The Older Adult and FEAR OF CRIME

The problem of fear of crime among the older adult population is a subject of current debate. Research has shown that the rate of crime against older adults (65 years and over) is low compared to other segments of the population (Ferraro & LaGrange, 1992; Vander Zanden, 1993). Older adults experience half the number of crimes that younger populations experience (Vander Zanden, 1993). Because of these statistics, some have argued that older adults have an exaggerated, unfounded fear of crime (Ferraro & LaGrange, 1992). Others contend that American society perpetuates a myth that older adults are afraid of crime (Ferraro & LaGrange, 1992; Vander Zanden, 1993). Vander Zanden (1993) suggested that the fear was a myth, reporting that 74% of the general public believes that fear of crime is a major concern for older adults, while only 25% of older adults thought fear of crime was a major concern for them. Similarly, a series of studies by Ferraro and LaGrange countered previous research that showed higher rates of fear of crime among older adults (Ferraro & LaGrange, 1987, 1988, 1992; LaGrange & Ferraro, 1987, 1989). They found that older adults’ fears may have been overestimated due to measurement errors such as non-specific, unreliable, and invalid questioning. Based on these findings, they doubt the accuracy of the research and question policy decisions based on that research (Ferraro & LaGrange, 1992).

The arguments that fear of crime is not a problem for older adults are troubling. The arguments could lead to the conclusion that fear of crime is not a priority problem for older adults, and does not need to be on the policy or nursing agenda at all; but this would be a misleading conclusion. Vander Zanden’s (1993) statements neglect to focus attention on the one-fourth of the older adult population that does fear crime. If his figures were adjusted to include only those living independently (excluding possible safer living zones such as nursing homes/retirement communities), they might reveal that an even larger percentage of older adults fear crime. Even Ferraro and LaGrange (1992) admit that there are groups of older adults who truly fear crime. In response to those who argue that older adults’ fears are unreasonable or insignificant, this article will not judge whether the fears are reasonable or justified, but will assert that they are a reality meriting attention. Using Johnson’s Behavioral System Model as a conceptual framework, living with the fear of crime is viewed as a serious problem because it has the potential to impact health-related, social, and functional behavior (Fawcett, 1995; Johnson, 1990). Indeed, it seems logical that older adults experience lower rates of crime because of their wisdom and years of experience in ways to avoid crime, their generally more limited mobility, and the extent to which they may adapt their lives to avoid crime (Fielo, 1987).

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### TABLE 1

**NURSING INTERVENTIONS**

**Client-Focused Interventions**

1. Allow time to discuss fear of crime (Fielo, 1987).
2. Facilitate a realistic self-assessment of ability to avoid and defend self (Bazargan, 1994).
3. Teach basic safety and security techniques (see Table 3).
4. Provide or refer to self-defense courses.
5. Correct sensory losses when possible (e.g., hearing aids, glasses) (Fielo, 1987).
6. Correct physical disability, if possible (e.g., pain treatment for arthritis, physical therapy) (Fielo, 1987).
7. Facilitate access to safe, reliable, and affordable transportation.
8. Identify family, friends, neighbors, or home aides who can support efforts to leave the home.
9. Encourage daily telephone contact with at least one supportive person (Fielo, 1987).
10. Encourage the client to get to know neighbors (Fielo, 1987).
11. Encourage older adults to perform outside activities and errands together (Fielo, 1987).
12. Refer to senior housing (Bazargan, 1994).
13. Encourage participation in local senior centers and other community-based programs.
14. Provide information on local services that assist and support victims (Fielo, 1987).

In this article, research that addresses fear of crime among older adults is reviewed. The review shows that among specific populations of community-dwelling older adults, fear of crime is prevalent. The literature also shows that fear of crime is a social problem with negative consequences. Living with the fear of crime can interfere with the social, functional, and health-seeking behaviors of an already vulnerable population. It can compromise quality of life. Because of the serious consequences of fear of crime, this article argues that gerontological nurses must routinely assess older adults for fear of crime. Appropriate interventions need to be developed and evaluated.

For the purpose of this article, crime is defined as a violation of bodily integrity or personal property inflicted by another person. The older adult's apartment may be broken into and items may be stolen. They may be mugged, and a purse, money, or check may be stolen. They may be injured or threatened with injury. Fear of crime is present when the older adult fears they may become a victim of a crime. The fear of crime can develop from a personal experience with crime. It can also develop from indirect exposure to crime, such as witnessing a crime, hearing about a friend or neighbor's experience, or hearing about crime through the media. Fear related to domestic violence and domestic abuse is beyond the scope of this article.

The hazards of fear of crime may follow a pattern remarkably similar to the "Hazards of Hospitalization of the Elderly" as defined in Creditor's (1993) model. The older adult enters the model with vulnerabilities caused by the normal changes of aging (Creditor, 1993). These normal changes, such as decreased muscle strength, reduced capacity for aerobic activity, increased risk for syncope, and declining vision and hearing (Creditor, 1993), lower the older adult's ability to anticipate, avoid, and escape crime (Fielo, 1987; Podniesiks, 1987). Decreased functional reserve and increased soft tissue and bone fragility place the older adult who experiences a violent crime at increased risk for injury, hospitalization, and a difficult or incomplete recovery (Fielo, 1987; Podniesiks, 1987). If the older adult has fewer social and financial resources, recovery from a victimization can be complicated and prolonged (Fielo, 1987; Podniesiks, 1987). Stolen money can translate into loss of food, medication, and rent (Podniesiks, 1987).

The older adult who lives with the fear of crime may make efforts to
avoid crime (Fielo, 1987). In efforts to avoid crime, the changes of aging can be accelerated and vulnerabilities exacerbated. For example, the older adult who fears crime may leave the home less, which could lead to less exercise and subsequently decreased mobility and muscle strength; less shopping could lead to fewer nutritious and adequate food choices; fewer trips to the pharmacy and health care providers could lead to less adherence to medical regimen and health deterioration; and less opportunity for socialization and recreation outside the home could lead to increased social isolation, decreased sensory stimulation and increased stress. A positive feedback loop is created, with more vulnerability driving more fear of crime, which drives more modification, which causes more decline, which results in more vulnerability.

This model is consistent with Johnson’s Behavioral System (Johnson, 1990), which proposes that a disturbance in one behavioral subsystem can cause disturbances in other behavioral subsystems. Fear of crime, according to this model, has serious consequences. This theoretical perspective is well summarized by Kauffman:

...to participate actively in the social life of their community, residents must be free of fear in their homes, walking on the streets, and associating in public spaces. To feel otherwise contributes to social isolation and alienation and increases the risks of mental and physical ill health. This is especially important for those who live with the infirmities and vulnerabilities of old age in the urban ghettos... (1995, p. 231).

Few studies in the current literature have examined fear of crime among older adults at high risk. Bazargan (1994) studied a random sample of 372 low-income, black, older (age 62 to over 80) adults living in an urban area in public subsidized housing. The population had fewer resources for coping with the consequences of crime, was demographically likely to have a poorer health status (due to age and race), and lived in a high-crime area. Fifty-three percent of the sample felt fear of crime was a serious to somewhat serious issue for them (Bazargan, 1994), whereas 25% of the general population of older adults (over 65 years) report similar fear of crime (Vander Zanden, 1993). Fifty-one percent were afraid of crime when outside alone in the daytime (Bazargan, 1994). Bazargan points out that even at home, 9.9% were afraid during the day, and 22.8% were afraid at night.

Bazargan found that women reported the greatest fear of crime. Increased fear of crime was also associated with loneliness, lower education level, feeling that neighbors were not trustworthy or not watchful, living in housing not limited to elderly, watching the news on television, and having physical limitations or disability (i.e., knowing someone who was a victim) (Bazargan, 1994). Older adults who lived in housing limited to senior citizens were less likely to have their crime rates (Bazargan, 1994). Bazargan’s results indicate that there are vulnerable populations of older adults who experience a high rate of fear of crime.

Bazargan (1994) also found that living with fear of crime affects older adults’ quality of life. Many of the older adults (29.6%) or sometimes (24.7%) avoided leaving the home because of their fear of crime (Bazargan, 1994). In fact, the primary predictor of avoidance of leaving the home was fear of crime. Older adults who feared crime were more likely to report poorer psychological well-being (Bazargan, 1994).

Bazargan’s (1994) results are particularly notable because of the attention to instrument design. Bazargan specifically responded to Ferraro and LaGrange’s (1992) criticism that poorly designed questionnaires inflate older adults’ fear of crime. He designed a questionnaire that was reliable (alpha=0.84) and that contained questions that were determined to have good validity in measuring fear of crime.

Kauffman (1995) conducted an ethnographic study of a similar high-risk population. She examined the experience of older adults (age 55 and older) living and coping in an urban community known for drug-related crime, dangerous streets, and unsafe public areas. The study primarily focused on older adults who attended a public daytime senior center, although some information was also gathered from older adults in the surrounding community. Kauffman (1995) found that older adults feared crime against themselves and their possessions. They were fearful both on the street and in the home. They were concerned not only that they might be targets, but also that they might be caught in the “cross-fire.” Drug use and drug dealing in the neighborhood made older adults feel unsafe. They were also fearful because they believed that young and middle-aged adults, especially those involved in the drug scene, no longer held the traditional respect for elders. Instead, older adults felt younger adults were disrespectful to them and viewed them.
TABLE 2
NURSING INTERVENTIONS

Community/Neighborhood-Based Interventions

1. Organize neighborhood, apartment building, or community meetings where mutual concerns are identified and plans developed, and where neighborhood support networks can be initiated.

2. Locate and organize volunteers, home health aides, homemakers, or escort services to accompany older adults on excursions.

3. Organize or get involved in local senior centers and other community-based organizations; promote the addition of services and activities to meet the older adults recreational, social, nutritional, transportation, health-related, and other needs.

4. Facilitate the development of community watches.

5. Initiate a crime prevention program co-administered by the police (Fielo, 1987) and nursing services.

6. Initiate home security assessments by the police (Fielo, 1987).

7. Locate funds to increase security in apartments, buildings, parks, and streets.

8. Conduct door-to-door outreach programs to identify new older adults who are homebound; provide them with nursing interventions and connect them with services.


10. Lobby for local, state, and national funding and programs.

as means to support their drug addictions (Kauffman, 1995).

Similar to Bazargan (1994), Kauffman (1995) found that fear of crime led to behavior modification and affected quality of life. Because of their fear, older adults rarely left home unless they had a specific destination. Men who were physically frail and women would not go on the street after dark. Without the senior center, many older adults stated they would have spent much more time at home. Many lived alone and had few recreational and social activities available in the home. For some, home was a stressful place because younger family members sought assistance with responsibilities from the older adults. The senior center provided a safe place for socialization, recreation, contribution to society and culture, and feelings of efficacy and industry.

To get to the senior center, older adults had to walk through the neighborhood. They reported a number of creative ways to cope with fear of street crime, such as dressing down, not carrying handbags, hiding handbags, avoiding strangers and drug-using neighbors, and socializing with proprietors and neighbors along the way (to show community alliance to any would-be-attacker). Though at risk for constrained behavior related to fear of crime, both the senior center and a high level of adaptation allowed this population of older adults to maintain much of their functional status (Kauffman, 1995). Kauffman’s (1995) study is notable for corroborating Bazargan’s (1994) findings through a qualitative methodology.

A number of studies have shown a relationship between fear of crime and “medical” health. A descriptive study by Happ, Naylor and Roe-Prior (1997) examined the factors contributing to rehospitalization of elderly heart-failure patients. Findings suggest that fear of crime can impact older adults’ ability to adhere to medication regimens. A reason for poor medication compliance was concern about the safety of the neighborhood pharmacy. One housebound older adult had difficulty obtaining her prescription medications because of her family caregiver’s propensity for purchase and use of illegal drugs. These findings suggest that fear of crime may contribute to medication non-compliance, which in turn may lead to rehospitalization (Happ, Naylor, & Roe-Prior, 1997). Once rehospitalized, the older adult is at risk for further functional decline (Creditor, 1993).

Ritter and Kirk (1995) surveyed low-income, frail, community-dwelling older adults to determine the impact of sociocultural and quality of life issues on use of health care. Older adults who were fearful of
crime reported more use of emergency medical services and less use of routine, long-term medical care than older adults who were not fearful. Women made up the majority of fearful non-users of long-term medical care. In fact, 74.8% of the women were very to moderately afraid of being victims of a crime, while 53.1% of the men were fearful; 69% of the total sample was very to moderately afraid. This study indicates that fear of crime may interfere with health-seeking behaviors, lead to exacerbated, acute conditions, and more expensive care (Rittner & Kirk, 1995).

The literature review suggests that fear of crime is a serious concern for specific populations of older adults.

Findings suggest that fear of crime can impact on older adults' ability to adhere to medication regimens.

Fear of crime disrupts other behavioral subsystems. Fear of crime can affect older adults' ability to leave home and interact with society, their ability to function and enjoy life, and their health-seeking behaviors. Not only are older adults' lives affected, but society and communities suffer. The social fabric is altered by the diminished presence and contribution of older adults who fear crime.

According to the research reviewed, older adults at higher risk tend to live in neighborhoods with a high crime rate and in housing not limited to the elderly; they tend to be women or frail men with low income and/or low educational level; they tend to be lonely and distrustful of their neighbors; and they have often experienced crime personally or indirectly (Bazargan, 1994; Kaufman, 1995; Rittner & Kirk, 1995). This list is incomplete because the research has not yet identified all the populations at high risk.

The research on fear of crime has numerous implications for nursing. According to Johnson's model, "the primary goal in patient care is [to promote]...behavioral system balance and dynamic stability...at the highest possible level under those conditions in which the behavior constitutes a threat to physical or social health" (Johnson, 1990, p. 29).

Since fear of crime is the source of numerous disruptions to behavioral system balance, nursing is obliged to intervene. Nursing interventions cannot afford to wait for an older adult to report an actual victimization. A complaint or report of fear of crime should be considered sufficient reason for nursing intervention.

Gerontological nurses must screen for fear of crime as part of the comprehensive assessment of the community-dwelling older adult. When the client is known to be in a high-risk category, a particularly attentive assessment should be conducted. When excess disability is present, i.e., the reported activity level is much lower than the expected activity level (Robinson &

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**TABLE 3**

**Basic Street Safety & Security Checklist**

- Do not wear jewelry.
- Do not carry a weapon (it can be turned against you).
- Do not carry large sums of money or valuables, especially not in a purse or wallet (Fielo, 1987).
- If you must carry money, pin it to the inside of clothing (Fielo, 1987).
- Keep money in the bank and use direct deposit (Fielo, 1987).
- Do not resist muggers who are not causing bodily harm.
- Avoid strangers.
- Fraternize with known neighbors and employees in local businesses on typical routes.
- Have drivers or escorts wait until you have entered your home (Fielo, 1987).
- Have keys prepared before you arrive at your front door (Fielo, 1987).
Fear of crime can affect older adults’ ability to leave home and interact with society, their ability to function and enjoy life, and their health-seeking behaviors.

Siebens, 1994), the nurse should consider fear of crime a possible culprit. Fear of crime should be considered whenever there is inadequate medication compliance (Happ, Naylor, & Roe-Prior, 1997), inadequate health-seeking behaviors (Rittner & Kirk, 1995), and less socialization, recreation, or poorer nutrition (Bazargan, 1994; Kaufman, 1995) than expected. Nurses should assess for actual or potential fear of crime when conducting discharge planning (Happ, Naylor, & Roe-Prior, 1997). When fear of crime is found, further inquiry should identify the impact on function, health, nutrition, and other behavioral subsystems.

Nursing should be responsible for developing interventions and care plans to address the problem of fear of crime. Nursing interventions gleaned and developed from a review of the literature are suggested in Tables 1, 2, and 3. Client-focused nursing interventions are listed in Table 1, and community-based interventions are listed in Table 2. Table 3 is a beginning checklist to guide nurses in client education on safety. Nursing interventions will be most effective if they address the underlying problem, fear of crime, at the same time that secondary disruptions (e.g., social isolation, inadequate nutritional intake) in the other behavioral subsystems are addressed. For instance, the nurse can teach and assist clients to better safeguard their apartments by installing secure locks on doors and windows. At the same time, the nurse may encourage social relationships with other tenants and seek donations for air conditioners for those who must keep their windows locked during hot summer months (Yarrow, 1991). At the community level, nurses can work to develop senior centers which provide socialization, recreation, and safe transportation not only to the senior center, but also to such places as the grocery store and pharmacy (Kauffman, 1995). The interventions should take into account older adults’ sensory changes, cognitive changes, and developmental needs. The care plan should include collaboration with other service providers and local organizations. For example, collaboration with the local police department would greatly enhance the quality of a safety and security education program (Kerr, 1982).

Nurses should share successful interventions with other nurses through formal and informal networks. Then these interventions can be implemented with similar populations. Research that documents the cost-effectiveness of these nursing interventions, particularly demonstrating the potential for promoting older adults’ health, functional status, and adherence to medical regimens, would help nurses argue for increased agency and government funding and for policy supporting deeper levels of change.

To address the problem comprehensively, nursing must engage others. Nurses can lobby at the local, state, and federal levels for fund allocations and policy development in the area of crime prevention and interventions specific to older adults. To determine the most effective ways to deal with the problem, research must be conducted and funded. Nursing is in an ideal posi-
tion to promote collaboration on the issue; nurses can encourage all health care providers, the health care system, and the social service system to focus attention on older adults’ fear of crime. Fear of crime can lead to constrained behavior, and in some cases, homebound clients. By addressing fear of crime, nurses can help make the home and community a happier, healthier living space for older adults.

REFERENCES


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