THE PERPETRATOR-VICTIM DICHOTOMY IN ELDER ABUSE RECONSIDERED

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Broad and narrow definitions of elder abuse

- It has been stressed every so often (e.g. Straka & Montminy 2006) that older people have had no input when defining the problem of elder abuse. Allegedly, elder abuse has been defined by health care professionals, service providers, and researchers.
- This view is only partially true:
  1. The professionals and gerontologists do not agree on the conceptualizations of elder abuse.
  2. There is a sufficient body of studies where the elderly – admittedly, not necessarily the victims themselves, but peers on their behalf – are asked to define elder abuse. Consultations with NGO's are finding their way into governmental documents.
- Principally, definitions employed by professionals and researchers tend to be rather *narrow* and definitions employed by the NGOs and the elderly themselves tend to be rather *broad*.

- ***Broad*** definitions often include “structural violence”, meaning that elder abuse is a built-in feature of societal systems. There are close connections to the political problems of age discrimination and the ageism debate in general.
- In its extreme form the ***narrow*** definition only includes incidents with physical injuries and, possibly, making serious threats. Obviously, the more occurrences we include, the more we are confronted with the problem of unclear boundaries.
- From the perspective of health care professionals all actions they perform are legitimate and cannot be considered violent or abusive as long as in accordance with professional standards, e.g. use of physical restraints.
- Most informal caregivers for older family members admit to a temporary loss of control leading to acts of inappropriate behaviour, like scolding. At the same time, they tend to trivialize violence as an unpleasant, but occasionally unavoidable, aspect of “normal” family life under the difficult circumstances of long-term care.

From definition problems to the perpetrator-focused vs. victim-focused debate

- The ***broad*** definition of elder abuse is more easily reconcilable with the victim-focused approach, since more or less every older person is regarded as vulnerable and as a potential victim.
- There is a parallel between the victim-focused approach and the feminist domestic violence paradigm. Actually, there is a discussion of merging domestic violence and elder abuse paradigms (Freysteinson 2011).
- The ***narrow*** definition of elder abuse is more easily reconcilable with the perpetrator-focused approach because the concrete acts of violence – the motivations of the offenders and the circumstances in the different environments where violence happens – are gaining more attention.
- There is a parallel between the perpetrator-focused approach and the caregiver stress paradigm. No reversal of guilt but a "two-victims-theory" is assumed.

Policy consequences of the perpetrator-victim debate

- Advocates of the victim-focused approach in later life have a double agenda:
  - Providing a safe environment, emotional support, counselling, access to medical and social services, empowerment.
  - Commitment to a wider political agenda by promoting victim rights; raising public awareness of gender-related power relations to *all* age groups ("ageing out" of violence).
- Advocates of the perpetrator-focused approach (usually in combination with the caregiver stress model) employ a certain attitude of relativism toward offenders:
  - The professional discourse in the health and social service sectors often centres on intra-organisational problems, especially on poor workplace conditions, such as understaffing, burnout etc.
  - Narratives by informal family caregivers usually circle around topics like stress-related disorders, depression, feelings of being trapped etc.

Institutional and family settings: similarities and differences

- In institutional settings, resident-to-personnel violence is an everyday experience. Staff is regularly confronted with aggressive behaviours; perceived as being unintentional it is often not worth reporting despite high levels of distress. Retaliation is unprofessional; nonetheless, there is evidence that reactive abuse happens regularly leading to an ethical dilemma.
- For family settings numerous models to explain elder abuse have been developed; the caregiver stress model is the most prominent.
- Three important differences between institutional and family caregiving:
  1. Most informal and family caregivers are still very poorly educated.
  2. Family members cannot escape easily and move to another “workplace.”
  3. Families are long-standing interactive systems with a high degree of reciprocity. Rewards or retributions need not be returned immediately or in the same manner.

Expert survey data on the perpetrator-victim debate

- ***Is there a relationship between type of agency or organisation where the experts are employed or operate and the experts' perception of responsibility for elder abuse?***
- Online, Austria, 2008, n=247, median age: 49 yrs., 70% female/30% male.
- Four categories of agencies or organisations
  1. self-help groups; seniors' organisations
  2. local authorities; ombudsman
  3. social welfare services; medical services
  4. violence intervention centres; victim counselling services.
- Each expert only was requested to evaluate the perpetrator-victim interactions within the settings where she/he possesses detailed knowledge, professional expertise, and practical experiences; consequently, sample size was reduced, based on variables analysed.

- *Do victims of elder abuse somehow "participate" in becoming victimized in the course of the interactions between perpetrator and victim?*
- *To which extent can complaints or accusations by elderly victims be regarded as overstated or exaggerated?*
- Both questions were asked with regard to institutional and family settings.

Table 1: Mean scores (standard deviations) as a function of type of expert group

	Type of expert group			
	Self-help groups; seniors' organisations	Local authorities; ombudsman	Social welfare services; medical services	Violence intervention centres; victim counselling services
"Participation" of victims (institutions)	3.33 (.922) n=30	3.53 (.862) n=38	3.40 (.927) n=53	4.15 (.784) n=26
"Participation" of victims (families)	3.08 (.969) n=38	3.14 (1.079) n=28	3.15 (.887) n=59	3.81 (.833) n=42
"Exaggeration" of complaints by victims (institutions)	3.08 (.712) n=38	3.07 (.818) n=44	3.13 (.771) n=55	3.43 (.676) n=21
"Exaggeration" of complaints by victims (families)	3.18 (.652) n=38	3.20 (.610) n=30	3.20 (.730) n=55	3.73 (.924) n=44

Lowest possible score is 1 and highest possible score is 5 per category. The lower the score, the more frequently "participation" of victims and "exaggeration of complaints" by victims is perceived by the respondent. "Don't knows" are omitted.

Conclusions

- Experts who are active in violence intervention and counselling agencies adhere strongly to the victim-focused approach in elder abuse.
- Plausibly, their everyday experience is primarily shaped by domestic violence against younger and middle-aged women and they are transferring their basic commitment to a perpetrator-victim dichotomy to elder abuse cases as well.
- All the other experts employ a more cautionary and moderate attitude. Their response patterns are rather similar, which is surprising considering the fact that their organisational and professional backgrounds are quite different.
- It may be speculated that these experts are in a dilemma between feeling empathy for both the abused and for the presumably overwhelmed caregivers. Many of these experts are frequently confronted directly with caregiver stress problems.
- Finally, it is interesting to note the high proportion of experts who cannot or are not willing to evaluate these questions, non-response amounts to roughly 24% of all the groups taken together. This restraint may reflect the experts' ambivalence in passing any judgement in a highly sensitive area.