

Aggressive behavior Against Elderly People in Institutional Settings

السلوك العدواني الممارس على المسنين المقيمين في دور الرعاية

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الملخص :

يتناول هذا المقال موضوع العدوان الممارس على المسنين المقيمين في دور الرعاية ، حيث تعتبر السلوكات العدوانية المرتكبة بحق هذه الفئة مشينة و لها عواقب وخيمة لكن غالبا ما يتم تجاهلها . قد يرتكب هذا السلوك العدواني من قبل القائمين على رعايتهم بقصد أو بدون قصد . و من بين عواقب هذا السلوك على كبار السن إقدامهم على الإنتحار حيث يعتبر هذا الفعل شهادة صامتة و مدوية على معاناتهم داخلها .

الكلمات المفتاحية : العدوان ، دور الرعاية ، المسنين .

Abstract:

This article addresses the issue of aggression against elderly residents in care homes. Aggressive behaviors directed at this vulnerable group are considered deplorable and have serious consequences, yet they are often overlooked. Such aggression may be perpetrated by caregivers either intentionally or unintentionally, for example as a result of work-related exhaustion. Among the consequences of this behavior is the increased risk of suicide among older adults, an act that constitutes a silent yet powerful testimony to their internal suffering.

Key words: aggression , Institutional Settings , Elderly People .

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Introduction:

Within families, the violence suffered by elderly people is often linked to the exhaustion of the relative caring for them. Alcohol consumption and the influence of drugs or medication are also significant risk factors, particularly in family settings, and may involve either the perpetrator or the victim. A lack of external social contact and the resulting isolation likewise contribute to the occurrence of mistreatment.

Moreover, the support provided to families remains insufficient, and caregivers receive too little training, despite the fact that caring for older adults is a demanding task. At times, this task can become grueling and emotionally draining. It is no coincidence that older people suffering from dementia—who are often aggressive toward their caregivers—are among the most exposed to abuse. While this may offer an explanation, it cannot serve as an excuse (Attias-Donfut, 1995, p. 41).

Within families, home care for an elderly parent can destabilize fragile family dynamics. There are still too many intolerable and tragic situations requiring social and judicial intervention: verbal abuse, neglect, or overmedication, for example, may leave few visible marks on the body, yet cause indelible trauma in the victim—who often remains silent or is unable to testify. How, then, can one detect this silent suffering?

Aggressiveness and complaints are common expressions of pain, though not always easy to interpret. Among the elderly, withdrawal, silence, and a reluctance to speak are even clearer signs of psychological distress. Memory problems, disorientation in time and space, and other cognitive disturbances can also indicate the presence of moral or physical suffering, even when it is unspoken (Fagherazzi, 1993, p. 248) . Unfortunately, this suffering often intensifies when elderly individuals are institutionalized without being informed or consulted by their families.

First : The aggression of Institutionalization

Admission to an institution, like any relocation, is a source of stress. It disrupts the elderly person's familiar points of reference and, by assigning them to old age, fractures their social and personal identity.

1 The aggression of Being Forced into Institutional Care :

The decision to enter institutional care is rarely made by the individual alone. Home care reaches its limits when the support required exceeds the family's capacity. The

exhaustion of these family caregivers is tied to changing family structures. Some children place their parents in institutions without even informing them. Such placements, often carried out behind the parents' backs, may provoke feelings of guilt in the children—yet they are not uncommon. When the feeling of obligation prevails, adaptation to communal living remains difficult (Attias-Donfut, 1995, p. 39).

Elderly people placed by social workers are paradoxically more aligned with transparency standards upheld by their children. They are aware that the institution will likely be their final home, yet subjective adaptation to communal life remains challenging. The feeling of compulsion is even stronger when individuals are unprepared for the idea of ending their lives in an institution. For the new resident, admission often reveals a sense of disorientation and fragility (Personne, 1996, p. 87).

2 The Symbolic Violence of Placement :

Residents often emphasize the speed with which the transfer from their former home to the institution occurred. This rapidity is one of the most neutral yet powerful expressions of the symbolic violence of placement. Admission is experienced as too abrupt: as the body undergoes recent upheavals and self-perception shifts, the person has no time to adjust to the idea of dying in a communal setting, having always imagined their final days at home (Fagherazzi, 1993, p. 250).

This disruption profoundly shakes their personal world. The absence of familiar objects exacerbates the difficulty of adapting to institutional life. When the change is perceived as rapid, imposed, and irreversible, it triggers negative perceptions of both the institution and the community. This loss of control over one's life gives a tragic dimension to the transition, and residents may temporarily retreat into their inner worlds as a means of escape (Couture & Beauvais, 1987, p. 199) .

3 The Violence of Uprooting :

Separated from their former homes, “uprooted” residents struggle to adapt. Many institutions are located in quiet suburbs, far from lively urban centers, making appropriation of the new environment difficult. These calm places soon turn into lifeless spaces. For residents with severe disabilities, the institution becomes merely the backdrop for a monotonous and hostile existence (Personne, 1996, p. 88) .

4 The Violence of Communal Living :

Institutionalization, typically decided externally to the individual, is often framed as a rational, inevitable life stage. Yet this rationality falters against the abnormality experienced in the institutional environment.

The new resident is absorbed into a community of the elderly, the disabled, and the disoriented, in spaces far removed from the warmth of a family home. It is a disorienting world marked by lack, degradation, and loss (Ennuyer, 2002, p. 72) .

To avoid identifying with others, new residents may withdraw, avoiding interaction. Others are viewed with suspicion—an understandable reaction during integration into a pre-existing group. But as few efforts are made to build connections, they end up living a dull, detached existence, awaiting their own end (Hugonot, 1998, p. 236).

Second : Potential Mistreatment in Institutions

To mistreat an elderly person is to force them to act against their will through coercion or intimidation, inflicting physical pain, emotional distress, or social harm. Such violence can only occur because the victim is vulnerable—if they were strong, they could command respect (Hugonot, 1998, p. 237) . Vulnerability may result from

- Physical disability: reduced mobility, dependence for meals, personal care or hygiene, being bedridden, incontinence, or general age-related weakness.
- Psychological vulnerability: social abandonment, fear of reprisals, helplessness, ignorance of available remedies, perceived domination, or generational conflicts.
- Confusion and senility: impaired judgment, memory loss, unpredictable behavior.
- Social abandonment: often underestimated. Violence is rarely inflicted when the resident receives daily visits from family members who can express concerns (Ennuyer, 2002, p. 75) .

1. Causes Contributing to Institutional Mistreatment :

Organizational Causes :

- Absence of a structured care plan (“Who are we? Where are we going? What do we aim to achieve?”), developed collectively by the caregiving team.
- Lack of team discussions to address encountered problems, leading to inadequate case-by-case learning; insufficient training and staff selection. The worst abuses occur when caregivers are poorly prepared or resent their tasks.
- Lack of coordinated work organization prioritizing both residents’ autonomy and caregivers’ accountability within clearly defined roles (Hugonot, 1990, p. 144).

Psychological Causes :

- Caregiver stress and frustration.
- Constant confrontation with aging, death, and the inability to grieve normally when emotionally attached to a resident.
- The nature of caregiver-resident interactions, where care demands exceed capacity, leading to fatigue and dehumanizing attitudes (Fagherazzi, 1993, p. 250).

2 Forms of Mistreatment in Institutions :

Psychological Mistreatment :

- Devaluation and ridicule: mocking or blaming elderly people, triggering anxiety, neglecting pain relief despite complaints, using patronizing language, giving nicknames (“granny,” “the old woman,” etc.).
- Abuse of authority: making decisions on behalf of the elderly without respecting their expressed choices, claiming they are “losing their minds,” rushing them, restricting them to a single room, moving them without consultation, or placing them with incompatible roommates.
- Verbal assault, threats, and blackmail: using fear to intimidate or infantilize.

- Social neglect: ignoring their presence during care, excluding them from meaningful roles or actions, and treating them as invisible.
- Omission-based violence: disregarding their clothing or personal habits “to save time” (Fagherazzi, 1993, p. 281) .

Material Mistreatment :

- Theft of money, pension checks, jewelry, etc.
- Fraudulent use of the person’s assets, such as premature inheritance claims or fictitious sales (Couture & Beauvais, 1987, p. 281) .

Physical Mistreatment :

- Inadequate diet, forced feeding, poor seating arrangements, or rigid dietary control.
- Neglect of medical or nursing care, disregard for privacy, failure to relieve pain, ignoring basic needs of disabled residents, endangering their health and safety.
- Inflicting physical or psychological pain through restraints or neglect of proper care.
- Intentional injuries (slapping, pinching, shoving, rough handling), or causing pain through tight clothing (Couture & Beauvais, 1987, p. 283) .

Violation of Rights :

- Denying personal autonomy and freedom.
- Disrespecting individual rhythms, needs, and rights.
- Withholding medications or prosthetics.
- Enforcing non-therapeutic drug consumption or unauthorized clinical trials (Personne, 1996, p. 89) .

Poor Environmental Conditions :

- Inadequate heating.

- Prohibition of personalizing living spaces; removing personal belongings without consent.

- Poor accessibility (e.g., high beds, narrow spaces).

- Imposed room changes without consultation.

- Lack of private spaces for receiving visitors (Couture & Beauvais, 1987, p. 285) .

Poor Organization of Care and Services :

- Poor food quality.

- Rigid rules governing waking, sleeping, and outings that disregard residents' habits or health conditions.

- Lack of privacy during intimate care.

- Excessive waiting times for essential services.

- Overmedicalization and lack of resources supporting autonomy.

- Leaving residents in bed on holidays.

- Reliance on rigid routines instead of stimulating activities (Ennuyer, 2002, p. 75)

Mistreatment by Other Residents :

Although rare, homicide among residents can occur. More commonly, dangerous altercations arise when residents defend their territory, leading to pushing, cane strikes, trauma, or injuries requiring medical attention (Hugonot, 1990, p. 150) .

Self-Endangerment by Elderly Residents :

Fugue and wandering episodes are common among cognitively impaired residents who may leave the institution, prompting large-scale search efforts (Couture & Beauvais, 1987, p. 200).

Suicide may take classical forms, but more often manifests through “equivalent suicidal behavior” such as withdrawal or passive refusal to live. Experts underline the intensity of suicide methods among the elderly, particularly hanging—the most common method for both men and women over 65.

Moreover, even failed suicide attempts often have more serious consequences for elderly individuals due to their weakened physical state. Elderly suicide results from a complex interplay of physical, biological, psychological, and social factors (Douguet, 2001, p. 29).

One study conducted in 1993 by a team of psychiatrists in the Haute-Garonne department in France showed that the suicide rate among people over 65 was significantly higher in nursing homes (51.3 per 100,000) than in the general population (18 per 100,000). The psychiatrists concluded that individuals in nursing homes are nearly three times more likely to die by suicide than those living at home (Douguet, 2001, p. 30) .

Conclusion:

For a long time, the mistreatment of elderly people was a taboo subject, so delicate that even addressing it seemed to hinder any possibility of change. Yet bringing the issue into the public sphere and denouncing it may help shift the negative societal gaze cast upon older individuals.

Those responsible are not necessarily criminals; they are often ordinary people who have simply forgotten that these elderly individuals—though not always easy or pleasant—are human beings, their equals. What is at stake is an ethics of care for everyone involved in the lives of residents within institutions.

Committing to such an ethics requires prior reflection on fundamental concepts, particularly the notions of personhood and dignity. The evolution of elderly individuals within institutional settings starkly illustrates how they are displaced from a familiar environment into one in which they must reconstruct their desires and their relationship to shared rules.

Collective operational structures clearly emerge here as essential frameworks for defining what must—and must not—be. There is a pressing ethical need within institutions; without it, practices risk becoming disconnected from the actual needs of elderly residents.

These ethical foundations will lay the groundwork for constructing a genuine ethics of care in institutions for older adults.

List of references:

Attias-Donfut, C. (1995). *Les solidarités entre générations: Vieillesse, familles, État*. Nathan.

Couture, M., & Beauvais, D. (1987). Violence aux personnes âgées. *Nursing Québec*, 7(2), 199–285.

Douguet, F. (2001). *Le suicide des personnes âgées: Étude destinée à la Direction départementale des affaires sanitaires et sociales du Finistère*. Université de Bretagne Occidentale.

Ennuyer, B. (2002). *Les malentendus de la dépendance: De l'incapacité au lien social*. Dunod.

Fagherazzi, P. (1993). *Mourir en long séjour*. Presses Universitaires de France.

Hugonot, R. (1990). *Violences contre les vieux*. Érés.

Hugonot, R. (1998). *La vieillesse maltraitée*. Dunod.

Personne, M. (1996). *La désorientation sociale des personnes âgées*. Érés