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# 5

## **How older persons explain why they became victims of abuse**

This chapter is based on the manuscript:  
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why they became victims of abuse. Under review.

### **Abstract**

Elder abuse greatly impacts the quality of life of older individuals. Worldwide, prevalence rates range from 3 to 30% depending on the definition used. Only few studies have explored how older victims themselves experience and explain abuse. Healthcare professionals are among the most important groups to handle and report abuse and it is therefore essential that they know the perceptions of older victims. A qualitative study on perceptions and experiences among victims of elder abuse was conducted using in-depth semi-structured interviews. Abused individuals, six males and eleven females aged 63 to 90 years, lived independently, in residential care facilities and nursing homes. The main causes of abuse identified by older victims themselves were mutual dependency between victim and perpetrator, power- and control-imbalances, loneliness and a marginalized position of older persons. Effects of abuse included negative feelings, physical and psychological complaints, a change of personal norms and values, a different outlook on money, and low self-efficacy. These differential effects seem to depend on the types of abuse experienced and the relationship with the perpetrator. Coping strategies as mentioned by victims were seeking informal or professional help and using self-help strategies. Older victims perceive abuse differently depending on the expected acceptability of the type(s) of abuse experienced and the expected stigma associated with the perpetrator involved. The effects and chosen coping strategies are influenced by these considerations and therewith also influence their help-seeking behaviour. Healthcare professionals are encouraged to use these findings in practice to detect, prevent and intervene in elder abuse.

*Key words:* elder abuse, causes, effects, coping strategies, qualitative research

## Introduction

The perspectives of victims of elder abuse are not prominently present in existing literature. The majority of research on elder abuse focuses on theories of elder abuse, definitions, prevalence, types, risk factors, and prevention and intervention strategies (Anetzberger, 2004; Bennett, Kingston, & Penhale, 1997; Biggs, Phillipson, & Kingston, 1995; Comijs, 1999; Cooper, Selwood, & Livingston, 2008; Dong, 2012; Kurrle & Naughtin, 2008; Mysyuk, Westendorp, & Lindenberg, 2013; O’Keefe et al., 2007; Penhale, 2008; Peshevska, Sethi, & Serafimovska 2014; Pot, van Dyck, Jonker, & Deeg, 1996). Remarkably, within this growing body of literature only a few dozen studies explore and discuss elder abuse in the “eye of the beholder” (Comijs, 1999; Chen, Dolinsky, Doyle, & Dunn, 1981; Hurme, 2002; Comijs, Pot, Smit, Bouter, & Jonker, 1998; Pillemer & Prescott, 1989; Pritchard, 2000; Wolf & Pillemer, 1989; Yan & Tang, 2001, 2004; Yu, Zhang, Draper, Kassab, & Miles, 1997). Even less studies have researched the conceptualization of victims, and current knowledge relies much on individual case-studies Hightower, Smith & Hightower, 2006; Pillemer & Prescott, 1989; Pritchard, 2000, 2001; Sandmoe & Hauge, 2014; Thomas, Scodellaro, Dupree-Leveque, 2005; Wolf & Pillemer, 1989).

The insights of victims themselves are especially important to address, as explanations of victims should line up with our understanding of the occurrence of abuse to develop appropriate preventive measures, to establish methods for detection and to initiate fitting interventions. For older individuals, healthcare professionals are among the most important groups to identify and to report elder abuse, but they are lagging behind in the identification and reporting of abuse. Only a small proportion of cases are reported (Ahmad & Lachs, 2002; Rodriguez, 2006; Cooper, Selwood & Livingston, 2009).

To enhance the understanding of healthcare professionals and their modes of detection and intervention, in this article we shed light on how older victims experience, perceive and explain the process of abuse. We discuss the ideas of victims on the causes, consequences and effects of abuse, ways of coping with abuse and explore how victims think about what occurred to them.

## Methods

A qualitative study on perceptions and experiences of elder abuse was conducted in the Netherlands among abused older persons. The method of data collection was in-depth semi-structured interviews with six older men and eleven older women in the age range of 63 - 90 years. Thirteen participants lived independently and four lived in residential care facilities or nursing homes. The male respondents were formerly employed in the field of finance, accounting or management. Four out of the eleven female participants had earlier worked as tailors or housekeepers; others had no professional experience and did not attend higher education. Participants in this research were fully informed of the purpose of the interviews and their contribution was completely voluntary. Respondents received a notebook as token of appreciation.

Six victims of elder abuse were recruited through advertisements in freely distributed local newspapers. Eleven were contacted via elder advisors and welfare managers who work in healthcare institutions or support centers of domestic violence. The main inclusion criterion was experience with any type of abuse. Some weeks before the interview, these contact persons asked older victims to participate in the study. When interested, the primarily responsible researcher contacted them personally. After a full explanation of the purpose of the research by phone, appointments were made for a place and time to meet as chosen by the interviewee. Before the interview, informed consent was obtained (confidentiality and anonymity were guaranteed) and permission for recording was given by all interviewees. All the participants were considered to be cognitively intact and had capacity to consent to involvement in the study. We did not ask for permission from the medical ethical committee because it did not concern patients, but we did adhere to the ethical standards as subscribed by the designated professional associations of anthropologists, in particular American Anthropological Association (AAA) and European Association of Social Anthropologists (EASA). In this article we have used pseudonyms for all informants.

The in-depth interviews were held with guidance of an interview guide as developed by the researcher. The interview guide was based on existing research literature on elder abuse. Five pilot interviews were held with older persons prior to present study and the interview guide was adjusted where necessary. The main topics of the interview were: demographic and social background; health status and daily life; care; experiences with elder abuse (including description of abusive situation, feelings, coping, changes in life); social network and help and support; and social life. In line with semi-structured interview techniques, open questions were formulated and adjusted while interviewing to enhance applicability, understanding and clarity for individual respondents. The interviews lasted two to four hours and took place between September 2012 and December 2013.

Interviews were transcribed verbatim for analysis. Verbatim transcripts were then thoroughly analyzed using NVivo, a computer software program for qualitative data analysis. The approach used was primarily inductive, and the coding technique was based on the grounded theory approach (Glaser & Strauss, 1967) in which concepts are derived from the transcribed data. Initially key themes were separated in segments, then coded on the basis of conceptual analysis, from which main categories were developed that served as the basis for exploring, analyzing and discussing experiences and perceptions of the participants. This method of analysis gives the opportunity to explore different ways in which respondents explain their experiences and feelings; it also allows unexpected topics, thoughts and ideas to arise that would be neglected with a predetermined questionnaire.

## Results

Table 1 provides details on the abusive situations experienced by our interviewees. In our study, physical abuse encompassed intentional infliction of pain ranging from hitting or kicking to pushing. Psychological abuse included threatening, manipulating,

insulting, blaming, offending, intimidation and humiliation. Financial abuse involved spending the older person's money without their knowledge or permission, scams, and extortion. Neglect included denying the older person adequate care, nutrition, clothing or a clean environment.

Here we describe the main findings, these include causes, effects and consequences and coping strategies. In the Appendix D we present two case studies that allow for an in-depth understanding.

### Causes of abuse

*"I am dependent on care, I need help with some activities at home, also with finance, groceries...that does not put you in a strong and advantageous position, you are much more vulnerable and can easily become a victim...(Frank, 81 years)"*

*"I feel redundant because our society perceives me as such. I feel like there is a label "too old" in this society (Ingrid, 80 years)"*

One of the first elements in self-explanations of older victims was the cause of abuse. First, they reported that loneliness and social isolation played a role in elderly becoming a victim of abuse. For instance, they often relied heavily on the perpetrator and did not have much contact with other relatives or friends, resulting in a limited social support network. They felt that this had contributed to the abuse, because there was a lack of alternative contacts to turn to when the abusive situation occurred.

In addition, our interviewees felt dependent on others for care and activities of daily living, and this support made them accordingly vulnerable and easy targets for abuse. At the same time they felt that the perpetrator was also dependent on them, for instance for living or financial support and victims felt responsible to support the perpetrator, even while they were mistreated.

Related to this was another cause of abuse identified, the inequality in power and control in relations between victim and perpetrator. Our interviewees felt that feeling powerless and losing control over the situation triggered violence from the abuser's side, for example, when victims relied much on the perpetrator the power balance shifted towards the perpetrator. At the same time, victims felt that abuse could occur rather as a response to a lack of power of that same perpetrator and an inability to deal with the situation concerned, for instance, when victims did not grant the wishes of the perpetrator or were unable to meet their requests. Victims thought that by abusing an older person the perpetrator tried to restore power and control, ultimately regaining superiority within the relationship.

Finally, our interviewees felt that the marginal position of older persons in our society impacts upon abusive situations. In this regard, the interviewees mentioned notions such as disrespect and devaluation of older persons. Perceptions of older victims of being useless and "too old" (as sensitively expressed by Ingrid in her statement above) were part of their explanations for the occurrence of abuse in their life. They reasoned that this change in the position of older people and the

associated negative image created a realm of acceptance and permissiveness for using violence against older persons.

**Table 1**  
*Description of abusive situations of victims*

Type(s) of abuse	Age	Gender	Relationship perpetrator/victim	Duration of abuse	Seeking help	Coping strategy
Physical abuse	82	Male	Caregiver	3 months	After a couple of weeks	Professional help
Psychological abuse	65	Female	Partner	6 months	After 2-3 months	Informal help
Psychological abuse	72	Female	Partner	Abusive situation was ongoing		Self-help
Psychological abuse	74	Female	Granddaughter	2-3 months	After one month	Professional help, self-help
Financial abuse	76	Female	Son	4-5 months	After 1-2 months	Professional help
Financial abuse	80	Female	Acquaintance	Abusive situation was ongoing	After 2-3 months	Informal help, professional help, self-help
Neglect	90	Male	Partner	Abusive situation was ongoing		Self-help
Neglect	79	Female	Grandson	10 months	After 4-5 months	Informal help
Psychological and financial abuse	81	Male	Previously unfamiliar person	2 years	After a couple of months	Professional help, self-help
Psychological and financial abuse	84	Male	Daughter	Abusive situation was ongoing	After a couple of months	Self-help, professional help
Psychological and financial abuse	80	Female	Neighbor	8-9 months	After 2-3 months	Professional help
Psychological and financial abuse	77	Female	Granddaughter	One year	After 3-4 months	Professional help, informal help
Psychological and financial abuse	63	Male	Acquaintance	Abusive situation was ongoing	After 1-2 months	Professional help, self-help
Psychological and financial abuse	75	Female	Acquaintance	Abusive situation was ongoing		Professional help, self-help
Psychological and financial abuse	79	Male	Neighbor	Abusive situation was ongoing	After 2 months	Professional help, informal help, self-help
Psychological, financial and physical abuse	78	Female	Son	One year	After 6-7 months	Professional help, informal help and self-help
Neglect and psychological abuse	90	Female	Son	More than one year	After 4-5 months	Professional help, informal help



## Effects of elder abuse

*"This experience is shameful and humiliating. I felt stressed and at the same time desperate... (Iris, 79 years)"*

*"Times are changing, values and norms in society are different. It was normal to help your parents they said, but now my children are not doing this for me. They see me as not worth it, "as rubbish". I was treated like trash that has no feelings or thoughts (Adriana, 75 years)"*

According to the interviewees the experience of abuse has various consequences for an older person, which were related to the type(s) of abuse, but also to the expected nature of the relationship with the perpetrator. Foremost, and rather independent of type and perpetrator, were mentioned psychological effects after becoming a victim of abuse. These included shame, helplessness, humiliation, fear and anxiety resulting in feelings of stress and depression. Older persons felt desperate, frustrated and hopeless. These effects came forth out of feelings of incompetence to change the situation.

Related to these feelings was that victims blamed themselves resulting in low feelings of self-worth. For victims, it was difficult to comprehend that trusted individuals, especially in the case of relatives, had become the perpetrators of abuse. This breach of trust not only placed shame on the perpetrator, but also on the abused for "letting it happen", as one of the interviewees stated who had experienced psychological abuse involving a family member as perpetrator. Older persons believed that they had contributed some way or another to the abuse.

Within the scope of physical effects, in the present study we have understood this as both the physical effects of abuse itself, and health problems encountered during or after abuse. Older victims brought up health issues that they deemed related to the stress or anxiety they had experienced during or in the aftermath of the abuse. The physical complaints they mentioned included continuous stomach ache, incontinence, sleeping problems and loss of appetite.

Victims suffering from financial abuse described that they had changed their perspectives on money. They became more watchful and meticulous with money and valuable items than ever before. They believed this attitude could protect them from similar abuse in the future. Saving money gave them some feeling of security and certainty.

Some of the interviewees, in particular those who were abused by non-relatives, noted that the abuse had changed their norms and values, for instance, they distrusted kindness, good intentions and fairness of others. They felt betrayed and deceived. Losing trust in people led to stress and frustration and for some of them also to depressive feelings. Changes in norms and values – as a result of the abuse – had a negative impact on their notion of certainty in approaching (daily) life, as these norms and values represented a fundamental basis in their lives.



The interviewees often reported, implicitly and explicitly, a low self-perception with as a consequence a decrease in self-efficacy, especially in cases in which they had trusted non-relatives. Victims of abuse used self-descriptors such as “rubbish”, “stupid” or “idiot”. These notions created a sustained, negative image about themselves. As a result of a feeling of incompetence and the denunciation of themselves, older persons also experienced difficulties in decision-making. This was especially prominent in cases of psychological abuse as this type of abuse caused interviewees to become uncertain of their own capabilities. Some of the older victims had difficulty in assessing what they wanted, sometimes they described being reluctant to suggest or follow-up on ideas. Such behaviors evoked further irritation among the perpetrator and often led to more abuse.

### **Coping strategies**

*“I’ve made a survival plan for myself. I have to do everything possible to be able to deal with the abuse and to keep living...I’m trying to keep myself busy: reading and reading, walking a lot, cycling...It helps (Anne, 65 years)”*

*“I needed to deal with the situation. I was trying to seek help; I called public health service, the support center for domestic violence. They were open to help... My relatives also offered their support and that meant a lot to me... (Gerda, 77 years)”*

Older victims used different coping strategies. Some relied on themselves (self-help), others were seeking help and support from family members and friends (informal help) or from different institutions (professional help) amongst which were public health services, non-profit organizations, and support centers for domestic violence. Often the interviewees used different coping strategies at the same time (see Table 1). None of our informants sought help from health professionals from the cure and care sector such as a physician or (neighborhood) nurse. Most of the victims described asking for help when the abuse had reached an unbearable point and seeking help seemed to be the only way out. The interviewees who turned to professional help mostly experienced various types of abuse simultaneously, or were cases in which perpetrators were family members (children, partners) or close friends (see Table 1). When a close family member was involved in the abusive situation the period of abuse before asking for help was reported to be longer. Victims felt ashamed and described how they anticipated denunciation by the community for having close relatives involved and they also wished to protect those relatives. Suffering from financial abuse was the clear exception to this pattern; even the involvement of a close relative was not a strong barrier for seeking external help. The interviewees felt that financial abuse is a more widespread and therewith more publically discussed type of abuse. Interviewees expressed that financial abuse is considered “normal” and easier to talk about. It is thus less shameful to share your experiences with others and seek help, outsiders would understand.

Other interviewees used a different strategy, which we designate “self-help”. They tried to continue their lives and overcome the negative effects by keeping themselves busy with hobbies, work, and relaxation techniques. Unlike the older victims who sought help from professionals or family and friends, these interviewees thought that they could deal with the abuse and its effects by themselves. Some adhered to this strategy because they were afraid to lose contact with the perpetrator, or, were afraid to suffer even more abuse when they would seek help from outsiders. These victims typically experienced psychological abuse or neglect. The perpetrators in these cases were family members (see Table 1).

### Discussion

The findings reported here illustrate the process of abuse as it is experienced and perceived by older victims. We inferred the main causes of abuse, explained why it tends to continue according to the victims, and reported on the impact it had on their well-being and self-perceptions, and finally we discussed the strategies victims used in order to deal with the abusive situation.

Other studies that have reported on perceptions and experiences of older victims of abuse are in line with our findings. A qualitative study among abused older women also found, similar to what our victims reported, that an imbalance in power and control was an important factor in the occurrence of abuse (Hightower et al., 2006). The mutual dependency between victim and perpetrator has also been identified earlier (Mysyuk, Westendorp, & Lindenberg, 2015a, 2015b). We additionally identified that the negative image of “being old” influenced the victims’ perception of themselves. This also led victims to conclude that abuse is somehow permitted by perceptions in current society and contributing to abusive circumstances.

There is also another side that emerges from the stories of the older victims. In retrospect, they felt that they did not stand up for themselves and allowed perpetrators to continue the abuse. They described themselves as being compliant with the abusive situation, which sometimes provoked even more violence. Other older victims felt that the abusive situation was beyond their control and influence. These reactions of older persons resemble the phenomenon of learned helplessness in which victims of abuse feel helpless to change abuse, refrain from doing anything and accept any treatment (Miller & Seligman, 1975; Quinn & Tomita, 1997).

The differential effects of abuse we found in our study have been reported earlier (Chen et al., 1981; Hightower et al., 2006; Pillemer & Prescott, 1989; Yan & Tang, 2001). Quite similar to our study, it was found that older persons who experienced abuse reported psychological effects such as grief, anger, disappointment, psychological distress, anxiety, depression, and feelings of social inappropriateness, social isolation, deterioration in physical health, loss of independence, and financial loss (Comijs et al., 1998; Yan & Tang, 2001; Mowlam, Tennant, Dixon, & McCreadie, 2007). In contrast to other studies, we found two

effects of abuse that were not commonly identified earlier: a change in values and norms and a lower self-efficacy. This might be the result of the qualitative design of the study that we have used and allowed participants to freely express their feelings and to detail on the consequences they experienced.

The findings of our study show that our respondents used different strategies to cope with abuse and overcome its consequences. The use of distinctive coping strategies appears to be explained by the different types of abuse and by the different relationships to the perpetrators. Although less clearly relating these two factors in abusive situations, previous studies have shown that older persons used informal and professional help to cope with abuse (Comijs et al., 1998; Mears, 2003). Survival strategies identified among older women in Australia, such as blocking out the violence, pitting energy into another activity, resemble the self-help strategies found in current study (Mears, 2003).

### **Implications and Recommendations**

Healthcare professionals can use the findings from this study to detect and address elder abuse. Next to the commonly identified signs of abuse, they could pay closer attention to mutual dependency to detect high-risk situations for abuse. Healthcare professionals can play a vital role in the prevention and detection of abuse as older individuals frequently visit healthcare institutions. Moreover, special attention should be given to the social situation of a patient, especially relationships with informal caregivers and relatives and possible feelings of powerlessness, social isolation and low self-esteem. Together, picking up these kinds of signals could help in the (early) identification of abuse.

Besides the well-identified signs of abuse (Paris, Meier, & Goldstein, 1995), it would be advisable for healthcare professionals to consider an abusive situation, especially in cases of unexplained physical symptoms among the elderly, depressive symptoms and decreased feelings of self-esteem and self-efficacy. The latter might express in difficulties in making decisions and lack of motivation to engage in activities.

The differences in help-seeking strategies we observe seem to be associated with distinct feelings of shame and anticipated humiliation that are related to the different types of abuse and the relation between victim and perpetrator. Self-blame is an important element in this rationale. Healthcare professionals could aid older victims by discussing abuse in related, more neutral, terms (e.g. harm, unhappy, not well) and by discussing elder abuse more openly to reduce the stigma associated with most types of abuse. If suspicions of abuse cannot (yet) be discussed, a sign of attention can already help the victim, and alternative measures (e.g. expanding the social or care network) than direct intervention might alleviate the situation.

One of the possibilities to deal with lower self-esteem and self-efficacy among older victims is the organization of support groups for victims that will be coached and led by an experienced professional or peer. Older persons will be able

to share their experiences, the coping strategies they used and receive feedback and advice from other participants who had similar experiences. The participation in these groups could enhance members' sense of empowerment and belonging, which may itself have positive effects on self-esteem and mental health (Levy, 2000). These groups can include face-to-face conversations, empowerment training, and psychological support. Also trainings directed at assertiveness and self-support strategies can help older victims deal with abuse and the reduced self-efficacy we identified in this study.

### **Limitations**

The sample size in this study may be considered relatively small. Some of the findings can therefore not be generalized to the whole population of abused older individuals; however our primary aim was to identify variables that play a role in the experience of abuse. We did so by an in-depth exploration of the understanding of the experiences of older victims of abuse. Although the empirical features of the variables might be different in different cases, we did identify variables that influence the process of abuse according to victims' experiences.

We only used one method of data collection to identify variables, mainly because in-depth interviewing allowed the older victims to express themselves unhampered. Although triangulation of methods is always preferable, the enduring sensitivity of the topic and the accompanying shame prevented the use of alternative methods, such as focus groups, to further delve into the self-explanations of older victims.

One of the possible limitations was self-selection bias; we did not use any exclusion criteria. Due to the sensitivity and complexity of the researched topic, it was difficult to reach respondents and that is why all the victims who agreed to participate in the study were included. Considering that the aim was to find variables of importance, the selection of informants does not impact the variables themselves.

The participants of this study were not followed-up longitudinally, which excluded the possibility to check how they feel nowadays and how their life changed over time. Therefore it is difficult to talk about the prolonged effects of abuse. Future studies can look into this.

### **Conclusion**

Older victims perceive abuse differently depending on the expected acceptability of the type(s) of abuse experienced and the expected stigma associated with the perpetrator involved. The effects and chosen coping strategies are influenced by these considerations and therewith also influence help-seeking behavior. Healthcare professionals are encouraged to use these findings in practice and help to detect, prevent and intervene in elder abuse. Paying close attention to mutual dependency of victim and perpetrator, unexplained physical symptoms, feelings of depression and low self-efficacy next to the commonly identified signs of abuse

and discussing these signs in unobtrusive terms might enhance the identification of abuse by healthcare professionals.

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### **Conflict of Interest**

None declared.

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