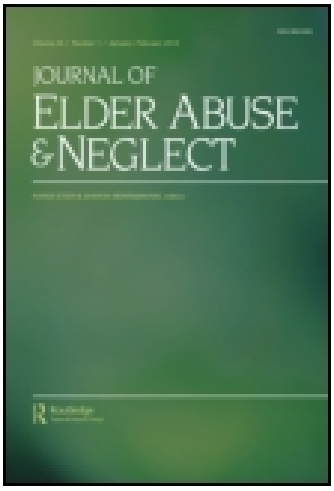

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Elder Abuse and Neglect in Institutional Settings: The Resident's Perspective

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Elder Abuse and Neglect in Institutional Settings: The Resident's Perspective

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This article strives to share research findings concerning the rights and empowerment of the elderly living in various long-term care (LTC) or residential care facilities (public and private sectors) in Quebec, Canada. Inspired by the theories of constructivism, the research aims to understand the residents' perception of abuse, as well as the strategies they are developing to exercise their rights and liberties. Data from semistructured interviews with 20 residents, mostly very old women aged 80 to 98, are presented. Results show that residents' perception of abuse: (1) is conditioned by sensationalistic media coverage; (2) is limited to physical mistreatment; and (3) tends to legitimize day-to-day infringements of their rights, as these "minor" violations seem inoffensive when compared to the "real" acts of violence reported in the media. Tensions that can build up among residents, sometimes resulting in intimidation or even bullying, were addressed.

KEYWORDS institutional settings, qualitative study, abuse, empowerment, strategies

INTRODUCTION

When illness and limitations affect the daily life of older adults, society's image of these persons changes considerably. These active and dynamic

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retirees become labeled as individuals who have "aged poorly" or who are "losing their independence." This labeling is even more negative when handicaps related to the seniors' advancing age necessitate a change in their way of life and a physical relocation, appallingly referred to as "placement." Seniors living in residences or long-term care centers are seen as being even more vulnerable and fragile, as these settings themselves are invariably associated with pejorative images: hospice, "dumping ground" for the elderly, hospital, old people's home (Bickerstaff, 2003). The image of the elderly woman rocking back and forth, silent and almost lifeless in the solitude of her room, is persistent and admittedly disturbing for everyone concerned about elder abuse. Unfortunately, these preconceived notions are regularly reinforced by the media's dramatic reports of scandals involving unsanitary premises, financial abuse, and physical mistreatment of seniors. In Quebec, society's deep concern for the well-being and safety of older residents has led to several major research projects, including a national study on the protection of seniors' rights conducted by the Commission des droits de la personne et des droits de la jeunesse du Québec (CDPDJ, 2001), government orientations for the promotion of quality living environments in residential and long-term care centers (Ministère de la santé et des services sociaux [MSSS], 2003), and action plans with particular focus on combating violence and elder abuse (Gouvernement du Québec, 2002, 2010).

This collective mobilization is taking place in a context of major social changes in the province. The rapidity with which the province of Quebec's population is aging, one of the fastest in the world, can no longer be ignored when talking about the living conditions, and the services and social policies concerning the aged. In July 2009, people aged 65 and over represented 15% of the population (Institut de la statistique du Quebec, 2010), and it is estimated that this number will reach 28% by 2056 (Institut de la statistique du Quebec, 2009). Even though most elderly people live at home without presenting a significant incapacity that could hamper their autonomy, [1] the state is facing a major challenge in trying to meet the increasing needs of the population aging with incapacities. Using the example of home-care service, institutional settings offering housing and care services to the elderly have faced key changes in recent decades: increased clientele, reduced availability of public residential facilities, expansion of the private sector, and rapid development of various types of public–private partnerships (Vaillancourt & Charpentier, 2005; Charpentier, 2002). As of June 2009, over 100,000 people were living in private residences for the aged in Quebec, which is more than double the number of elderly living in public institutions (MSSS, 2009).

Since the publication of Goffman's classic, *Asiles* (1968), a large body of scientific literature has underscored the organizational and institutional limits faced by residential care facilities, which can rapidly become restrictive, debilitating, and even abusive (Lindbloom, Brandt, Hough, & Meadows,

2007). Various social partners, "experts," and stakeholders have proposed a range of measures for the prevention of abuse and the protection of residents: a stricter legislative framework for private residential facilities, including mandatory accreditation, varied systems for evaluating the quality of services, and the role of ombudsperson. However, at the heart of this ever-changing social scene, the point of view of the persons directly concerned, the residents themselves, remains almost completely absent. They are seen as passive victims with no say in the reflection process (Argoud & Pujalon, 2003). How do senior residents see their situation and their daily lives in an institutional setting? How do they perceive their rights and, most importantly, how do they deal with abusive situations?

This article presents the results of a research project prompted by these questions, which used qualitative methodology to gather the points of view of seniors living in various institutional settings in Quebec (Charpentier & Soulières, 2006). Following a description of the theoretical framework and the research methodology, we will present the residents' perceptions of abuse, with emphasis on the influence of the media. We will then examine the strategies developed by the residents to deal with these situations, and conclude with some recommendations based on our research.

METHODS

Theoretical Considerations

One of the original features of this study is its use of the concept of empowerment to examine the residents' situation, which is usually presented from the perspective of their lost abilities rather than from that of their resources and capabilities. A review of the literature shows that questions related to power are of ever-increasing concern to researchers interested in aging (Charpentier & Soulières, 2006). However, the different definitions of empowerment proposed by the authors create a certain degree of confusion, as some may even be contradictory. Furthermore, we were concerned about the use of empowerment as a concept that, by recognizing the power of the elderly person to control his/her life, subtly implies his/her responsibility for health problems or incapacities. It was important, especially in a study such as this, to base the research on a notion of empowerment that would avoid the usual dichotomies between power and dependence (Morell, 2003), while reflecting the day-to-day strategies developed by residents despite their vulnerability and loss of independence. In other words, the exercise of power by frail elderly people should be understood through the notion that nobody is ever completely independent from their social surroundings. It is from a co-dependent position that we all negotiate our daily decisions and the respect of our rights (Beaulieu & Caron, 2000). Thus, when facing an infringement to our rights, choosing not to fight is not necessarily a sign of disempowerment

but could rather be a choice made in the light of the circumstances and priorities of the person. From this perspective, the definition of power as the ability to act, but also the ability not to act, "without fear of the consequences, whatever the solution chosen" [translation], seemed appropriate (Micheline De Séve, 1988, in Lemay, 2001, p. 27).

To fully grasp the subtlety of the residents' point of view with regard to abuse and the exercise of their rights, without compromising a broader understanding of the obstacles to their empowerment, we opted to base the development of our theoretical framework on the structural and constructivist approaches to empowerment. The structural approach refers to the need to perceive empowerment in collective terms and brings to light the organizational and macrosocial constraints on the residents' ability to exercise power. We share the view of Barnes and Walker (1996) that the empowerment of residents is not an alternative to adequate funding of public services and should not lead to the exploitation of other social groups, including family members or employees. Thus, we believe it is necessary to talk about double and even triple empowerment, as a process involving not only individuals but also organizations and the community. Constructivism, for its part, affirms the validity of individuals' experiences and takes into account the multiple subjective constructions of reality, calling into question positivism and scientific objectivity (Schindler, 1999). The notion of power and the means used to exercise it are closely linked to the values, personal and social history, and culture of the individuals concerned, and, in that regard, it can be seen that current generations of older people may perceive personal power and empowerment in a very different way than the researchers and service providers might wish them to (McCall, Heumann, & Boldy, 2001, p. 10).

It is precisely with the objective of understanding the residents' perception and giving them a voice within the social debates surrounding their quality of life that this project was undertaken, based on individual interviews with older people living in long-term care settings.

Methodological Considerations

To obtain access to the residents' subjective point of view, a qualitative methodology based on in-depth, face-to-face interviews was developed. Given the subject of the study and the context of mistrust resulting from the media's coverage of extreme situations in certain institutional settings, the selection of the research subjects was particularly sensitive, especially to minimize the risk of reprisals against the participants. Thus, we opted for a two-stage sampling strategy. First, we selected residential facilities that would ensure the diversity of the sample based on pre-established variables: private and public sector, metropolitan or suburban area, residence size (small: up to 9 residents; medium: 10 to 49; and large: 50 or more), socioeconomic

characteristics of the neighborhood, and the like. We approached the managers of the facilities chosen to inform them about the project and clearly explain the research objectives. It was stressed that this was not in any way an evaluation process of the facility or the services offered. The managers were asked to collaborate with the project by releasing general information on their center (health profile of the residents, number of rooms, etc.), and by identifying all the residents who had the cognitive and emotional ability to complete an interview. The fact that the managers would preselect the participants represents an evident risk of bias in this research, yet it seemed to be the best way to ensure that the administration would not misinterpret our presence within their facility and that the participants in our study would not suffer any form of pressure or reprisal. It also enabled us to avoid some of the methodological pitfalls encountered when a high percentage of the potential participants present significant cognitive losses (Robinson & Patterson, 2000; Pearson, Hocking, Matt, & Riggs, 1993). The risk of bias also is reduced greatly by the open-mindedness showed by the managers who agreed to participate in this study. Some even willingly put some residents on their list that seemed to be unsatisfied with their life in long-term care.

For each facility, the research team then selected one resident (two in the larger facilities) from the list provided by the manager of all the residents with sufficient cognitive ability to participate in the study. This second stage of selection aimed at ensuring a diversity in terms of gender, age category, ethnic origin, and length of residence in the facility. The interviewer then was introduced to the selected residents by the manager or another member of the staff. The written consent to participate in the study was given freely by the resident to the interviewer, in the absence of any employee from the facility. The final sample was composed of 20 participants aged between 65 and 98 years (average 83 years), the majority of whom were women. The main characteristics of the sample are presented in Table 1.

To establish a relationship of trust and to ensure that the information collected was as rich as possible, two interviews were conducted with each resident (see Table 2). The first used open-ended questions to invite the

TABLE 1 Characteristics of Residents Making Up the Sample ($n = 20$)

Gender	Female 15	Male 5		
Language	French 15	English 3	Other 2	
Age category	60 to 69 years	70 to 79 years	80 to 89 years	90 years or over
	2	6	5	7
Length of time living in the residence	3 months to 2 years	3 to 5 years	6 to 9 years	10 years or more
	6	6	4	4
Residence size (no. of residents)	Small (9 or less)	Medium (10–49)	Large (50–99)	Very large (100+)
	3	8	5	4

TABLE 2 Interview Grids Used for the First and Second Interviews With the Residents

First Interview	Second Interview
• Life trajectory Personal history and professional trajectory, experiences of immigration, loss, etc. • Moving to a housing facility Type of facility; circumstances of the move and people involved; expectations, fears, and emotions. • Integration process What were the easiest and the most difficult facets of the integration in the housing facility? • Daily routine Description of a typical day. • Recommendation What advice would you give to a new resident?	• Perception of institutional abuse We sometimes hear about abuse toward residents; how do you feel about that? • Fundamental rights on a daily basis What do you think about abuse in a home for the aged? • Scenarios and strategies: (questions asked for each of the following scenarios) Did you ever face that kind of situation? Did it (or would it) bother you? What did you (or would you) do about it? Decision-making autonomy *(Proposed scenarios: Someone comes to help you get dressed, but you would prefer to wear something else that day. / You don't like the meal one night.)* Access to health care services *(Proposed scenarios: You need to see a doctor, a dentist or any other health care specialist.)* Intimacy and privacy *(Proposed scenario: The aid leaves the door open as she comes to help you with your bath.)* Protection against abuse *(Proposed scenario: An employee talks to you in a disrespectful way and is rough with you.)*

residents to talk about their personal history, the circumstances of their move to the residential facility, and their daily lives in the institutional setting. The second interview focused on the rights of seniors in institutional settings. Rather than proposing widely accepted definitions of abuse to the participants (World Health Organization, 2002)[2] and asking them if they ever experienced any types of abuse (physical, psychological, neglect, etc.), the objective was to enable the residents to identify for themselves what constitutes abuse from their perspective. Practical scenarios were presented to illustrate each of the fundamental rights to which reference was made (self-determination, dignity and privacy, access to the necessary care and services, and protection from abuse). For each of those vignettes, the participants were asked if something similar ever happened to them, if this type of situation was okay with them or not, and what they would do if they would find themselves in that situation.

We were touched by the residents' generosity in sharing information about their daily lives, and the richness of their accounts allowed us, through

vertical and horizontal thematic analyses, to better understand their view of respect for their rights in an institutional setting.

RESULTS

This section presents the main results and analyses of the interviews with the residents. It underlines the extent to which senior residents' perceptions of abuse and the strategies they develop to deal with abuse are conditioned by sensationalistic media coverage as well as by their fear of losing the services they require and even of "losing their place" and being uprooted again.

Media Coverage and Perception of Abuse

During the interviews, many participants alluded to the periodic media reports recounting the details of tragic stories of abuse of elderly residents in institutional settings. This wide media coverage, usually sensationalistic in nature, is not lost on the residents. A number of them seem to have formed a very narrow definition of abuse, based on isolated incidents reported on television, on the radio, or in the newspapers. It follows that their idea of abuse is limited to physical mistreatment, usually rather extreme in nature and perpetrated by malicious individuals.

> Those poor old people in the unregulated residences. They must have suffered horribly! In the newspaper, they talked about a poor old man whose toenails had been cut so short that they were all bleeding. Imagine how much that hurt! Another resident was scalded in her bath. . . . She had no care for three days and she died. (Ms. M., age 96 [translation])

All the study participants, without exception, immediately dissociated themselves from this image, saying that fortunately, it was very different from their own situation. Although keenly aware of the climate of mistrust surrounding institutional settings and of their own vulnerability, most participants nonetheless stated confidently that such tragedies would not happen in their living environment. They repeated, in some cases several times during the interviews, that their residence was not "like that," and that "those things don't happen here." Sometimes they even expressed anger at the media's distorted portrayal of the situation in residential facilities for seniors.

> I think about it sometimes. . . . I wouldn't want that to happen to me; I can't defend myself very well. . . . My sister was always talking about it. She said, "I don't want to go there, look at the stories you see on television." I told her, "No, we're pretty well off here. It's good and it's clean." . . . I'm fine here. I don't think anything bad could ever happen . . . .

> Anyway, when we heard that on the radio, I was pretty upset. They always make it sound worse than it is. (Ms. C., age 76 [translation])

Without denying the various vulnerability factors associated with their physical and social condition and the special context of dependency on the care and services required, the participants said that they felt safe in their living environment. Are we then to conclude that abuse and lack of respect for the rights of residents in institutional settings are a myth? Does this mean that there is no infringement of the fundamental rights of our older citizens in their daily lives in these facilities? Unfortunately, the participants' accounts suggest a very different reality.

Trivialization of Day-to-Day Violence

It is clear, from our interviews with the residents, that the images presented in the media have a pernicious effect. Rather than heightening residents' awareness and encouraging them to be more vigilant, they actually trivialize the disrespectful and sometimes even violent acts committed against or witnessed by seniors living in institutional settings. In this regard, our analyses are similar to those of Griffin and Aitkens (1999), underscoring the residents' tendency to legitimize day-to-day infringements of their rights, as these "minor" violations seem inoffensive when compared to the "real" acts of violence reported in the media: "We know about the scandals that have come out in some other residences! That has never happened here. There are a few minor incidents, but nothing horrible" (Mr. N., age 66 [translation]). Indeed, "nothing horrible" was reported by the respondents; however, they did give numerous examples of violations of their rights: disrespectful comments, deliberate and excessive delays in providing a meal or assistance, abusive regulations and controls, and so on. These situations, completely trivialized and in most cases related simply as anecdotes, were never associated with abuse in the residents' accounts. The residents showed more than a mild reluctance to make negative comments about their environment. The result is a discrepancy, if not a contradiction, between their words and the concrete examples they shared with us. Indeed, certain residents affirmed that their rights were respected, while in the same breath reporting blatant violations of those rights.

> We're free to do as we like. We dress the way we want to. If there is a problem, the owner tells us. Last summer I was wearing a dress that was a bit short, and she let me know. I had put it on because it was summer. It didn't take me long to change into another dress. (Ms. B., age 79 [translation])

Most of the time, the violence is insidious and not recognized as such by the residents. Two women described incidents that, in our opinion,

constituted physical abuse. However, they referred to them simply as examples of rough or impolite behavior, which they attributed to the fact that the employee was having a "bad day," was overworked, had too little time, or was overtired.

> [Research assistant: If a new attendant comes to see you in the morning and she is rough and speaks to you sharply, what do you do?] Oh heavens, that happens often! (Ms. M., age 96 [translation])

> Some of them could be a little more polite. The one that is here today, she's very good . . . but is she rough! . . . And they pull something [gesture like they're pulling her arm] and they don't think that you can fall. So, some of them are a little careless, you know. So you find out [which ones]. We have a couple of those. (Ms. O., age 94)

Accounts of physical abuse remained the exception, while those related to psychological violence and lack of respect for fundamental rights were prevalent. Again, it is important to note that the residents avoid referring to such situations as abuse. Thus, experiences involving infantilization, negligence, passive retaliation, and various forms of psychological violence are presented as difficult and unacceptable situations, without the term "abuse" ever being used.

> "OK, that's enough grandma, shut up!" We see this type of thing regularly. Or "come on, granny, let's go wash your behind!" That's no way to speak to an 80-year-old woman! Some people use "tu" respectfully, but when others do it, it's offensive! Some types of rudeness are totally unacceptable. (Mr. N., age 66 [translation])

> It was young boys who gave us our bath. They told me they didn't have enough time, "We have one minute per patient." I told them you couldn't call that a proper bath. . . . They said, "You know, you're only temporary." (Ms. C., age 76 [translation])

However, these examples of lack of respect or psychological violence by staff members do not seem to be the main focus of the residents' day-to-day preoccupations. Many residents are resigned to the situation, summarizing it as follows: "Some have what it takes, and others don't!" (Mr. N., age 66 [translation]). For the participants, their very positive relationships with certain employees seem to counterbalance what they consider to be unfortunate but inevitable incidents. In fact, they are more upset by the difficulties of living with their fellow residents. Indeed, while they provided many examples of mutual assistance, good relationships, and even friendships, all the participants mentioned the existence of tensions among peers: "They're not all friends, you know. There are certain people that you're sometimes better off not seeing" (Mr. D., age 74 [translation]). Exacerbated

by close living quarters, conflicts can even degenerate into intimidation or bullying.

> The tragic thing is that there are people who have been here for 23 years. So they do what they want. Often, patients are treated roughly or disrespectfully, not by the staff but by those residents, who think they're gods. They think they're allowed to do whatever they want. Sometimes the employees help to create that atmosphere. . . . There's one woman here who is really impossible to live with. She has no respect for anyone. She has a motorized chair and runs into everyone in the elevator. No one says or does anything. . . . I've seen three or four incidents, and she's going to end up injuring someone. (Mr. N., age 66 [translation])

Relationships with peers with cognitive disabilities seem to be a particular source of anxiety for the participants. All the residents interviewed, without exception, mentioned experiencing major repercussions from daily contact with individuals "who aren't all there" and from exposure to the disturbing behavior of these persons (wandering, shouting, sexual disinhibition, or even aggressiveness). Unexpected intrusions into their rooms, aggressive behavior by certain residents, or even constant wailing during the night are among the examples mentioned by participants to show that living with cognitively impaired residents is a source of stress and even an obstacle to the exercise of their fundamental rights to privacy, dignity, and protection from abuse.

> Some of them are so lost that they get undressed and walk around. Those are the ones with Alzheimer's. It's so sad; I thank God that my mind is good. One evening, I heard a noise. [The resident] had come into my bathroom. Apparently she walks around all night. . . . They had moved her downstairs so they could watch her more closely. She came up anyway. (Ms. E., age 93 [translation])

The participants' level of understanding of cognitive impairment and its possible behavioral consequences appears to influence their reaction to these incidents. Some claim to be very understanding and seem to feel a combination of compassion and pity for these residents. However, others perceive malicious intent and react very negatively to these incidents, sometimes presenting symptoms generally associated with victims of abuse: anxiety, fear of the other person, isolation, withdrawal. As the next section shows, these reactions are typical of the strategies often used by residents when their rights are violated in an institutional setting.

Strategies Adopted by Residents

Some residents, fortunately in the minority, seem to have given up completely, renouncing the very idea of defending their rights. They have

not accepted their life in an institutional setting, which has been more or less imposed on them by the state of their health or by their families. The interviews with these few participants were heavily charged with a feeling of imprisonment. These residents, who were very emotional during our conversations and sometimes showed symptoms of depression, have abandoned all hope of seeing their situation improve.

> It was [my children] who put me in this place, but I didn't want to come here. I couldn't say no to them. I felt that I didn't want to stay here. I couldn't believe they were leaving me here. . . . I was crying. That's not how I was brought up. But rather than say anything, I cried. (Ms. G., age 93 [translation])

> You're all alone; you can't go out. You might as well be in prison. It's not a prison, but you're doomed to live all alone. (Mr. F., age 73 [translation])

At the other end of the strategy spectrum, some residents maintain that they are ready to make a formal complaint when faced with a problem situation. In some cases they would go and see the manager or the owner of the residence, but most often they would first approach a trusted employee. These residents are generally better educated and have greater personal resources, including a strong social network that provides them with considerable support.

> I would say something! Directly to the person concerned [the employee]! I would complain to the authorities! Either to the director's office, or even higher up: I would lodge a grievance with the health department! (Ms. J., age 84 [translation])

Between these two extremes, the great majority of the participants have found less official ways to use the latitude available to them by developing original strategies that allow them to maintain some degree of control over their daily lives. These strategies, while widely varied, generally involve avoidance and bypassing in order to escape direct confrontations with staff or peers: leaving well enough alone, staying in their rooms, using humor, "making friends" with the staff, taking care of their own housekeeping tasks or finances, making special arrangements with the establishment or with certain employees.

> I don't always like the food. I buy myself steaks and veal chops. . . . I freeze them and when I want some I ask for them. (Mr. D., age 74 [translation])

> Some of them meddle too much in other people's business. I don't like that! That's why I stay in my room and close my door. (Ms. A., age 89 [translation])

Although these strategies do not conform to the traditional models of assertion of rights generally found in a unionized or political context, they must not be underestimated. They represent silent practices of resilience and show a keen understanding of the imbalance of power that exists between the residents as beneficiaries and the staff as caregivers. Indeed, the risks of passive retaliation against "disruptive" residents are very real. Residents quickly understand that a "passive" attitude, or the appearance of one, earns them the sympathy of the staff and is more likely to guarantee them "good service." It also should be noted that some residents clearly mentioned their fear of being uprooted again against their will. For that reason, they avoid complaining and try to be liked by everyone.

> I'm not doing anything to jeopardize my stay here. I like it here. So it's best to keep quiet. (Mr. P., age 82 [translation])

> If we complain too much we get a reputation as old troublemakers! Grumpy old complainers! It's easy to put negative labels on us. My philosophy is that if you want to be liked you have to be likeable. I do my best not to upset anyone. (Ms. M., age 96 [translation])

> My advice? Get along with the employees. You have to do what they tell you. . . . I would say that you should try to make friends with the employees and not turn them against you. We can't forget that we're not really at home here. (Mr. D., age 74 [translation])

It is from this position of vulnerability, both objective and subjective, that the residents forge empowerment strategies aimed at ensuring respect for their rights. Consequently, it is not surprising that the results of this study clearly show an underutilization of official mechanisms for the protection of senior residents. As already demonstrated in earlier studies (Charpentier, 2002; Lindbloom et al., 2007), these measures and recourse mechanisms are little known, little used, and not adapted to the reality of older adults living in institutional settings. None of the participants mentioned the existence of a complaints commissioner (also known as an ombudsman in some jurisdictions) or any official process for handling complaints. Apart from one participant who was a member of his establishment's residents' committee, the respondents seemed to be generally unfamiliar with this structure.

> There has to be a users' committee. Oh, there are a lot of offices downstairs. The committee members are always having meetings among themselves. They're mostly the younger ones. They settle all the problems that concern them. . . . I don't get involved much myself, as long as things are going alright for me. (Ms. C., age 76 [translation])

It is this subjective vision that must be taken into account if we want to develop protection mechanisms that make sense to seniors living in institutional settings. We believe it is necessary to try to design practices that are in line with the residents' perceptions and their own strategies. In our view, the most promising approaches would no longer be based on residents' denunciations or on a formal and impersonal complaints system, but rather on the meaningful social relationships that exist in a context of proximity.

DISCUSSION

At the end of this research project, which gave us the opportunity to meet elderly citizens full of humor and personal resources, we have no doubt that the empowerment potential of residents who are losing their independence is underestimated. We believe it is essential to create opportunities for empowerment and to develop new intervention practices. In terms of prevention, it seems clear that the exercise of power by senior residents in institutional settings must be viewed from a much broader perspective and must begin prior to their admission to these facilities. Indeed, the current system of "placement" of older adults who are losing their independence constitutes serious symbolic violence. When seniors are reduced to an abstract calculation of the sum of their lost abilities or their needs in terms of hours of care, they become caught in a maze of assessment checklists and institutional priorities, and they are left with a perception of total disregard for their right to freely choose their living environment. Most of the residents speak of this move or "placement" period in terms of loss of control: "We didn't really visit anything. It was the only room left and I took a chance. I've been here ever since" (Ms. A., age 89 [translation]). When these older adults are deprived of their fundamental right to determine their future and are "placed" in a new living environment, which the majority never really consider to be their home, how can we hope that they will be able to exercise their rights on a daily basis? We must first and foremost humanize the practices surrounding seniors' admission to an institutional setting and involve them more directly in the process by allowing them to exercise their decision-making power.

Once seniors are admitted to a residential facility, the institutional context strongly influences their attitude; they quickly identify the behaviors that will put them in the employees' good graces and guarantee them continued care and services, often hard won and long awaited. From this perspective, behaviors such as keeping quiet and "buying peace" are not only symptoms of a lack of power, but also the result of a strategic and conscious choice on the part of the residents. Thus, despite the many limits brought to light in this study, we believe that empowerment or the reinforcement of power represents a potential for renewal in terms of the reflections and

practices used with seniors living in institutional settings and their families. However, it is important to create an atmosphere of openness that provides opportunities to name, identify, and talk about the inevitable tensions created by environments where several social groups live in close proximity. To this day, despite the fact that violence is recognized as a social problem, it is still a taboo subject in residential centers, which avoid talking about it for fear of being perceived as undesirable institutions. Certain more proactive centers organize information and awareness-raising activities for the groups concerned (families—residents—staff): abuse awareness days, lectures, discussion groups. These activities include discussion of intervention mechanisms and problem-resolution strategies. What is violence? What do we do if we witness violence? Interventions aimed at affirmation at any cost and the use of formal complaint systems do not appear to be very effective in ensuring that residents' rights are protected and respected. We must act on the very dynamics that that discourage people from speaking out and denouncing problem situations: poor knowledge of recourse mechanisms, worry about getting someone fired, and above all, fear of retaliation and of being labeled as a disruptive elderly person or family.

NOTES

1. According to Lefebvre (2003), 90% of the people aged 65 and over live at home without any moderate or major incapacity.

2. The World Health Organization (2002, Organisation Mondiale de la Santé, 2002) defines elder abuse as a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.

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