Chapter 9
The Victim-Perpetrator Problem in Elder Abuse and Neglect

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Introduction

Maltreatment of older people is a social fact which can no longer be seriously called into question. By now, there is a rich corpus of international studies on the extent and the consequences of elder abuse the maltreatment of older people. Cooper et al. (2008, p. 151) conclude that "(e)lder abuse is associated with distress and increased mortality in older people and caregiver psychological morbidity." Elder abuse is not only a social problem but also a major public health problem that results in serious health consequences for the victims as well as for overstressed caregivers.

Any open-minded society must regard this state of affairs as a scandal which is just as atrocious as other forms of interpersonal violence. This realization pertains not only to the logical demand to put an end to the actual physical and/or mental suffering of the individual victims and to holding perpetrators responsible for such acts but also to counteracting this social epidemic at the overall societal level. Transgressions, maltreatment, and abuse are extremely disturbing not only to those affected but also to observers and may in the long run threaten the moral basis and cohesion of society; hence it is essential to take effective intervention and prevention measures.

The phenomenon of interpersonal family violence emerged at first in the cases of child abuse and abuse against women. These types of abuse were originally called baby battering and wife beating, respectively. Later, the problem of elder abuse emerged. The abuse of older people was first described in British scientific journals in the seventies and was initially called "granny battering" (Baker, 1975). Despite these efforts, elder abuse has not gained the same "reputation" that would promote it to an urgent social problem as other forms of family violence have achieved, primarily because for a long time no powerful lobbies have taken up this issue as its cause.

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Recently, however, national and international seniors' organizations are becoming more active in the field of designing policies that relate to the maltreatment of older people, and it seems reasonable to assume that consultations with these nongovernmental organizations (NGOs) are finding their way into governmental, official, or semiofficial documents.

We have to bear in mind the demographic impact of older people. Elderly persons in this context are persons aged 60 years and over. Their number and percentage will increase dramatically in the near future. The population aged 60 or above is growing at a rate of about 3% per year, and the global population of this age group is projected to be 1.4 billion in 2030 and 2.1 billion in 2050. Over the next few decades, a further increase in the population of older persons is almost inevitable, given the size of the cohorts born in recent decades (United Nations, 2017, p. 11). Although the proportion of older people out of the total population is higher in the developed nations (highest in Europe with 25%), the percentage of increase of the elderly population is greater in the developing world. Although there are only a handful of statistics or prevalence studies in the developing world, available results, crime records, and other reports contain evidence that abuse, neglect, and financial exploitation of elders are occurring everywhere. Elder abuse is now recognized worldwide as a serious problem (World Health Organization (WHO), 2002; WHO, 2011).

Prevalence of Elder Abuse in Community Settings

Despite the fact that "(d)iscovering the prevalence of abuse, perpetrated against vulnerable people by those they rely on, is inherently difficult" (Cooper et al., 2008, p. 151), there have been several attempts to research the magnitude of elder abuse. Regardless of differences in quality and the wide spectrum of quantitative findings, this is a crucial first step in the public health approach to prevent this type of violence.

Using meta-analytical methods, Yon, Mikton, Gassoumis, and Wilber (2017) pooled the prevalence estimates of elder abuse within community settings reported in 52 publications published between 2002 and 2015. In this study, the global prevalence of elder abuse was 15.7%, or about one in six older adults. This estimate is similar to the estimate from a review by Pillemer et al. (2016, p. S197) which found a global aggregate of 14.3%. The convergence between these two global estimates, from two independently conducted systematic reviews, lends them credibility. Given the approximate 2017 population estimates of 962 million people aged 60 years and older (UN, 2017, p. 11), these rates amount to 150 million victims of elder abuse annually.

Additionally, the findings by Yon et al. (2017) provided insights into the large geographical differences in prevalence estimates, with Asia at 20.2%, Europe at 15.4%, and the Americas at 11.7%, possibly reflecting true variation in abuse rates across cultures as well as the differences in defining and measuring abuse. These rates are probably an underestimate, as some people may be reluctant to report abuse.

Prevalence of Elder Abuse in Institutional Settings

Unfortunately, empirical research on prevalence of abuse in institutional (nursing home) settings or service organizations is still rare at least as far as studies are concerned where some form of random selection is used to select the sample. Obviously, it is very difficult to obtain permissions for systematically interviewing elderly residents or doing observational studies. Cooper et al. (2008) reviewed the literature on abuse by professional care providers and found that in nursing homes, 80% of the staff witnessed psychological abuse or physical violence by professional care providers, 40% of the staff admitted to psychological abuse, and 10% admitted to physical violence.

Anyhow, there can be little doubt that nursing home staff may abuse elderly persons who display aggressive behaviors. Two types of nursing home staff abusers, the reactive and the sadistic abuser, can be identified; the sadistic nursing home abuser intentionally and systematically abuses residents of nursing homes, while the reactive abuser has—for whatever reasons—either never developed or has lost immunity to residents' aggressions and thus reacts to immediate situations of aggressive behavior in abusive ways (Goodridge, Johnston, & Thomson, 1996; Shaw, 2004). The nursing home environment may also contribute to elder abuse and neglect, especially inadequate numbers of staff. There is a growing body of research dealing with the ethical dilemma, as nurses are caught between their intentions to fulfill professional standards, while concurrently attempting to safeguard and maintain their own rights to personal safety (Enmarker, Olsen, & Hellzen, 2011; Needham, 2006).

Definitions of Elder Abuse

According to the overall definition by the World Health Organization, elder abuse is "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" (WHO, 2002).

Despite such laudable efforts, there is still a lack of consensus in defining and measuring elder abuse and its major subtypes. In addition to legal differences among different countries, the recognized experts in the field themselves continue to disagree on definitions. Consequently, different definitions among the various groups of gerontological experts and professionals may potentially lead to difficulty in intervention and treatment. Apart from the most obvious cases of physical mistreatment, behaviors such as neglect, self-neglect, financial exploitation, isolation, or sublime forms of threats are included or excluded. Furthermore, creating valid and reliable operational definitions of elder abuse in survey designs presents an additional challenge (Anetzberger, 2005; Dixon et al., 2010).

Until now, elder abuse has been defined primarily by health-care professionals, service providers, and researchers. In its extreme form, the narrow perspective of elder abuse includes only incidents which encompass physical injuries and, possibly, certain unwanted behaviors like making serious threats. Of course, the more occurrences we include, the more we are confronted with the problem of unclear boundaries.

Older people have had little input when defining the problem of elder abuse—quite in contrast to the case of domestic violence, which was defined by women themselves focusing on the feminist paradigm of gender or power dynamics (Harbison, 2017; Straka & Montminy, 2006).

Yet, recently there is a growing body of studies and reports where the elderly were asked to define elder abuse themselves (Moon & Benton, 2000; Mowlam, Tennant, Dixon, & McCreadie, 2007; WHO, 2002). Definitions given by elderly persons (and also by lobby organizations) tend to be rather broad. For example, widespread feelings of discrimination in everyday life and the loss of respect, especially in intergenerational relations, are expressed frequently by older people in focus group discussions. For them, violence means to be situated uncomfortably on the perimeters of society (Hörl, 2007).

The broadest perspective of elder abuse was developed employing the concept of "structural violence" (Galtung & Höivik, 1971), which extends beyond direct physical and psychological harm to include indirect actions. In this understanding, elder abuse is a built-in feature of societal systems and can be detected in unequal power relations and unequal opportunities in life. This includes—but at the same time goes far beyond—violent acts in the usual sense, and there is an obvious connection to the problems of age discrimination, marginalization, and the ageism debate in general. The concept draws attention to the role that institutions and social practices play in preventing people from meeting their basic needs or realizing their human potential. Furthermore, the concept of structural violence can be used to identify the heavy workloads, low levels of decision-making autonomy, low status, rigid work routines, and insufficient relational care as forms of violence in institutional settings. Not only are these poor working conditions experienced as sources of suffering, but they prevent care workers from providing the kind of care they know they are capable of.

Subtypes of Elder Abuse

For practical reasons, the following subtypes of abuse as defined by the US Centers for Disease Control and Prevention (2015) may be considered.

Overall abuse might consist of any combination of

- Physical abuse: when an older person is injured as a result of hitting, kicking, pushing, slapping, burning, or other show of force.

- Sexual abuse: involves forcing an older person to take part in a sexual act when the elder does not or cannot consent.
- Psychological or emotional abuse: behaviors that harm an older person's self-worth or well-being. Examples include name-calling, scaring, embarrassing, destroying property, or not letting the elder see friends and family.
- Financial abuse: illegally misusing an older person's money, property, or assets.
- Neglect: failure to meet an older person's basic needs. These needs include food, housing, clothing, and medical care.

Most studies of prevalence coincide that among those abuse subtypes, the highest frequencies are found for psychological abuse, followed by financial abuse, neglect, physical abuse, and sexual abuse. Interestingly enough, Yon et al. (2017, p. e153) found in their meta-analysis no significant difference in prevalence between older women and older men as victims.

Risk Factors for Elder Abuse and Neglect

As far as risk factors in family and community settings are concerned, substantial evidence exists for the importance of the following factors, as summarized by Lachs and Pillemer (2004, p. 1265): first, a shared living situation is a major risk factor for elder abuse and people living alone are at lowest risk (except financial abuse). Increased opportunities for contact—and thus conflict and tension—occur in a shared living arrangement.

Second, a string of studies have reported higher rates of physical abuse in patients with dementia than in people without this disorder. A likely mechanism is the high rate of disruptive and aggressive behaviors of patients, which are a major cause of stress and distress to caregivers and which can provoke them to retaliate. Caregivers, who might be old themselves, can also be victims of assault by demented relatives.

Third, social isolation has been identified as characteristic of families in which elder abuse occurs. Victims are more likely to be isolated from friends and relatives (besides the person with whom they may be living) than non-victims. Social isolation can increase family stress, heightening the potential for abuse. Furthermore, behaviors that are illegitimate tend to be hidden; the presence of other people can lead to intervention and sanctions.

Fourth, there is agreement that pathological characteristics of perpetrators, particularly mental illness and alcohol misuse, contribute to elder abuse. A history of mental illness seems to be more common among those who commit elder abuse than in the general population. Depression is observed as a common characteristic of elder abusers. Alcohol misuse by perpetrators also seems to be a significant risk factor for elder abuse.

Finally, people who commit elder abuse tend to be heavily dependent on the person they are mistreating. Abuse results in some cases from attempts by the relatives (and especially adult offspring) to obtain resources from the victim. Moreover,

situations have been identified in which a tense and hostile family relationship is maintained because a financially dependent son or daughter is unwilling to leave and thus lose parental support.

In discussing risk factors, it is of utmost importance to remember the diverging initial situations of family and professional caregivers.

Firstly, most informal and family caregivers are still very poorly educated in regard to illnesses like Alzheimer's disease, and they cannot interpret erratic or violent behaviors by the patient correctly; secondly, family members cannot escape the situation easily and move to a less stressful "workplace." The research on family caregiving usually circles around topics like stress-related disorders, depression, feelings of being trapped, the loss of quality of life, alcoholism, etc. Most importantly, of course, is the fact that families are structured as long-standing interactive systems with a high degree of mutuality and reciprocity. However, rewards or retributions need not be returned immediately or in the same manner. Due to the special features of family life, we have to be cautious so as not to misinterpret supposed cases of, for example, financial abuse, prematurely. Family exchanges often follow along rather tortuous paths; however, outright theft or deception is rather seldom.

On the other hand, the professional and expert discourse in the health and social service sectors often centers on intraorganizational problems, especially on poor workplace conditions in nursing homes and other facilities of long-term care, such as understaffing, burnout as a response to chronic emotional and interpersonal stressors encountered on the job, lack of quality assurance, overuse of uneducated personnel, and other factors (Buzgová & Ivanová, 2009; Hawes, 2002). Health and nursing care professionals normally stress that certain actions they have to perform (e.g., bathing, toileting, dressing and feeding the residents, or providing tranquilizing medication) are always legitimate and cannot be considered violent or abusive as long as these are in accordance with acknowledged professional standards even if residents subjectively may feel otherwise. Another prominent example is the use of physical restraints, such as bedrails or electronic tagging and locking devices to prevent cognitively impaired patients from running away (Hamers & Huizing, 2005).

Victim-Focused vs. Perpetrator-Focused Approaches

As far as the question of an adequate societal response to elder abuse is concerned, the problem arises whether a victim-focused or a perpetrator-focused approach is more appropriate for gaining a true picture of assigning responsibilities and for implementing intervention practices (Bergeron 2001).

The victim-focused approach stresses the safety needs of older persons. Especially the frail elderly are regarded as highly vulnerable and as potential victims in danger of being harmed. The victim is the primary client, not the entire family, thus ignoring relationally based factors and characteristics. The perpetrator's motivations or personal difficulties are only a matter of secondary importance, if at all.

Consequently, "using monies allocated to elder abuse prevention to promote messages to caregivers about reducing stress is a misuse of the limited funding there is to address elder abuse, and may have minimal impact on preventing harm to older adults" (Brandl & Raymond, 2012, p. 37). Before all other possible further considerations, the abuse has to end. At the same time, it is up to the victims if they want to continue to have a relationship with their abuser. Within a victim-focused approach, the victim's needs consistently remain the highest priority in planning care. Recent Austrian research (Hörl, 2009) found that a majority among professionals—especially those working in the fields of violence intervention and counselling—denies strongly that the victims' (aggressive) behavior is of any significance for their victimization, in the sense that they participate somehow in becoming victimized by overstating or exaggerating complaints or accusations.

In the partnership with the victim, the professionals are required to be careful not to use their power in the relationship as abusers do; a one-size-fits-all intervention approach across all clients would not be feasible (Burnes, 2017; Hightower, Smith, & Hightower, 2006; Spangler & Brandl, 2007).

As an example for the ever-increasing significance of elderly persons as potential victims, it may be cited that recent consumer protection legislation in Austria clearly has been designed with elderly victims in mind, even if this cannot be declared publicly because of the constitutional principle of equality (Ganner, 2014). It has also been argued that in civil and criminal law, there has also been a paradigmatic shift toward a more pronounced victim-focused jurisdiction not least because of altered gender roles (Brammer, 2007; Connolly, 2010; Heisler & Stiegel, 2004; Malley-Morrison, Nolido, & Chawla, 2006; Penhale, 2008). As recently as two decades ago, such a victim advocacy approach was inconceivable; at that time the victim was considered a piece of evidence or maybe heard as a witness and nothing else.

Clearly, there is a certain parallel to be observed between the victim-focused approach in elder abuse and the (feminist) domestic violence paradigm. Actually, there are proposals of merging domestic violence and elder abuse paradigms, grounded in the alleged fact—which is strongly disputed by other scholars—that women are overwhelmingly more likely than men to be victims of domestic violence at all ages (Freysteinson, 2011; Straka & Montminy, 2006).

Those who advocate a victim-focused approach have a double agenda when working with victims of abuse in later life. As said before, first of all, they wish to provide a safe environment, emotional support, counselling, information, access to medical and social services, etc. In applying empowerment principles, it is recognized that the victims are the best to judge their own lives and they are encouraged to make an informed choice about future steps.

Secondly, in addition to the focus on the safety needs of the individual older person, the advocates of the victim-focused approach are regularly committed to a wider political agenda by promoting victim rights on a societal level. The rationale for this attitude can be found in the underlying power and control dynamics of society, which allegedly discriminate old persons systematically. They strive to extend their concerns of raising public awareness of (gender-related) power relations to all

age groups. In this context, they regard it as useful to concentrate on one special form of abuse in later life, which is the phenomenon called "aging out" of violence; here, older women stay in abusive relationships because they feel a commitment to take care of partners despite the fact that they had been abusive for years. The dynamics and risk factors of mistreatment remain the same regardless of age (Ansello & O'Neill 2010; Band-Winterstein & Eisikovits, 2009; Freysteinson, 2011; Straka & Montminy, 2006).

Victim-focusing requires being on the victim's side unequivocally on all individual and societal levels. Now, when someone strongly pursues a political agenda, it is not advisable to show a kind of wishy-washy empathic attitude toward everyone, including the worst offender. Quite the contrary, it is recommendable to highlight the "structural" gap or dichotomy between the perpetrator and the victim. Under this point of view, any suggestion of seeing caregiver stress (see the following paragraph) as a primary cause of abuse has unintended and detrimental consequences that affect the efforts to end this widespread problem (Brandl & Raymond, 2012).

On the other hand, the perpetrator-focused approach places much more attention and sympathy on the motivations of the offenders and the specific circumstances in the different environments where violence happens. For example, Anetzberger (2000) proposes a model where elder abuse is primarily a function of the perpetrator's characteristics and secondarily a function of the victim's characteristics. Caregiving serves as a contextual framework for victim-perpetrator interaction. The dynamics related to caregiving, including the victim-perpetrator interaction and the situation, along with other contexts, such as intimate relationships, isolation, and accessibility to valuables, trigger abuse. It may be expected that a greater understanding of the victim-perpetrator relationship and the characteristics of abusers, victims, and incidents can help to identify proactive responses for abuse prevention. For instance, when domestic violence among an elderly couple occurs, it can include mutual combative situations. Both parties are thus guilty of contributing to the violent incident.

As mentioned, the strongest connection is between the perpetrator-focused approach in elder abuse and the caregiver stress overload paradigm. Basic to this paradigm is the effect on the caregiver from providing long-term care to a physically or mentally impaired elderly person. This caregiver effect becomes stress that may result in the caregiver becoming overburdened. Other factors of the caregiver are important, such as his or her coping skills, perception of burden, the voluntary nature of the caregiving role, isolation of the victim, and lack of supportive services (Bergeron, 2001; Pillemer & Finkelhor, 1989; Sengstock & Hwalek, 1986). Of course, this theory is strongly associated with caregiving provided by informal caregivers such as adult children or spouses.

An often-cited illustrative case example is the husband suffering from Alzheimer's disease—exhibiting volatile and dangerous behaviors—and his wife caring for him (Ramsey-Klawsnik, 2000). In the end, she becomes overwhelmed and sometimes turns abusive, verbally or otherwise. Violent reactions can never be justified, but it is understandable nonetheless, if one holds compassionate feelings for a caregiver

who exhibits good intentions while being overburdened. Quite frequently, abusive family caregivers admit to a temporary loss of control leading to acts of inappropriate behavior, like scolding or isolating the person being cared for. (See also the section on risk factors.) At the same time, they tend to trivialize as an unpleasant, but occasionally unavoidable, aspect of "normal" family life under such difficult circumstances. Violent behavior itself is not condoned, but the question of responsibility for abuse becomes much more blurred or is left latently resting in the background altogether (König & Leembruggen-Kallberg, 2006; Lee, 2008; Moon & Benton, 2000). Of course, advocates of this approach try to avoid any suggestion of a reversal of responsibility, but it becomes quite obvious that sort of a "two-victim theory" is assumed and the unintentional character of such "derailed or misspent care" (De Donder et al., 2011, p. 131) when the amount of needed care exceeds the capacity of the caregiver to provide this is emphasized.

The impression cannot be easily resisted that those who employ a perpetrator-focused approach (usually in combination with the caregiver stress concept) show a certain attitude of relativism and even leniency toward offenders. The result is a model where dependent elderly persons who often enough exhibit severe behavioral problems like aggressive acts are cared for by caregivers who are doing their job as best they can and are sometimes even sacrificing themselves. They are left behind by society, however, and are therefore always on the brink of a breakdown. Professionals who are active in the fields of social welfare, medical services, and ombudsman or self-help groups express a certain degree of sympathy toward this view (Hörl, 2009; Sandvide, Fahlgren, Norberg, & Saveman, 2006; as mentioned, professionals from other fields employ a different, victim-focused view).

Of course, there is a thin line between doing social justice also to perpetrators and blaming the victim. Victim blaming occurs when the victim of an abuse is held responsible for the actions committed against them and is perpetuated by a couple of mechanisms. One of them is the just-world theory, originating in the Old Testament. The idea is that only bad things happen to people if they did something wrong to deserve it. People get what they deserve and victims are sinners.

Conclusion

Summarizing the pros and cons of the victim-focused and the perpetrator-focused approaches, both fail to address the systemic context in which elder abuse is allowed to occur. Each model does in its own way encourage an acceptance of the victim-perpetrator dichotomy and does not take into account the complexity of personal relationships or the societal pressures and traditions that affect individuals inside and outside of institutions. Dow and Joosten (2012, p. 853) rightly emphasize that the "danger of limiting understanding of abuse to include only those actions that are perpetuated at the individual level upon vulnerable elders is that it runs the risk of also limiting our view of older people. Rather than seeing older people as having distinct identities and a variety of valuable roles that they fulfill in society, elders

are seen only in regard to the aspects of their self that may be protected from or suffer abuse."

For analytical purposes, empirical studies in elder abuse usually employ a perpetrator-victim dichotomy, too. A person may be considered having been victimized or not and having abused or neglected or not. Especially in caregiving, however, interaction processes are of great importance, and elder abuse is normally embedded in complex intimate interactions. It is well known that professional staff in old age institutions or social services as well as family caregivers are frequently confronted with verbal or physical aggression, like spitting or yelling, noncompliance with care needs, deviant behaviors, etc., often caused by cognitive impairments. Thus, violence has become an everyday experience for many nurses and family caregivers. Due to the fact that the act committed by the elderly perpetrator is perceived as being unintentional, it is often not worth reporting. Consequently, there is a lack of awareness about the possible psychological effects of such aggressive assaults, e.g., the high levels of distress (Shinan-Altman & Cohen, 2009). Of course, any acts of retaliation must be regarded as misdemeanor. There can be no excuse for "taking the law into one's own hands." It is no easy task gaining a balanced, nondiscriminatory assessment and proposing adequate intervention measures, since the parties and stakeholders involved often enough exhibit high degrees of "ideological" commitments and uncompromising views with regard to the cause of elder abuse.

Discussion Questions

1. At what age are people considered to be "older" victims?
2. How can the definition of what constitutes elder abuse be improved?
3. Which perpetrators under what circumstances can be considered in a position of trust?
4. To what degree a difference exists between elder abuse victims and crime victims?
5. How can risk profiles for both victims and perpetrators be improved?
6. How does cognitive impairment affect elder maltreatment investigations (e.g., regarding testimony of victims)?
7. How can better mechanisms be created whereby researchers can gain access to victims and perpetrators (in community and institutional settings)?
8. Are there differences between cultural and ethnic groups in defining or excusing elder abuse?
9. What evidence-based strategies can be developed to improve the evaluation of existing elder maltreatment intervention and training programs?
10. Contrasting the victim-focused intervention approach with the perpetrator-focused intervention approach: which approach holds the most promise for the prevention of elder abuse?

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