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Psycho-emotional Consequences of Hospitalized Elder Abuse from Older Patients' Perspective

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ABSTRACT

Introduction and Objective: The present study aimed to identify and describe psycho-emotional consequences of hospitalized elder abuse from older patients' views.

Methods: An inductive qualitative content analysis research was conducted at various wards of six educational hospitals affiliated to Shiraz University of Medical Sciences. A total of 16 elderly patients aged 60 years and older were selected using purposive sampling and data gathering was done using semi-structured, individual interviews. The data were analyzed using the qualitative content analysis method proposed by Elo and Kyngas (2008).

Results: The Psycho-emotional consequences of hospitalized elder abuse were reflected in three main categories, namely feeling of insecurity, aggression, and learned helplessness.

Conclusion: Hospitalized elder abuse could be accompanied with immediate Psycho-emotional consequences, such as feeling of insecurity and aggression, as well as persistent and long-term consequences, such as helplessness. Thus, monitoring and training the healthcare staff and raising their awareness regarding consequences of hospitalized elder abuse are necessary to prevent this phenomenon.

Keywords: elder abuse, elder neglect, hospitalization, patient outcome assessment, qualitative research

INTRODUCTION

Elder abuse is a major public health problem, which is accompanied with serious social, economic, and health consequences (1). It can occur in various settings, including individuals' houses, daily centers, hospitals, and nursing homes (2), and for all elderly people irrespective of sex, race, living arrangement, health status, and inability. Indeed, it can be committed by family members, hired caregivers, friends, neighbors, and healthcare providers including nurses (3). Elder abuse is classified into domestic and institutional categories (4).

Institutional elder abuse and abuse in healthcare settings are a part of violence in society (5,6). In this context, elder abuse in institutions is one of the main concerns in taking care of elderly patients (7) and they are at risk of abuse in hospitals and clinical environments, and clinical practice (2,3). Evidence has shown an alarming image of healthcare providers' unacceptable behaviors, including insensitivity and disrespect, towards elderly patients (8). Accordingly, care providers' burnout workload, individual and professional demands, job satisfaction rate, stressful work settings, weak education, patients' behavioral problems, and daily activities limitations,

eventually leading to elder abuse (7). The prevalence of elder abuse in institutions might be higher than that reported in the literature because under-reporting of this phenomenon has been estimated to be around 80%. Moreover, the total prevalence of elder abuse in institutions was 64.2% based on the staff's reports. Accordingly, two out of each three personnel had committed elder abuse during the past year (1).

Not only elder abuse has physical consequences, but it also exerts negative effects on individuals' mental health (9). Indeed, aging and its related diseases worsen the impacts of physical and psychological violence on older people's health (10). On the other hand, abuse in healthcare causes long-term suffering among patients, but the personnel have little knowledge in this respect (11). Such suffering is accompanied with negative consequences on patients' health and well-being as well as their future contacts with healthcare providers (12). Considering the consequences of abuse in the healthcare system, its ignorance would result in an ethical challenge for the system (13). In this regard, the patients who have experienced abuse in healthcare are considered to be a rich source of information (14) and using qualitative content analysis is quite appropriate for investigation of the characteristics of such a sensitive multifactorial phenomenon (15) and can help understand the consequences of hospitalized

elder abuse and its latent components. Such studies would also enhance healthcare providers' awareness of outcomes of their abusive and negligent behaviors towards hospitalized elderly patients, which could be effective in prevention of elder abuse.

OBJECTIVE

The present study aimed to identify and describe psycho-emotional consequences of hospitalized elder abuse from older patients' views.

MATERIALS AND METHODS

Research design: This exploratory qualitative study was conducted using inductive qualitative content analysis approach in order to determine the Psycho-emotional consequences of hospitalized elder abuse among older patients.

Participants and research context: In this study, 16 older patients in different wards of six educational hospitals affiliated to Shiraz University of Medical Sciences (internal, surgical and CCU) who had rich information about hospitalized elder abuse were recruited from October 2017 to September 2018. The participants were selected via purposive sampling and based on the informed judgment of the researcher, and also the need for variety in samples during the study. Data collection was continued until achieving data saturation where no new codes or categories were obtained. Data saturation refers to obtaining repeated information confirming the previously collected data. At this stage, no new data is obtained in interviews to complete and enrich to the categories developed throughout the research.

The older patients aging 60 years and above who have experienced elder abuse in hospital and going longer than three days since the patient's current admission in the hospital, and had proper physical, mental, and psychological conditions for taking part in interviews were entered into the research. The patients had to possess verbal expression and be able to provide rich information about the intended phenomenon. They also had to be willing to participate in the study and respond to questions. The exclusion criteria of the study were not being willing to take part in the interviews and developing a critical condition.

Data collection: Data were gathered via individual semi-structured interviews, which are among the best techniques for collecting data regarding sensitive issues. The interviews began with a general question: "can you tell me what hospitalized elder abuse means to you" and the following more specific questions were asked including "Do you have any experience of being abused by healthcare providers during your hospitalization period? Please mention.", "How did you feel in that situation?", "What happened between you and the personnel?", "What were the consequences of that incident for you?", "Have you had similar experiences of being abused by nurses, physicians, and other healthcare personnel in hospital settings before? Please mention them.", "What were the consequences of that incident for you?", "In your opinion, what are the consequences of hospitalized elder abuse?" These questions were only designed as interview guides, which were given open and interpretive answers. In fact, the participants'

responses directed the interviews. All interviews were conducted by the first author (Z.N.) in a private room in the ward where the participant was hospitalized. The interviews were continued depending on the participants' conditions and, if necessary, further interview sessions were arranged. Each interview lasted for around 45 minutes. It should be noted that one of the participants had two interviews. Thus, a total of 17 interviews were carried out.

Data analysis: The study data were analyzed using the inductive qualitative content analysis method proposed by Elo and Kyngas (2008), which contained three stages. The first stage, preparation, which involved immediate transcription of the interviews and reading the transcriptions several times with the purpose of immersion in the data. The second stage, organization, consisted of coding, creating code tables, classifying the related codes, categorizing similar groups, and abstracting the main meaning of generic categories to form the main categories. Finally, reporting the main categories constituted the last stage (15).

Data trustworthiness: In this study, credibility was achieved by prolonged engagement, selection of participants from different sexes and age groups and various lengths of hospital stay, time integration (investigation in different shifts), place triangulation (different wards and hospitals), and peer debriefing. Dependability and conformability were ascertained via audit chain, including accurate interview techniques, precise transcription, maintenance of research documents, precise direction of interviews for data collection, and peer debriefing. Data transferability was strengthened via thick description of the study results, rich presentation of the results together with participants' quotes, purposive sampling, data collection from a sufficient number of a variety of knowledgeable participants.

Ethical considerations: This study was approved by the Ethics Committee of Shiraz University of Medical Sciences (Code: IR.SUMS.REC.1396.S613). At first, the participants were informed about the objectives, procedures, and voluntary nature of the study. They were also reassured about the confidentiality and anonymity of their data as well as their right to withdraw from the study any time during the research. After all, they were required to sign written informed consent forms for taking part in the study. Additionally, the interviews were recorded after gaining permission from the participants.

RESULTS

The participants were 16 hospitalized older patients aging 60-83 years (**Table 1**). Data analysis revealed 29 subcategories, 8 generic categories, and 3 main categories (**Table 2**). The main categories were feeling of insecurity, aggression, and learned helplessness.

Feeling of Insecurity

This category composed of three generic categories, namely perceived mental concerns, mistrust of healthcare team, and treatment abandonment.

Most patients stated that they felt insecure because of their perceived concerns resulting from the treatment team's abuse or negligence, including worry and doubt about the accuracy of the taken therapeutic measures, worry about wrong diagnosis and unnecessary procedures, fear from medical mistakes during medical processes and procedures, Worry

Table 1. Demographic and clinical characteristics of the participants

Variable	Elderly Patients
Gender	Male
	Female
Ward	Medical
	Surgical
	CCU
Education level	Illiterate
	Elementary education
	Secondary education
	Diploma
	Upper diploma
	Bachelor
Age	Min:60, Max:83
length of stay	Mean: 70.25±6.94
in hospital(days)	Min:3, Max:24
	Mean:10.56±5.60

Table 2. Main categories, generic categories, and subcategories

Subcategory	Generic category	Main category
Worry and doubt about the accuracy of treatment measures		
Worry about one's life		
Worry about the personnel's disrespectful behaviors	Perceived mental concerns	Feeling of insecurity
Worry about treatment costs		
Reviewing traumatic memories		
Worry about the need for future hospitalizations		
Being alert	Mistrust of healthcare team	
Suspicion about treatment team		
Early self-discharge	Treatment abandonment	
Non-adherence to treatment		
Irrascibility	Rage and anger	
Mental tension		
Tendency towards hurting the personnel	Tendency towards hostile behaviors	Aggression
Tendency towards damaging hospital equipment		
Bewilderment	Feeling of lack of control over the conditions	
Feeling of disability		
Feeling of lack of power		
Feeling of being prisoned		
Surrender and reduction of expectations	Not making attempts to get one's rights	Learned helplessness
Silence and Internalizing		
Fear from objection		
Flattery and humility		
Disappointment and absurdity	Depressed mood	
Preference of death to life		
Humility and degradation		
Sadness and crying		
Disgust with one's situation		
Sleep disorders		
Persistent suffering		

about one's life, fear from adverse events associated with surgical and invasive procedures performed by nursing and medical students, and worry about falling, hospital-acquired infections, or bed sore.

"I feel that my physician is doing a wrong treatment. S/he doesn't know what's wrong with me. S/he is doing the measures on the basis of my words. I may not know. I may have another disorder. They should do tests to diagnose my disease. S/he doesn't examine me. Only the students come for examination ... " (female patient, 60 years old).

"I didn't want to undergo treatment anymore. I felt bad. I just wanted to get out of the emergency department. I am a very patient person, but it was a hotchpotch. I felt they might make mistakes about me" (female patient, 63 years old).

The patients' feeling of insecurity also resulted from concerns about treatment expenditures due to long hospital-

stay or expensive drugs, reviewing previous traumatic memories like returning to the past and remembering bitter memories of abuse and negligence during prior hospitalizations, worry about the personnel's disrespectful behaviors, reduction of their dignity, violation of their privacy, and suddenly and rude behaviors of personnel, and deep fear from future hospitalizations.

"I'm always stressful about experiencing previous problems, disrespects, and useless measures that wasted my time" (female patient, 63 years old).

"They prolonged my treatment process and I'm afraid of the costs at the end. I'm here for several days and the medications are being repeated again and again. I'm afraid of the costs. I will also have trouble getting rid of the complications. I should consume some medications again. They receive money for all these measures and the cost will be

similar to that paid in private hospitals. I pay a lot of money and waste my time. Indeed, the long stay will break my spirits..." (male patient, 77 years old).

Another generic category of feeling of insecurity was the sense of distrust, including two subcategories: 1) being alert and remaining in the defensive mode and 2) pessimism towards the treatment team and getting disgusted with the hospital. In this regard, one of the participants maintained:

"One doesn't feel safe when coming to the hospital; a feeling of security that one is under treatment. I felt that they had abandoned me. If I don't follow things up, if I'm not careful, they do not care about me. I'm mentally disturbed. I am a tough person and I don't get disturbed easily, but I was really bothered here..." (female patient, 62 years old).

"When you are in the hospital, you should always be careful that nothing bad happens to you. I've experienced that you should never have complete trust in them; not in nurses, not in physicians. You should never be fooled by a doctor's name or fame..." (male patient, 68 years old).

Treatment abandonment was another dimension of feeling of insecurity, which was composed of two subcategories, namely early self-discharge from the hospital and non-adherence to treatment. In this respect, one of the participants stated:

"I said to myself that I'm ready to die in my own house but not to go to the hospital. I'm ready to suffer from pain, die, but not to go to the hospital. I don't want to continue my treatment. This is what I decided nine months after my operation..." (female patient, 60 years old).

"I suffered too much ... I wanted to discharge myself. I don't have a good economic status, but it doesn't matter. I sell what I have, but I save my life and will not get annoyed here..." (male patient, 72 years old).

Aggression

Aggression was a severe emotional response, which was shown by some elderly patients due to psychological tensions resulting from deprivation and irritability following the treatment team's abuse or negligence. This response was manifested through violence, anger, and irascibility towards the family members as well as the treatment team. Other features of aggression included tendency towards hostile behaviors with the treatment team, such as verbal and physical violence, or causing damage to hospital equipment in order to drain emotions and fears as well as to exert power, threat, and retaliation.

"I really got upset. I really wanted to die at that moment. I was so nervous, so angry that God knows I would take his/her life if I could. It affects one's spirits; someone insults you in front of others and you can't defend yourself..." (male patient, 77 years old).

"I had an argument with them last night. I wanted to throw it (the serum stand) at his/her face. They didn't give me my sleeping pills. They didn't change my foot's wound dressing and it was burning. I suffered both physically and mentally last night. They were talking and laughing at the station, but they didn't care about me. Then, the nurse came and asked why I had rung the alarm. Well, this alarm is here for patients. I really got upset. If s/he had said it again, I would have thrown it (the serum stand) at her face and it was not important at all; I said it to her, as well..." (male patient, 65 years old).

"I wanted to put the hospital on fire at that moment, because I felt lonely. I felt I had no support. I groaned too much, but it was not important for them at all..." (female patient, 63 years old).

Learned Helplessness

Due to the perceived abuse and negligence, some elderly patients believed that they could not control their conditions in the hospital and felt disabled, weak, powerless, and prisoned.

"Their maltreatments affect people, particularly older people. Older people are highly under pressure and feel that they are the weakest people in the world. They feel that they are so weak that someone insults them. They say they are so physically weak that a woman insults them and they can do nothing about it. They even wake up during the night..." (male patient, 77 years old).

"Their maltreatments affect people's spirits. An old person expects love from everyone, the youngest and oldest ones. When they are under pressure and in pain, they get tired, they want someone to look after them, they expect everything to go well. When they do not care, they would get upset, they cannot stand it, they think they are in a cage..." (female patient, 72 years old).

The participants who felt unable to control their conditions stopped making attempts to get their rights and tried to reduce their expectations. They kept silent against any abuse or inclined towards flattery and humility due to their dependence on the personnel, fear from being rejected, fear from the personnel's retaliation, and prevention of the treatment team from taking offense.

"I know they won't care. I've seen myself that some people in worse conditions raise objections. They say "what can we do? Are you our only clients? You drive us crazy. We will give you your records and you can go wherever you want". I've seen these. So, I say it's useless. What can I say? I have white hair (I'm old), but they don't respect me. They say something and I'll be upset for several days. I'll be humiliated. They want to shout, OK, let them do so without offense. We care, but they don't. They don't understand that we be trying to have patience ..." (male patient, 73 years old).

"I never objected. I felt miserable, I just cried. For example, why do I suffer from this pain? This person is watching you, s/he has knowledge, s/he sees you are struggling with the disease. You want to be hopeful, but they do something that you lose hope completely..." (female patient, 76 years old).

Some elderly patients indicated that they had experienced the signs of depression, such as sadness, crying, disappointment, absurdity, preference of death to life, humility, shame, disgust with one's conditions, sleep disorders, and long-term suffering, due to their experienced abuse or negligence in the present or previous hospitalizations.

"I feel humiliated; something like shame, frustration. I don't know what to do, who to talk to. What should I do? ..." (male patient, 80 years old).

"I'll never forget that night. I may forget the pains, but I won't forget that suffer lasted from night to the next morning. Their behaviors caused me to feel the pain more. I have bad feelings when I remember that. I get broken spiritually..." (female patient, 62 years old).

“I woke up during the night even days after that situation. I imagined it. I had a dream that I was fighting with the guard. It causes such mental pressure, it affects one’s spirits...” (male patient, 77 years old).

“Well, these have negative mental effects. Such sufferings create a bitter memory for us and the memories will remain in our minds for years. I’ll never forget that doctor’s face...” (female patient, 63 years old).

DISCUSSION

Based on the study results, the Psycho-emotional consequences of hospitalized elderly abuse among hospitalized patients included three dimensions, namely feeling of insecurity, aggression, and learned helplessness.

Need for security is one of the most important human needs, and feeling of safety and security is associated with being free from physical threats and emotional injuries (16). Evidence has indicated the centrality of the feeling of security for hospitalized elderly patients (17). In this context, patients who feel safe and secure respond better to treatments, are discharged sooner, and will have lower treatment costs. A prior study revealed a relationship between gap in services and patients’ feeling of safety (18). It seems that elderly people’s lower health status together with inefficiency of the health system would enhance their feeling of insecurity (16). Healthcare insecurity has been defined as the feeling of uncertainty, anxiety, and vulnerability towards obtaining or maintaining sufficient healthcare services. This concept evaluates an individual’s mental feeling of vulnerability, lack of control, and worry about getting healthcare services when needed (19).

Studies have shown that feeling of awareness, being recognized as a human being, and trust in the personnel’s availability and efficiency for relieving patients’ symptoms could facilitate the elderly patients’ feeling of security. According to evidences, feeling of illness and pain could reduce patients’ feeling of security. Therefore, healthcare providers must provide efficient medical and communicational support, including symptoms relief, in order to strengthen the patients’ feeling of security (20). Additionally, the patients’ feeling of security was influenced by coverage of all their needs, including the need for understanding, regaining control, being hopeful, and developing trust. In case these needs were not met, the patients felt insecure and their experiences ranged from turbulence and hopelessness to anxiety, struggle, and paranoid. For instance, the patients felt insecure in case they lost trust in the personnel (21). Perceptions of insecurity, in turn, affect individuals’ subjective well-being, because insecurity is manifested through individuals’ lack of control or autonomy in management of their surrounding environment. Perceptions of insecurity are also manifested through fear from losing control of one’s life, one’s properties, one’s social relations, and even one’s life (22). Moreover, insecurity beliefs with emotional origins are often accompanied with unpleasant feelings and hopelessness, and are normally labeled as feeling of insecurity (23). Insecure individuals feel that they are rejected and isolated, feel anxious and hostile, are pessimist and unhappy, and present the signs of tension and conflict. They are also more prone to selection of negative and incompatible responses, such as risk avoidance and overreaction (24).

In the present study, the participants mentioned aggression to be one of the main consequences of hospitalized elder abuse, which was manifested through severe rage and anger and tendency towards hostile behaviors. Anger has been defined as an experience of aggression, a syndrome of specific emotions and cognitions, and physiological reactions related to the tendency towards causing damage. Anger can involve mild mental emotions, such as irritability and annoyance, as well as severe emotions, such as extreme excitement and rage (25). On the other hand, aggression has been defined as hostile, traumatic, or destroying behaviors, particularly resulted from hopelessness (26). Aggression leads to physical or emotional damages to other individuals or destruction of properties, which involves obvious physical actions (fighting or breaking objects), verbal abuse (27), or threat to attack (28). Overall, anger is the emotional component and aggression is the behavioral component of irritability towards a negative emotional stimulant (29).

Unfortunately, aggression is quite common in acute care centers and can result in serious damages to the patient, personnel, other patients, and companions. Aggression may be caused by lack of control or respect. In this context, arousal due to the disease, environment, or communication problems with the personnel or the organization might result in strong emotions or cognitive or personality restrictions, which might be difficult to control. Aggression may also originate from emotions, such as fear, anxiety, grief, hopelessness, or anger, which are normally experienced by individuals or their close ones in the field of ill-health. External factors, such as the personnel’s attitudes and behaviors, physical environment, and limitations, might cause aggression, as well. Overall, aggression represents the patients’ distress or an attempt to meet the needs in individuals with excessive coping abilities (28). Older patients’ aggression may cause great stress and provoke care providers to elder abuse of the patient (30). It seems that aggression may result in a vicious cycle for abuse in which hospitalized elder abuse results in older patients’ aggression on one hand and older patients’ aggression can lead to abuse toward them by caregivers on the other hand.

The current study findings indicated that learned helplessness was another important psycho-emotional outcome of hospitalized elder abuse, which might be experienced depending on the severity of abuse. Learned helplessness is a psycho-cognitive state in which individuals who cannot control a particular situation feel unable to exert logical control on other situations. Thus, they think that they cannot achieve their desired goals and stop making attempts. These individuals learn that they are helpless and, consequently, become depressed (31). Therefore, frustration and hopelessness occur due to considering the experienced outcome to be uncontrollable and unpredictable (32). Learned helplessness in older people may be caused by repetitive encounters with uncontrollable incidents, eventually resulting in cognitive, motivational, and emotional shortcomings (33). Evidence has indicated that learned helplessness, depression, fear, feeling of guilt, shame, and post-traumatic stress syndrome, which are caused by elder abuse, provide the ground for emotional distress (34). Studies have also demonstrated that in cases individual-centered care is missing and replaced with institution-centered care, resulting in routine care services, limited opportunity to take communication and psychological dimensions into account, lower time, and lower engagement with elderly patients, they

adapt with and surrender to the situation, eventually leading to depression and emotionlessness (35).

Solomon (1990) mentioned three psychological factors for development of learned helplessness in healthcare centers, including healthcare providers' attitudes, interactions between healthcare providers and elderly patients, and injustice resulting from stereotypes. In that study, stereotypical behaviors towards older people were considered to play a major role in development of learned helplessness (36). Moreover, researchers have reported that increased number of hospitalizations and longer hospital stay could prone the patients to learned helplessness (32). This status may cost much for the elderly people and result in development of psychological pathologies with horrible consequences (36). Learned helplessness may also affect elderly people's cognitive performance, emotions, motivations, and self-esteem (37) and cause them to experience helplessness, anxiety, depression, lack of power, reduction of life satisfaction and ethics, and alienation (36).

Limitations and future research: One of the limitations of this study was the patients' fear from expressing the realities about elder abuse. In other words, worrying about not being provided with sufficient care services could disturb complete description of the consequences of hospitalized elder abuse. Moreover, since the participants were selected from various wards and hospitals, focus groups could not be formed to gain a richer understanding of hospitalized elder abuse consequences. This is recommended to be taken into consideration in future studies. Furthermore, this study was only conducted on the patients with complete cognitive ability. Therefore, further studies are suggested to investigate the consequences of elder abuse among the patients with cognitive disorders who are more vulnerable to abuse. Finally, the qualitative nature of the study might restrict the generalizability of the findings to other cultures and societies.

CONCLUSION

The findings of the present study indicated that hospitalized elder abuse could be accompanied with immediate Psycho-emotional consequences, such as feeling of insecurity and aggression, or serious and persistent consequences, such as learned helplessness. Thus, comprehensive investigations are recommended to be performed on each of these consequences so as to clarify and enrich the existing knowledge on the issue. Moreover, healthcare personnel must be aware of the consequences of their behaviors towards the elderly patients. In this regard, training the personnel and monitoring their performances are essential to prevent hospitalized elder abuse.

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