wish to acknowledge the contribution of Milène Giasson at the results section.

REFERENCES


noeuil=0&noeud2=0&cle=0


