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Ana João Santos

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Ana João Santos

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Violence against older adults: multidimensional perspective

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LIST OF TABLES AND FIGURES

TABLES

Part 1 – Background and conceptual framework

Table 1. Outputs 6
Table 2. Elder abuse theories 19
Table 3. Outputs and objectives 42
Table 4. Ageing and Violence surveys methods 43
Table 5. Variables included in the structured questionnaire of the two surveys of the Ageing and Violence project 45
Table 6. Abuse types and behaviours 46
Table 7. Studies conducted with data from the Ageing and Violence project 47

Part 2 – Empirical work

Chapter IV - *Psychological elder abuse: measuring severity levels or potential family conflicts?*

[Study 1] Table I. Distribution of the participants according to their sociodemographic characteristics and health variables 79
[Study 1] Table II. Prevalence rates of two measures for three psychological abuse behaviours 80
[Study 1] Table III. Evaluation of RRR in two groups of self-reported victims of psychological abuse 83

Chapter V

Estudo de validação em Portugal de duas versões reduzidas da Escala de Depressão Geriátrica [Portuguese validation study of two short versions of the Geriatric Depression Scale]

[Study 2] Tabela 1. Distribuição do sexo e idade nas duas amostras 102
[Study 2] Tabela 2. Sensibilidade e especificidade da GDS5 face ao IDB-II 104
[Study 2] Tabela 3. Correlações tetracóricas dos itens da GDS5 105
[Study 2] Tabela 4. Coeficientes de ponderação fatorial e variância de dois modelos confirmatórios da Escala de Depressão Geriátrica 106

Exploring the Correlates to Depression in Elder Abuse Victims: Abusive Experience or Individual Characteristics?

[Study 3] Table 1. Distribution of the participants according to their sociodemographic characteristics, health variables and reported violence types 122
[Study 3] Table 2. Bivariate analysis for predicting positive screening for depressive symptoms . 124
[Study 3] Table 3. Final model: covariates predicting the prevalence ratio of depressive symptoms 125

Chapter VI - *Older adults' emotional reactions to elder abuse: individual and victimisation determinants*

[Study 4] Table 1. Types of abuse and abusive behaviours included 145

[Study 4] Table 2. Demographic and health variables distribution 147

[Study 4] Table 3. Distribution of abuse variables: abuse type, polyvictimisation, severity and perpetrator 148

[Study 4] Table 4. Frequencies of the reported emotions and feelings elicited by the most serious violence incident 148

[Study 4] Table 5. Association between individual and abuse characteristics and evoked emotions 150

Chapter VII

From appointed perpetrators and abusive behaviours to victimisation patterns: new approaches to elder abuse typologies using two cross-sectional surveys

[Study 5] Table 1. Population-based and victims' surveys description (sample and data collection) 170

[Study 5] Table 2. Sociodemographic and health variables distribution of the participants from the two surveys 173

[Study 5] Table 3. Abusive behaviours and perpetrators distribution reported by the participants from the two surveys 174

[Study 5] Table 4. Items response probabilities (population-based survey) 176

[Study 5] Table 5. Sociodemographic and health variables of victims, conditional on class membership (N=245) 177

[Study 5] Table 6. Items response probabilities (victims' survey), conditional on class membership (N=510) 180

[Study 5] Table 7. Sociodemographic and health variables of victims, conditional on class membership (N=510) 181

Personal stories within elder abuse: betrayed trust in a vulnerable age and abusive bonds that just grown old

[Study 6] Table 1. Description of participants by gender, age, relationship with the perpetrator, and type of abuse reported 198

Chapter VIII - *Maus Tratos e Negligência da Pessoa Idosa: Modelos Teóricos e Intervenção [Mistreatment and neglect against older adults: theoretical models and intervention]*

Quadro 1. Síntese dos modelos de intervenção nos maus-tratos e negligência sobre as pessoas idosas 223

Quadro 2. Síntese das etapas de intervenção no modelo de gestão de casos 237

FIGURES

Part 1 – Background and conceptual framework

Figure 1. Elder abuse conceptual model 36

Part 2 – Empirical work

Chapter IV

[Study 1] Figure 1. Frequency of the three assessed psychological abuse behaviors 80
[Study 1] Figure 2. Frequency of three psychological abuse behaviors by perpetrator 81

RESUMO

A primeira referência teórica à violência contra pessoas idosas surge em 1975 sob a nomenclatura “Granny Battering” e, desde então, a literatura científica sobre a violência tem sido dominada por controvérsias em torno dos conceitos, definições e modelos teóricos utilizados para a descrever e analisar. Parte das dificuldades de desenvolvimento concetual têm sido atribuídas à sua multidimensionalidade. A violência contra as pessoas idosas remete-nos para um fenómeno que pode ser estruturado em diferentes dimensões consoante o foco de estudo (e.g., tipos de violência, vítima, agressor e contexto), e o seu desenvolvimento teórico e concetual tem convivido com a dificuldade de englobar as diferentes categorias de cada uma das dimensões (e respetivas possíveis apresentações do fenómeno) em conceptualizações suficientemente objetivas para a sua operacionalização e, consequentemente, para a sua validação empírica.

Esta tese reconhece que a multidimensionalidade é um aspeto essencial para a compreensão da violência, uma vez que as experiências de vitimização se caracterizam, definem e compreendem na confluência entre atos abusivos ou violentos, vítima, agressor e contexto. Tendo em conta esta premissa, a tese apresenta uma série de estudos que visam, globalmente, descrever a multidimensionalidade da violência contra pessoas idosas a residir na comunidade, e fornecer uma descrição de possíveis apresentações do fenómeno que tenham em conta mais do que uma das suas dimensões. Após uma breve revisão da história de investigação, onde se descreve como o problema foi inicialmente contextualizado e o desenvolvimento concetual até à inclusão da perspetiva multidimensional (capítulos I e II), são apresentados os estudos empíricos que resultam de uma análise secundária dos dados do Projeto “Envelhecimento e Violência”, desenvolvido entre 2011 e 2014 no Instituto Nacional de Saúde Doutor Ricardo Jorge.

No estudo apresentado no capítulo IV, avaliamos a utilização de duas medidas para a mensuração da violência psicológica, refletindo sobre a inclusão de dinâmicas familiares conflituosas na estimação da sua prevalência. O capítulo V inclui dois estudos. O primeiro apresenta as propriedades psicométricas para Portugal de duas versões curtas da Escala Geriátrica da Depressão (Geriatric Depression Scale), as quais demonstraram ser instrumentos apropriados para avaliar a sintomatologia depressiva na idade avançada. O segundo estudo do capítulo V propõe uma análise aprofundada da relação entre sintomas depressivos e violência, examinando a associação com as características dos indivíduos e diferentes dimensões da vitimização. No capítulo VI, descrevemos as principais emoções evocadas por vítimas de violência e analisamos a sua associação quer com características individuais, quer com diferentes dimensões da vitimização. Os

dois estudos seguintes procuram descrever e caracterizar a multidimensionalidade da violência contra as pessoas idosas (capítulo VII): o primeiro estudo utiliza a análise de classes latentes para categorizar a ocorrência de violência em subgrupos ou classes, de acordo com duas dimensões - atos de violência e a natureza da relação entre vítima e agressor; o segundo estudo, com uma abordagem qualitativa, examina as narrativas e a perceção de vítimas de violência. O tipo de relação mantida entre vítima e agressor é considerado elemento chave a partir do qual também se examina o processo de envelhecimento e a sua interação para a ocorrência de violência. De um modo geral, os resultados dos diferentes estudos sugerem: (i) que a violência contra pessoas idosas constitui um constructo que integra fenómenos distintos (por exemplo, violência doméstica envelhecida e negligência) que partilham de aspetos comuns; (ii) que a violência contra pessoas idosas é melhor caracterizada considerando simultaneamente diferentes dimensões (ou seja, contexto, relação entre a vítima e agressor, atos de violência e padrões de severidade); (iii) a natureza da relação entre vítima e agressor é uma das dimensões mais relevantes, seguindo-se a severidade e o tipo de atos de violência; (iv) a interligação entre as diferentes dimensões potencia a apreensão da natureza e dinâmicas das diferentes configurações de violência. No capítulo VIII (contributo para a tese sob a forma de capítulo do Manual “Vítimas de crime e violência: Práticas de intervenção”) reconhece-se a dificuldade de desenvolver uma única intervenção e através de um caso prático estima-se o impacto que a natureza da relação entre vítima e agressor poderá ter na adequação das respostas.

No seu conjunto, os seis estudos e a revisão aqui apresentados contribuem para enriquecer a compreensão sobre a violência contra pessoas idosas a residir na comunidade, providenciando pistas para configurações-tipo às quais profissionais deverão adequar respostas específicas, criando intervenções mais compreensivas e, desejavelmente, mais eficazes.

ABSTRACT

The first theoretical reference to violence against older adults appeared in 1975, firstly described as “Granny battering”. Since then, the field has dealt with controversy over concepts, definitions and theoretical models used to describe and conceptualise the problem. The difficulties of the fields conceptual development can be partly attributed to the multidimensionality of the construct. Violence against older adults can be defined and categorised according to different dimensions (e.g., abuse types, victim, perpetrator and context), and its theoretical and conceptual development has coexisted with the difficulty of including the various categories of each of these dimensions (and the range of possible presentations) in conceptualisations sufficiently objective for its operationalization and, consequently, for its empirical validation.

This thesis recognises that multidimensionality is an essential feature for understanding violence against older adults, since victimisation experiences are characterised, defined and understood within the interplay of abusive behaviours, victims, perpetrators and contexts. Bearing these assumptions in mind, the thesis presents a series of studies that aimed to describe the multidimensionality of violence within community dwelling older adults and to provide a more complex representation of victimisation experiences in a description of configurations encompassing more than one of the problems’ dimensions. First a brief review of the research history and the fields conceptual development is presented, including the multidimensional perspective (chapter I and II).

It follows the study empirical work that involves a secondary analysis of data from the Ageing and Violence research project. This was a project that took place between 2011 and 2014, and was conducted by the National Heath Institute Doutor Ricardo Jorge.

In the study presented in chapter IV, we determined the impact of employing two different measures to evaluate psychological violence and reflect whether family dynamics is being included within the prevalence of this form of violence. Chapter V includes two studies. The first is a contribution to the validation of two short versions of the Geriatric Depression Scale, both of which have shown to be an appropriate instrument to measure depressive symptoms in old age. The second study proposes an in-depth analysis of the relationship between depressive symptoms and violence, by examining its association with both the individuals’ characteristics and distinct violence dimensions. In chapter VI we describe the main evoked emotions and feelings of community-dwelling older adults who have experienced violence and explore the association between these emotions and individual and distinct violence dimensions.

The following two studies (chapter VII) sought to describe and characterise multidimensionality of violence against older adults. The first uses latent class analysis to

categorise violence occurrence into subgroups considering two of the problems dimensions - abusive behaviours and appointed perpetrators. The second study is a qualitative study on the narratives and perceptions of self-reported victims. The relationship between victim and abusive individual is considered the key element based upon which we examine the ageing process and the interplay with violence occurrence. Overall, the findings from the different studies suggest: (i) violence against older adults is a construct that encompasses distinct phenomena (Intimate Partner Violence grown old and neglect) sharing common features; (ii) violence against older adults is best characterised by considering different dimensions (e.g., context dyad victim-perpetrator, abusive behaviours and severity); (iii) the dyad victim-perpetrator is one of the most important dimensions, followed by severity and type of abusive behaviours; (iv) the interplay of these different dimensions helps apprehend the nature and dynamics of different elder abuse configurations. In chapter VIII (contribution to the thesis in the form of a chapter of the book manual entitled “Manual sobre “Vítimas de crime e violência: Práticas de intervenção” [Victims of Crime and Violence: Intervention Practices]), we recognise the difficulty of developing a single intervention and, through a case study, we reflect on the importance of the nature of the relationship between victim and abusive individual for the responses´ appropriateness.

Altogether, these studies advance new knowledge on violence against community-dwelling older adults, providing important clues to victimisation configurations-types to which practitioners can tailor specific responses, creating more comprehensive and, hopefully, more effective interventions.

LIST OF PAPERS

The work presented in this thesis is an expanded and updated version of six scientific articles and a book chapter. It includes national and international publications and papers submitted for publication in peer-reviewed journals (same order as in the thesis):

Study 1 [Chapter IV] Santos, A.J., Nunes, B., Kislaya,I., Gil, A.P. & Ribeiro, O. (2017). Psychological elder abuse: measuring severity levels or potential family conflicts? *The Journal of Adult Protection, 19*(6), 380-393. doi:10.1108/JAP-06-2017-0025
Study 2 [Chapter V] Santos, A.J., Nunes, B., Kislaya,I., Gil, A.P. & Ribeiro, O. (accepted). Estudo de validação em Portugal de uma versão reduzida da Escala de Depressão Geriátrica [Portuguese validation study of a short version of the Geriatric Depression Scale]. *Análise Psicológica*
Study 3 [Chapter V] Santos, A.J., Nunes, B., Kislaya,I., Gil, A.P. & Ribeiro, O. (2017). Exploring the Correlates to Depression in Elder Abuse Victims: Abusive Experience or Individual Characteristics? Journal of Interpersonal Violence. doi:10.1177/0886260517732346
Study 4 [Chapter VI] Santos, A.J., Nunes, B., Kislaya,I., Gil, A.P. & Ribeiro, O. (2018). Older adults' emotional reactions to elder abuse: individual and victimisation determinants. *Health & Social Care in the Community.* doi: 10.1111/hsc.12673
Study 5 [Chapter VII] Santos, A.J., Nunes, B., Kislaya,I., Gil, A.P. & Ribeiro, O. (submitted). From appointed perpetrators and abusive behaviours to victimisation patterns: new approaches to elder abuse typologies using two cross-sectional surveys. *BMC Geriatrics.*
Study 6 [Chapter VII] Santos, A.J., Nunes, B., Kislaya,I., Gil, A.P. & Ribeiro, O. (submitted). Ageing and abuse: vulnerabilities and limited time. *Quality in Ageing and Older Adults*
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CONTENTS

AGRADECIMENTOS v

LIST OF TABLES AND FIGURES vii

ABSTRACT xiii

LIST OF PAPERS xv

CONTENTS xvii

General introduction 1

Part 1 - Background and conceptual framework 9

Chapter I *Elder abuse: historical review* 11

1. 1975 – Discovering “granny battering” 13

2. 2000s – Moving beyond “granny battering” 15

2.1. Terminology and definition 16

2.2. The (lack of) conceptual development 18

2.3. Interventions 21

3. Moving forward: from cultural differences to individual perceptions 24

Chapter II *Conceptualising elder abuse* 27

1. Definition 29

2. The victim-abuser relationship 31

3. Risk and protective factors – applied ecological framework 33

4. The facets of a multifaceted problem 35

Chapter III *Context of this thesis* 39

References 49

Part 2 – Empirical work 65

Chapter IV 67

Psychological elder abuse in perspective: measuring severity levels or potential family conflicts? 69

Abstract 71

Introduction 72

Method 74

Results 78

Discussion 84

Conclusion 87

Chapter V 93

Estudo de validação em Portugal de uma versão reduzida da Escala de Depressão Geriátrica [Portuguese validation study of a short version of the Geriatric Depression Scale] 95

Resumo 97

Introdução 97

Métodos 101

Resultados 103

Discussão 106

Exploring the correlates to depression in elder abuse victims: abusive experience or individual characteristics? 113

Abstract 115

Introduction 115

Methods 118

Results 121

Discussion 125

Conclusion 128

Chapter VI 135

Older adults' emotional reactions to elder abuse: individual and victimisation determinants 137

Abstract 139

Introduction 140

Methods 141

Results 147

Discussion 151

Chapter VII 163

From appointed perpetrators and abusive behaviours to victimisation patterns: new approaches to elder abuse typologies using two cross-sectional surveys 165

Abstract 167

Background 168

Methods 170

Results 172

Discussion 182

Conclusion 185

Supplementary material 189

Ageing and abuse: vulnerabilities and limited time 193
Abstract 195
Introduction 196
Methods 197
Results 200
Discussion 204
Conclusion 207
Chapter VIII 213
Maus Tratos e Negligência da Pessoa Idosa: Modelos Teóricos e Intervenção [Mistreatment and neglect against older adults: theoretical models and intervention] 215
Introdução 217
Modelos teóricos explicativos e de intervenção 220
Intervenção psicológica 224
O modelo de gestão de casos 226
Caso prático 227
Conclusão 237
Part 3 – General discussion and conclusion 243
General discussion 245
The relevance of multidimensionality for elder abuse configurations 247
Severity 249
The dyad victim-perpetrator 250
Abuse types and behaviours 251
Multidimensionality and responses to elder abuse in community settings 253
Intimate Partner Violence (IPV) grown old vs. with late onset 254
Longstanding interpersonal abuse by offspring 258
Psychological abuse by the nuclear family. 262
Financial abuse by individuals outside the nuclear family 263
Other configurations 264
Concluding remarks 267
References 271

General introduction

Violence against older adults has gained increasing attention since the 1970s (Podnieks, Anetzberger, Wilson, Teaster, & Wangmo, 2010). At various times and rhythms, countries have since then began to tackle the issue (Penhale, 2006; Podnieks et al., 2010) and currently violence against older adults is recognised as an extensive and serious problem, which implicates health, social, legal, and psychological approaches (Payne, 2002; Pillemer, Burnes, Riffin, & Lachs, 2016).

Also referred to as elder abuse and elder mistreatment, the phenomenon has had a steady increase of interest from several research fields for the past 40 years (Biggs & Haapala, 2010; Penhale, 2006; Podnieks et al., 2010). Nevertheless, knowledge on violence against older adults still dwells with widely varying, and sometimes poorly constructed, critical conceptual aspects, including, but not limited to, definitions, operationalization and theoretical models (Goergen & Beaulieu, 2013; Jackson & Hafemeister, 2013; Mysyuk, Westendorp, & Lindenberg, 2013; Pillemer et al., 2016).

The different terminologies applied to the phenomenon mirror the lack of conceptual agreement within the field. The term “violence against older adults” in the thesis title attempts to overcome distinctions among mistreatment, abuse, and neglect (Mysyuk et al., 2013). However, because the term “elder abuse” is present in most of the empirical work, reflecting the editorial preferences of the journals, this thesis uses this term inclusively and interchangeably.

Several aspects have been suggested as hindering the field’s conceptual development (Biggs & Haapala, 2010; Jackson & Hafemeister, 2013). The fact that it is a relatively recent “discovery”, the difficulties of researching such a sensitive topic, and the different approaches driven by several disciplines and professionals are some of the factors (Biggs & Haapala, 2010; Jackson & Hafemeister, 2013; Penhale, 2003). Other aspect that seems to be drawn from research findings is the multidimensionality of the construct (Burnes, Pillemer, & Lachs, 2017; Jackson & Hafemeister, 2013; National Research Council, 2003).

Elder abuse can present itself within a wide range of configurations and different elements can come together within a particular victimisation experience. It can take several forms and include a wide number of acts of commission (as well as omission), include distinct dyad relationships (e.g., spouse, offspring, neighbours), and occur in different contexts (e.g., residential home or private household) (National Research Council, 2003). The multidimensionality of elder abuse recognises abusive behaviours, victims, perpetrators and contexts as elements that define victimisation experiences, all of which are necessary

to characterise and understand it (Jackson & Hafemeister, 2013). But such variability is difficult to capture and to translate into the conceptualisation of the phenomenon.

The field is still interspersed with varying concepts, definitions and conceptualisations that affect value of research evidence, measures, social policies, clinical tools and/or interventions guidelines. While the complexity of elder abuse contributes to this state of art, the perspective of the phenomenon as “monolithic” and the tendency of overinclusion all its possible configurations partly explain the difficulty of capturing its scope and nature. A research approach that takes into account the multidimensional nature of the issue lies at the basis of this thesis.

In the first chapter, a brief review of the research history describes how elder abuse was historically conceptualised within a protectionist framework, where the older adult was seen as a dependent and vulnerable individual. Ever since the time it was “discovered”, elder abuse went from being very strictly defined (encompassing only physical abuse and neglect against vulnerable and dependent older adults) to a widen focus, reflecting both socio-historical and research developments (Biggs & Haapala, 2010; Mysyuk et al., 2013). The field’s development on definitions, typologies, characterisations, theoretical and explanatory models and interventions are discussed, namely some of the issues that remain poorly understood and lacking conceptual delimitation.

The second chapter focuses on the conceptualisation of elder abuse. Research has shown that elder abuse may incorporate configurations very similar in nature and dynamics to those present in other forms of family violence (e.g., Intimate Partner Violence) and others very different and specific (e.g., financial abuse). While being vulnerable or dependent is not a factor *per se* to elder abuse occurrence, vulnerability increases the risk of elder abuse. On the other hand, distinguishing elder abuse from abuse of younger adults implies that age and the ageing process are taken as key concepts, since they influence the relationship between the older person and the perpetrator, the society and the systems within which they operate.

This is to say that addressing elder abuse is not just about the older person. Research, theory and practice also need to consider the abusive behaviours and the history of the relationship with the perpetrator. For instance, neglect perpetrated by a formal caregiver against a cognitive impaired older adult and financial abuse committed by an adult-child towards an independent older adult may be two distinct victimisations experiences. Some evidence does suggest pronounced differences of risk factors, case characteristics and interpersonal dynamics across single and co-occurring types of abuse, but also across

perpetrators within the same type of abuse (Burnes, Lachs, Burnette, & Pillemer, 2017; Burnes, Pillemer, et al., 2017; Jackson & Hafemeister, 2013).

This thesis assumes that elder abuse is a complex phenomenon that comprises the interplay of several dimensions. Recognises that the term is best used as a descriptive umbrella that encompasses a broad range of behaviours, victims and perpetrators, and that blanket approaches to elder abuse are therefore unlikely to address its complex nature. Bearing these assumptions in mind, the thesis aims to describe the multidimensionality of community dwelling elder abuse, and to reflect on how research could be adapted to account for this complexity. It also attempts to provide a more complex representation of elder abuse victimisation experiences by incorporating more than one of the problems' dimensions in a description of possible configurations.

Focusing on elder abuse, occurring on community-based setting, the thesis' empirical work involves a secondary analysis of data from the Ageing and Violence research project. This project took place between 2011 and 2014, and was conducted by the Department of Epidemiology of the National Heath Institute Doutor Ricardo Jorge (see Chapter III for details on this project). The project, commissioned and funded by Fundação para a Ciência e a Tecnologia (FCT) (PTDC/CS-SOC/110311/2009), included two surveys targeting individuals living in Portugal who were aged 60 and over: a population-based survey that aimed to estimate prevalence and characterise situations of community elder abuse; and a survey targeting self-reporting victims. The project evaluated psychological, physical, sexual and financial abuse in addition to neglect. It also included in-depth interviews throughout the country to older victims in the pilot and exploratory phase (n=13), in 2011, and after the data collection and statistical analysis, in 2013 (n=19). The studies included in the present thesis were conducted with data from both survey samples (according to the studies objectives and the adequacy of data), in addition to the data from the in-depth interviews.

Three main approaches have driven the empirical work (Part 2 Empirical studies). Firstly, to capture elder abuse diversity, often overlooked in cross-sectional studies usually with dichotomous information (e.g., yes abuse /no abuse), regarding prevalence (Chapter IV), risk factors (Chapter V), and emotional reactions (Chapter VI). Secondly, to provide a more complex representation of elder abuse victimisation experiences, which encompasses more than one dimension of the problem (e.g., abusive behaviours and victim-perpetrator relationship) (Chapter VII). Thirdly, to reflect on how interventions can respond to elder abuse complexity (Chapter VIII). Table 1 lists each of the independent documents (outputs) comprised in this thesis.

Table 1. Outputs

	Outputs
Chapter IV	Psychological elder abuse: measuring severity levels or potential family conflicts?
Chapter V	Estudo de validação em Portugal de duas versões reduzidas da Escala de Depressão Geriátrica [Portuguese validation study of two short versions of the Geriatric Depression Scale]
	Exploring the Correlates to Depression in Elder Abuse Victims: Abusive Experience or Individual Characteristics?
Chapter VI	Older adults' emotional reactions to elder abuse: individual and victimisation determinants
Chapter VII	From appointed perpetrators and abusive behaviours to victimisation patterns: new approaches to elder abuse typologies using two cross-sectional surveys.
	Personal stories within elder abuse: betrayed trust in a vulnerable age and abusive bonds that just grown old
Chapter VIII	Maus Tratos e Negligência da Pessoa Idosa: Modelos Teóricos e Intervenção [Mistreatment and neglect against older adults: theoretical models and intervention]

In the study presented in Chapter IV, we determined the impact of employing two different measures to evaluate psychological elder abuse and reflect whether milder psychological abuse behaviours are etiologic predictive forms of psychological abuse or of family functioning. We analyse these two measures considering different dimensions of the phenomenon, namely identified perpetrators and victims' risk factors. As research developed, researchers felt the need to create a threshold that could distinguish psychological abuse from "normal family conflicts" (Conrad, Iris, & Ridings, 2009; Gil, Santos, & Kislaya, 2015; Lachs et al., 2011; Manthorpe et al., 2007; Mowlam, Tennant, Dixon, & Mccreadie, 2007; Pillemer & Finkelhor, 1988). Because a great part of elder abuse in community-setting takes place within the family, it is important to understand what are the conflicts and disputes - that do not necessarily report to abnormal or unhealthy familiar relationships - and what is abuse (Astrachan & McMillan, 2003; Phillips, 1986; Reher, 1998). The importance of correctly apprehend the scope of the problem and the influence of the definitional "inflation" has been acknowledged by several researchers, and mirrors some of the difficulties of elder abuse conceptual development (Biggs & Haapala, 2010; Goergen & Beaulieu, 2013).

Chapter V includes two studies. The first is a contribution to the validation of two short versions of the Geriatric Depression Scale, one of which was used to evaluate participants' depressive symptoms. The second study proposes an in-depth analysis of the relationship between depressive symptoms and elder abuse, by examining both

characteristics of the individuals and characteristics of the abusive experience. Even though depression and depressive symptoms have been commonly associated with elder abuse, some research findings are contradictory (Lachs & Pillemer, 2004; Pillemer et al., 2016). Understanding if depression or depressive symptoms are risk factors or consequences is of great importance because the development of effective interventions depends on these distinctions. Whether to develop prevention programs that target older adults with depression or depressive symptoms (e.g., screening) or to tailor specific responses towards victims, this is a relevant distinction.

In Chapter VI, we describe the main evoked emotions and feelings of community-dwelling older adults who have experienced abuse and explore the association between these emotions and individual and abusive characteristics. The emotional response of older adults to victimisation experiences has been associated with intervention outcomes, and to older adults' willingness to take action in regard to the abusive situation (Anetzberger, 2005; Desmarais & Reeves, 2007; Ploeg et al., 2009; Quinn & Tomita, 1997). In elder abuse, the array of possible configurations (e.g., age and personal vulnerability, type of relationship with the perpetrator and type of abuse) convenes different emotional reactions (Burnes, Lachs, et al., 2017; Mysyuk, Westendorp, & Lindenberg, 2016a). For instance, studies have shown that older adults that are victimised by adult offspring are reluctant to take action because they feel responsible for the actions of the perpetrator (Harbison & Morrow, 1998; Moon & Benton, 2000).

The two studies presented within Chapter VII sought to capture the different configurations of the phenomenon. The first focuses on configurations of victimisation experiences other than the usual employed typologies. The recognition of the multidimensionality of elder abuse presupposes that the abuse experienced cannot be characterised or explained without considering the abusive behaviours, the perpetrator and the context. The study uses latent class analysis (LCA) to categorise abuse occurrence into subgroups considering both abusive behaviours and appointed perpetrators. It also evaluates the differences and similarities of the victims' characteristics between the subgroups. The second study is a qualitative study on the perceptions and experiences of elder abuse. Focusing on the insights of victims themselves, the study attempts to understand the perception and the history of victimisation. Attention was given to the relationship with the perpetrator as a key element in defining, explaining and experiencing elder abuse. We sought to understand the differences and similarities between three groups (victimised by spouses/parents; by offspring; by others) about their abuse experience, but also in relation to ageing. Given the different approaches and

perspectives to elder abuse (e.g., feminist theories, life-course perspective) and the possible complex overlap of issues (e.g., ageism, domestic violence, gender, caregiving) it is important to understand how older adults perceive the relationship and the ageing process intertwined with elder abuse occurrence.

Finally, chapter VIII is a theoretical review of clinical interventions on elder abuse, which summarises the different theoretical explanations that have been used to respond to elder abuse. In this chapter, we attempted to link the theoretical and conceptual development of the field to the interventions and responses to older victims. The complexity of elder abuse is considered in the practical case presented to illustrate an intervention approach. The "case management approach" accepts the multidimensionality of elder abuse, as it highlights that each situation requires a response specifically tailored to the individual's needs and wants.

In the final part of this thesis (general discussion and conclusion), we discuss the empirical studies in light of the possibility to incorporate elder abuse multidimensionality in research and the dimensions evidenced by the findings. We further reflect on how these results permit to portray distinct elder abuse configurations and the possible implications for intervention.

Overall, the importance of understanding elder abuse complexity pertains not only to an academic exercise (Goergen & Beaulieu, 2013; Nerenberg, 2002). The development of sound and rigorous evidence on the scope and nature of the phenomenon has critical implications for intervention (Jackson & Hafemeister, 2013). Interventions to prevent abuse or to enhance victims' safety are drawn from the conceptualisation of the problem, and this information is urgently needed, as there is a lack of high-quality evidence supporting elder abuse interventions in all contexts (Daly, Merchant, & Jogerst, 2011; Pillemer et al., 2016). This thesis aims to provide a contribution on this matter.

Part 1 - Background and conceptual framework

Chapter I *Elder abuse: historical review*

1. 1975 – Discovering “granny battering”

Initially recognised by English doctors in the mid-1970s, elder abuse was firstly described as “Granny battering” (Baker, 1975). This and other descriptions (e.g., the battered elder syndrome, granny bashing, inadequate care of the elderly and granny abuse) created a delimited notion of the problem (Loue, 2001). Elder abuse was conceptualised as the harmful actions of well-meaning but overburdened caregivers against very old (75 or more years) and dependent women (Anetzberger, 2000; Wolf, 1997). At this time and based on early research, caregiver stress was determined as the primary cause of the problem (Pillemer & Finkelhor, 1988). This depiction produced a very simplistic representation of elder abuse (Wolf, 1997), and clearly stereotyped it as a single-sex problem (Bennett & Kingston, 1993). Nevertheless, it helped to bring the issue into the attention of the media and policy-makers (Wolf, 1997). Although the phenomenon was initially recognised in the United Kingdom (UK), the public and policy-makers in the United States of America (USA) and Canada developed the first research efforts (Bennett & Kingston, 1993). The first studies were developed independently within different fields and conducted on small, non-random samples, which hindered the overview of the problem (National Research Council, 2003). Conceptualised mainly either as a social or a medical problem, studies focused on clinical signs and symptoms that could not be explained by disease markers or attempted to describe intervention and practices (National Research Council, 2003; Payne, 2002).

From the 1980s onward, the recognition of elder abuse as a problem increased worldwide and the research interest intensified (Podnieks et al., 2010). Public, states and researchers felt the need to put a number on the problem and establish its prevalence and incidence (Biggs & Haapala, 2010; National Research Council, 2003; Podnieks et al., 2010). But this was not an easy task. Elder abuse was a fairly recent problem and a topic not easy to research (Penhale & Kingston, 1997). The most noticeable difficulty came from the lack of agreement concerning a standard definition (Bennett & Kingston, 1993). Since “granny battering” several definitions had been advanced, which started to include actions beyond physical abuse. For instance, the definition of O’Malley and colleague’s states: “the wilful infliction of physical pain, injury or debilitating mental anguish, unreasonable confinement or deprivation by a caretaker of services which are necessary to the maintenance of mental and physical health” (1979, p. 13). Abuse was also considered intention to harm. A clearer distinction of the different types of abuse was later provided by Eastmen’s definition: “the systematic maltreatment, physical, emotional or financial, of an elderly person by a care-giving relative” (1984, p. 23). Nevertheless, the specific context of the relationship between abuser and abused remained deeply framed

within caregiving situations and emphasis was again put on the dependency and vulnerability of the older person and the stress caused by the act of providing care.

In the late 1980s and 1990s elder abuse prevalence studies begun to take place. The first prevalence study based on a random sample of community dwelling older persons (65 or older) was conducted in the USA (Boston metropolitan area) in 1988 to estimate physical, psychological abuse and neglect (Pillemer & Finkelhor, 1988). In the beginning of the 1990s other prevalence studies were being conducted in Canada (Podnieks, 1993), the UK (Ogg & Bennett, 1992) and Finland (Kivelä, Köngäs-Saviaro, Kesti, Pahkala, & Ijäs, 1993). Despite all these studies having employed different methods and definitions, the overall prevalence of the phenomenon was established between a 3-5% range.

At this time, other empirical studies begun also to display a different characterization of elder abuse, questioning the caregiver stress explanation that dominated the field until that date. Findings from studies using different populations and methodologies suggested that caregiver stress was not the primary risk factor (Bristowe & Collins, 1988; Godkin, Wolf, & Pillemer, 1989; Phillips, 1983; Pillemer, 1985; Pillemer & Suitor, 1988). Research did not find greater functional impairment and dependency or caregiver stress among abused older adults and their family members when compared with non-abused older adults families (Bristowe & Collins, 1988; Godkin et al., 1989; Phillips, 1983; Pillemer, 1985; Pillemer & Suitor, 1988).

The perpetrators characteristics become to be recognised as an important aspect to elder abuse occurrence, as different studies begun to observe similar patterns. Unlike what had been reported, perpetrators tended to be dependent on the abused older adult, either for financial or instrumental support (e.g., living arrangements) (Anetzberger, Korbin, & Austin, 1994; Greenberg, McKibben, & Raymond, 1990; Pillemer & Wolf, 1986; Wolf, Strugnell, & Godkin, 1982). In addition, studies also showed compelling evidence that certain characteristics were more commonly found among perpetrators, namely mental illness (Godkin et al., 1989; Pillemer & Finkelhor, 1988) and alcohol or drug use problems (Bristowe & Collins, 1988; Godkin et al., 1989; Greenberg et al., 1990; Homer & Gilleard, 1990). These findings helped to question the caregiver stress as the main explanation for elder abuse occurrence. However, the caregiver stress model as the leading cause for elder abuse still dominated part of the literature for the following years, inherently influencing the development of action and intervention practices (Anetzberger, 2001).

2. 2000s – Moving beyond “granny battering”

Research evidence supported the shift of elder abuse from a more restricted to a wider focus. Early conceptualisations of the problem had mainly focused on physical abuse against vulnerable older women (Anetzberger, 2000; Bennett & Kingston, 1993). Research suggested that other older people could also be victims, while the perpetrators risk factors became as relevant as the victims’ characteristics, if not more, for elder abuse occurrence (Lachs & Pillemer, 2004; Wolf, 1997). At the same time, the context of elder abuse identified the “trusted relationship” and the different settings where it could take place (Mysyuk et al., 2013). The definition and restriction on the problems conceptualisation was facilitated by developments in the field of elder abuse. Nonetheless, critical conceptual issues were still present.

Despite the attempt of finding common ground within the elder abuse research field, its novelty as a scientific object was still present by 2000, as only about 50 peer-reviewed articles based on empirical research had been published (National Research Council, 2003). Furthermore, literature on the subject showed the same set of names, with few new researchers entering the field (National Research Council, 2003).

The body of knowledge was slowly growing and in the first decade of 2000 several reviews on the overall topic (Daly et al., 2011; Dyer & Rowe, 1999; Kleinschmidt, 1997; Lachs & Pillemer, 2004; O’Connor & Rowe, 2005; Swagerty, Takahashi, & Evans, 1999; Wolf, 1997), prevalence (Cooper, Selwood, & Livingston, 2008; de Donder et al., 2011; Espíndola & Blay, 2007; Pérez-Rojo & Penhale, 2006), measurement instruments (Anetzberger, 2001; Daly & Jogerst, 2005; Fulmer, Guadagno, Bitondo dyer, & Connolly, 2004; Perel-Levin, 2008) and risk factors (Brozowski & Hall, 2003) were being conducted. Nevertheless, lack of knowledge and research on specific areas of the problem was commonly reported (Biggs & Haapala, 2010; Lachs & Pillemer, 2004; National Research Council, 2003). First, despite some consensus on definitions and types of abuse that characterised elder abuse, different studies or authors employed different terminologies and other forms of abuse (self-abuse or self-neglect) were sometimes lumped together (Biggs & Haapala, 2010; National Research Council, 2003). Second, the body of research was largely descriptive and pragmatic without conceptual development (Biggs & Haapala, 2010; Daly et al., 2011; National Research Council, 2003). Finally, there was practically no empirical data on interventions (Biggs & Haapala, 2010; Lachs & Pillemer, 2004; National Research Council, 2003).

2.1. Terminology and definition

Anglo Saxon countries often use the expression “elder abuse” whereas in Francophone countries “maltraitance, violence and victimisations*”* are more commonly employed (Gil et al., 2015). In the USA, elder mistreatment has been suggested to be a preferable term as it distances itself from more legal terms (e.g., abuse) and because as a broader category it includes abuse as well as neglect (National Research Council, 2003). Those who favour the use of “elder abuse”, usually consider that the term restricts the problem to situations where the victim is in a trust relationship with the perpetrator, or where the victim was targeted at least in part because of his or her age (Kohn, 2013). In overall, elder abuse and neglect remain the more common terminology.

Two different definitions came to be more commonly employed. The Panel to Review Risk and Prevalence of Elder Abuse and Neglect in the USA developed a definition of elder mistreatment which included: “(a) intentional actions that cause harm or create a serious risk of harm, whether or not intended, to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder; (b) failure by a caregiver to satisfy the elder’s basic needs or to protect the elder from harm” (National Research Council, 2003, p. 39). The other widely accepted definition was first proposed by the Action on Elder Abuse group from the UK (Brammer & Biggs, 1998) and later adapted by the World Health Organization (WHO): “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” (World Health Organization, 2002, p. 3).

There is some agreement as to the types of abuse encompassed within the construct (Lachs & Pillemer, 2004; National Research Council, 2003; Penhale, 2003; Pillemer et al., 2016; Wolf, 1997). Researchers, practitioners and some legislation recognise the following five types of abuse: physical abuse; psychological, emotional or verbal abuse; sexual abuse; financial or material abuse or exploitation, and neglect (Lachs & Pillemer, 2004; National Research Council, 2003; O’Connor & Rowe, 2005; World Health Organization, 2002). Some authors additionally differentiate between active and passive neglect, defining the former as the refusal to perform caregiving tasks, and the second as an unintentional failure to provide care (Wolf & Pillemer, 1989). Other proposed typologies, not often included in the studies, are: self-neglect, violation of rights, and structural or societal abuse (Cohen, Levin, Gagin, & Friedman, 2007; National Research Council, 2003; Perel-Levin, 2008; Swagerty et al., 1999; World Health Organization & The International Network for the Prevention of Elder Abuse, 2002).

Elder self-neglect refers to the failure of an older person to satisfy his or her own basic needs and to protect himself or herself from harm (National Research Council, 2003). It is often found among socially isolated older adults with untreated medical conditions (Pickens-Pace et al., 2007). The aetiology of self-neglect is yet unknown. It may be associated with the development of a cerebral executive dysfunction, a condition in which an individual is unable to translate simple tasks into complex, goal-directed behaviours, namely, cooking, dressing oneself, and performing housework (Pickens-Pace et al., 2007).

Violation of rights was first included in the elder abuse discussion within residential or institutional settings (Cohen et al., 2007). It encompasses the infringement of personal rights such as the violation of privacy, the right to autonomy, freedom, refusing access to visitors, isolating the elder or reading or withdrawing mail (de Donder et al., 2011). This topic seems to be of extreme importance for older adults themselves, as a study with qualitative interviews with older adults revealed (World Health Organization & The International Network for the Prevention of Elder Abuse, 2002) but it is not usually included in most research (Lachs & Pillemer, 2004; National Research Council, 2003; Pillemer et al., 2016).

Structural or societal abuse is exercised by governments and institutions and includes discrimination in politics towards older people, the lack of resources to meet their care needs, as well as the lack of guaranteed income and accommodation (Swagerty et al., 1999; World Health Organization & The International Network for the Prevention of Elder Abuse, 2002). Ageism corresponds to age-based discrimination of a particular society, reflecting stereotypes, prejudices and attitudes based on global perceptions about age and old age in particular (Biggs & Haapala, 2010; Hagestad & Uhlenberg, 2005; World Health Organization & The International Network for the Prevention of Elder Abuse, 2002). Structural or societal abuse are drawn from ageism and reflect the mistreatment of a society towards their older population (Hagestad & Uhlenberg, 2005; World Health Organization & The International Network for the Prevention of Elder Abuse, 2002).

Self-neglect and structural or societal abuse (by means of ageism) are the “types of abuse” that gathered the least support in the literature. Criticisms to their inclusion refer to the unmet concepts considered to be critical in elder abuse definition, namely, the fact that the perpetrator is someone known to the victim and that there is a relationship between the two with recognised pre-existing expectations by both parties (Biggs & Haapala, 2010; Dyer & Rowe, 1999). However, the differences between self-neglect, structural and social abuse imply different reflections about its inclusion in the typology of elder abuse. Self-

neglect is a situation widely recognised in the professional practice of services and agencies, with direct consequences for the elderly, which in turn correspond to what will be some of the consequences of the abuse (Mixson, 1991; Stevenson, 2008). On the other hand, the categorizations of structural and social abuse comprise a differentiated macro-social framework, which is linked to aspects and societal traits (Biggs & Haapala, 2010). Although the organisation and development of different societies and countries may in some cases reflect or even reinforce abuse, it is not in itself coincident with the phenomenon (Biggs & Haapala, 2010; Hagestad & Uhlenberg, 2005). In addition, a clear distinction between elder abuse and social and structural features in which it occurs allows reflection on how environments can be either permissive or preventative of elder abuse (Biggs & Haapala, 2010).

2.2. The (lack of) conceptual development

The lack of agreement on definitions of “elder abuse” mirrors the difficulties of developing a consensual and integrative conceptual and theoretical framework. This results in part from the fact that elder abuse is a relatively new “scientific object”. The knowledge development for recent or new scientific objects is usually characterised by sets of essentially different findings without a common framework (Kuhn, 1970). More than a decade ago, Lachs and Pillemer had referred to the published work as “complex and sometimes contradictory” (2004, p. 1263). Others have later argued that the recent growth of interest on the phenomenon influenced the empirical work (Biggs & Haapala, 2010). The increasing awareness of the problem, public expectations and the importance of defining estimates have steamed the growth of prevalence studies without a guiding framework (Biggs & Haapala, 2010; National Research Council, 2003). The lack of conceptual and theoretical development is still acknowledged and is reflected upon elder abuse multiple theoretical models and explanations (Biggs & Haapala, 2010; de Donder et al., 2011; Goergen & Beaulieu, 2013; Penhale & Kingston, 1997; Wolf, 1997).

Regardless of the scarce number of conceptual models, a number of theories have been proposed to explain elder abuse (National Research Council, 2003; Phillips, 1986). However, because the causes and effects had not been demonstrated conclusively, the growing assumption was that elder abuse was multifaceted, hardly fitting into one single unifying theory (Anetzberger, 2001; National Research Council, 2003; Penhale & Kingston, 1997; Wolf, 1997). The emphasis was made on risk factors rather than on explanatory theories, as it was the case of the characteristics that were found to be associated with an increased risk of victimisation (Wolf, 1997). The growing knowledge on

risk factors has driven the development of some theories, while others were just imported from other family violence fields (Penhale & Kingston, 1997).

In overall, the available existing theories can be organised into four distinct levels: (i) intraindividual, (ii) interindividual, (iii) sociocultural, and (iv) multisystem theories (see Table 2). At the intraindividual level, the psychopathology of the perpetrator was developed from the risk factors research findings, which indicated the significant role of some abusers' personal characteristics (Jackson & Hafemeister, 2013; Penhale & Kingston, 1997; Wolf, 1997). Interindividual theories, on the other hand, are developed on the assumption that abuse is caused by the dynamics of the relationship between older adults and the perpetrator. These include the caregiver stress theory (Anetzberger, 2000), the social learning behaviour theory (Pillemer & Finkelhor, 1988; Quinn & Tomita, 1997), the social exchange theory (Homans, 1966; Quinn & Tomita, 1997; Walker & Allen, 1991) and the dyadic and discord theory (Quinn & Tomita, 1997; Riggs & O´Leary, 1996). Even though these theories considered the relationship between the older adult and the perpetrator, they do not provide an overall picture that can reasonably explain elder abuse in different settings (e.g., community vs. institutional) and within the variety of relationships in which it might occur (e.g., formal caregiver, spouse, offspring, neighbour, friend).

Table 2. Elder abuse theories

	Theories	Explanatory hypothesis	Observations
Intraindividual	Psychopathology of the perpetrators (Elder abuse risk factors research)	Abuse is due to the flawed characteristics of the perpetrators: mental health problems; personality disorders; alcohol or drugs use problems.	Many individuals with mental health or substance abuse problems do not engage in abusive behaviours.
Interindividual	Caregiver stress (Elder abuse research)	Abuse is a situational phenomenon and occurs because the caregiver becomes overwhelmed and frustrated	Elder abuse occurs in different relationship contexts: not all victims are dependent and not all abusive caregivers are stressed.
	Social Learning Theory (Child abuse field)	Violence is a learned behaviour passed on through the generations.	Does not so easily apply to all settings; research has yet to provide evidence in the case of elder abuse.
	Social Exchange Theory (Economic and psychology fields)	The dependence and/or lower perceived social status results in a relationship change of power and reciprocity. A caregiver feels more power, but less reward.	Assumes automatic dependency within the ageing process; some studies rather showed the dependency of the perpetrator on the victim.

	Theories	Explanatory hypothesis	Observations
	Dyadic Discord Theory (Intimate Partner Violence)	Relationship discord results from a combination of contextual factors (e.g., a history of family violence) and situational factors (e.g., a lack of relationship satisfaction).	Does not apply to all settings and it might be more adequate for certain types of relationship (e.g., affective rather than formal).
Socialcultural	Power and control (Intimate Partner Violence)	Considers domestic violence to stem from unequal and oppressive power relation - power differential from ageism.	Though it may capture the core dynamics of some types of elder abuse, it leaves out others (e.g. perpetrated by impaired caregivers).
	Biopsychosocial Model (Elder abuse, adapted from George Engles' 1977 model)	Highlights "social embeddedness" (social network) of the dyad and captures the individual factors of both parties which affects the status inequality and relationship type.	Considers variables at distinct levels and the interaction between them. Doesn´t account for the mutual dependency between older adult and perpetrator documented in some cases.
Multisystemic	Ecological theory (Bronfenbrenner, 1979, already employed in Intimate Partner Violence)	Multidimensional perspective: combines risk factors from different approaches. Violence as the outcome of the interaction between individual, relational, community level and societal factors.	Helps to identify variables for inclusion but does not constitute any particular set of predictions to test – difficult to evaluate its applicability.

Adapted from Burnight & Mosqueda, 2011; Jackson & Hafemeister, 2013; Penhale, 2003; Walsh et al., 2007

Sociocultural theories focus on societal norms and patterns and include the Power and Control Theory (Spangler & Brandl, 2007), which is borrowed from the feminist approach to domestic violence, and the Biopsychosocial model. This latest was developed by the Panel to Review Risk and Prevalence of Elder Abuse and Neglect in the USA (National Research Council, 2003) and is based on the model first introduced by Engel in the 70's to correct for limitations resulting from the application of the biomedical model. The model argues that social as well as biomedical factors contributed to illness (Engel, 1977).

Finally, the ecological theory is included in the multisystemic approach. It was adapted from Bronfenbrenner's theoretical approach and tries to capture a number of potential causes and organize them into groups (Bronfenbrenner, 1979). Ecological theory promotes the inclusion of variables from both the victim and perpetrator and the social context. The variables of interest are the perpetrator and the ageing adult, the relationships established between them and with immediate others and external institutions, and broad ideological values and norms of a given culture where the abuse takes place (Schiamberg & Gans, 1999).

None of the existent theories has gathered enough agreement to be used as a consensual conceptual framework for elder abuse. And, although adopting or adapting existing theories from other fields can be an efficient approach, there is lack of validity testing regarding most of the "imported" theories (Jackson & Hafemeister, 2013; National Research Council, 2003). The problem for elder abuse is that the construct presents multiple possible configurations with variations on victims (e.g., impaired and not impaired), perpetrators (e.g., family, formal service providers, friends, etc.) and contexts (e.g., community or institutional settings) and no single theory is going to be able to encompass the problem. In fact, some evidence suggests that elder abuse is not a unitary phenomenon (Anetzberger, 2000; Kinnear & Graycar, 1999; McDonald et al., 2012; Penhale, 2003). A focus on the scope and nature of different configurations might help improve the understanding the problem and the development of more adequate conceptual approaches (Jackson & Hafemeister, 2013).

2.3. Interventions

The lack of a conceptual framework also hindered the development of elder abuse interventions (Jackson & Hafemeister, 2013). In addition, the intradisciplinary approach (Payne, 2002), and the fact that it was one of the latest's forms of family violence to become acknowledged did not help the advance in the field (National Research Council, 2003; Pillemer et al., 2016). Elder abuse encompasses a wide range of experiences and behaviours in a variety of settings, which makes it difficult to develop and identify one single effective intervention. Several reviews indicate that few intervention strategies and programs have been evaluated, and of those who have, the findings suggest several limitations due to methods, sampling procedures, data collection and dissimilar outcomes measures (Baker, Francis, Hairi, Othman, & Choo, 2016; Daly et al., 2011; Phelan, 2015; Ploeg et al., 2009).

Regardless of the difficulties and potential impossibility of establishing a single effective intervention, different paradigms have been used to develop responses to elder abuse, based on different theoretical explanations and, consequently, presenting distinct interventions programs, strategies and techniques (Nahmiash & Reis, 2001; Nerenberg, 2006, 2008). These include protective services (mostly adapted from the child mistreatment paradigm), the family or domestic violence services, and public health intervention models (Nahmiash & Reis, 2001; Nerenberg, 2006, 2008).

Adult protective services were a common response in the USA, because when elder abuse come to the attention of the public authorities, these services had already been established nationwide (Anetzberger, 2000; National Research Council, 2003). The adult protection agencies or services would be responsible for receiving and investigating reports of elder abuse and for providing the victim with services that could ameliorate the abuse and stop it from occurring (Anetzberger, 2000, 2001; National Research Council, 2003; Nerenberg, 2008). The social work within protective services conceptualises elder abuse as child mistreatment, viewing older adults as vulnerable and in need of protection (Anetzberger, 2000). Defining elder abuse as a social problem, instead of a public health concern or a crime, focuses the attention on the victim and may not account for the different configurations in which elder abuse takes place (Anetzberger, 2000). In fact, most of the Adult Protective Agencies legal framework in the USA states pertain to adults who have a disability, vulnerability, or impairment that reduces their capacity to protect themselves (National Research Council, 2003); however, that is not the case for all victims of elder abuse. Overall, the caregiver stress model seemed to be highly prevalent in the conceptualisation of elder abuse within protective and social services (Anetzberger, 2000).

As for the family or domestic violence services, these are grounded in the feminist approach. Within this conceptual framework, domestic violence steams from women unequal gender and status in society, which shapes social relationships (Brandl & Raymond, 1997; Nerenberg, 2006; Spangler & Brandl, 2007). Considering that a significant part of elder abuse involves intimate partner relationships (Penhale, 2003; Pillemer et al., 2016; Spangler & Brandl, 2007), some elder abuse programs have attempted to make domestic violence services and resources available to victims of elder abuse (National Research Council, 2003; Nerenberg, 2006). This approach focuses more on the symptoms than on the underlying causes (Anetzberger, 2000); the primary goal is to help victims move beyond perceiving themselves as victims to seeing themselves as “survivors” and taking the lead in self-protection (Alon & Berg-Warman, 2014). Associated services include providing information, individual and group counselling, safety planning, financial assistance, and supportive services (Alon & Berg-Warman, 2014). Despite some researchers arguing that spousal abuse provides a better model for understanding and addressing elder abuse than child mistreatment (Pillemer & Finkelhor, 1988), the underlying dynamic does not appropriately account for all elder abuse configurations. For instance, a frequently identified risk factor for financial abuse, unlike physical and psychological abuse, is social isolation and living alone (Hwang, 1996; Podnieks, 1993; Quinn, 2000). Furthermore, this approach focuses on the perpetrators’ accountability and

legal prosecution (Alon & Berg-Warman, 2014; Spangler & Brandl, 2007), which may be more difficult to obtain in cases where older adults are being victimised by their offspring. Acierno (2003) proposes that elder abuse interventions based on the child mistreatment or based on domestic violence approaches take in consideration the cognitive status of the older adult. Victims without cognitive impairment victimised by family members could resemble more closely to and benefit from the domestic violence approach. The development of interventions designed for abuse of cognitively impaired older adults could resemble to and be drawn from the child mistreatment intervention models.

Public health intervention models distinguish primary, secondary and tertiary prevention (Alon & Berg-Warman, 2014). Primary prevention focuses on legislation, raising awareness, advocacy, and education, whereas the second aims at identifying high-risk groups and alleviating potential risk factors (e.g., caregiver stress through support groups). The third prevention level aims at stopping abuse from reoccurring and diminishing its consequences by providing support services (Alon & Berg-Warman, 2014; Nahmiash & Reis, 2001; Nerenberg, 2006, 2008). The public health approach defines elder abuse as a health problem, which helps bring awareness to the subject and provide a framework for a broader view of the problem (Wolf, 2003).

Recognising the diversity and complexity of elder abuse configurations has promoted the development of multidisciplinary teams composed of workers from many community and state agencies (Alon & Berg-Warman, 2014; Nerenberg, 2008). The teams provide the combined expertise of social workers, attorneys, physicians, psychologists, police, and protective services workers. This approach intends to respond to the victim's needs and wants, providing a single service or a variety of services from different organisations working in collaboration with one another, according to the case specificity (Alon & Berg-Warman, 2014; Nerenberg, 2008). For instance, an older adult that has been victim of financial abuse once by a friend may only require legal assistance, whereas an older adult recurrently victimised physically and psychologically by a formal caregiver may require case management and health services to stop the abuse and alleviate its consequences. There seems to be some evidence as to the effectiveness of multidisciplinary teams, even though integrating multiple services and professionals demands the existence and availability of such services, which strongly depends on regional and national contexts (Pillemer et al., 2016).

In sum, consensus is increasing to elder abuse's multiple configurations and the need for multiple intervention strategies and techniques. Other developments in the field of family

violence should be considered, particularly for elder abuse configurations that may share similar dynamics and risk factors.

3. Moving forward: from cultural differences to individual perceptions

In addition to the fields' developments on terminologies, definitions, prevalence, types, risk factors, and prevention and intervention strategies, researchers have more recently started to pay a greater acknowledgement to the impact of social and cultural aspects on elder abuse. Such an acknowledgment has steamed two major lines of research/work: one focusing on the social and cultural differences in elder abuse, and another one focusing on older adults' subjective experience.

The increased interest over the last years in examining elder abuse distinct cultural contexts considers that values and norms may vary greatly from culture to culture, and from society to society (Mercurio & Nyborn, 2006; Mouton et al., 2005; Patterson & Malley-Morrison, 2006). It also came from the realisation that, in some instances, elder abuse studies have failed to identify the implications of the variations in cultural backgrounds of different countries (Kosberg, Lowenstein, Garcia, & Biggs, 2003). Some studies have suggested differences between countries' most common abuse types or perpetrators (Pillemer et al., 2016). Even though further research studies are needed to better describe and understand these differences, the available evidence indicates that different cultural background might correspond to different perceptions as to what constitutes "abuse" and its attributed seriousness (Anetzberger, Korbin, & Tomita, 1996; Kosberg et al., 2003). For instance, a study conducted more than a decade ago (Anetzberger et al., 1996) found that the perception of elder abuse severity differed between those representing four cultural backgrounds (i.e., Native Americans, Mexican Americans, Japanese Americans, African-Americans). Mexican Americans viewed scenarios of elder abuse as clearly abusive, compared to the other groups, whereas African Americans were the only group to pick financial abuse as a form of elder abuse. Other study observed that Americans found physical abuse to be more offensive whereas Koreans found psychological abuse as more offensive (Malley-Morrison & You, 2000). Beach, Schulz, Castle, and Rosen (2010) found that African-American victims reported less upset than non-African-American victims on items related to screaming/yelling and threats to hit or throw something.

It is important, however, to understand whether differences in attitudes or behaviours are influenced by ethnicity or race, or other social norms and values such as religion,

religiosity, social class, geographic location, family characteristics, and degree of acculturation (Kosberg et al., 2003). A study with Asian Americans individuals from Hawaii, for instance, suggests that differences can be more linked to acculturation, as the results of the study found more similarities between the perceptions of Filipino and Koreans respondents and Caucasian individuals from Minnesota, compared to Koreans from the mid-west of the USA. Authors suggest better access to cultural appropriate services from the Asian respondents in Hawaii. To understand the factors that influence whether a victim appraise abusive behaviours as serious or benign is crucial to understanding why some victims stay in potentially harmful mistreatment scenarios while others seek or accept help (Burnes, Pillemer, et al., 2017).

The second research approach that has lately been gaining increasing attention is the older persons' perspective (Cadmus, Owoaje, & Akinyemi, 2015; Erlingsson, Saveman, & Berg, 2005; Fitzpatrick & Hamill, 2010; Helmes & Cuevas, 2007; Mysyuk et al., 2016a; Pickering & Rempusheski, 2014). This aspect was missing from elder abuse research in general (Mysyuk et al., 2016a) although some studies have suggested that older persons have different perceptions on what constitutes abuse when compared to professionals' views (Erlingsson, Carlson, & Saveman, 2006; Helmes & Cuevas, 2007; Liao, Jayawardena, Bufalini, & Wiglesworth, 2009). For instance, the WHO recognised the importance of social representations in the "Missing Voices" study, which was developed in eight countries and aimed to identify older adults' conceptualisation of violence through focus groups with community-dwelling older persons and primary health care workers (World Health Organization & The International Network for the Prevention of Elder Abuse, 2002). The emerging theme was the discomfort in talking about or acknowledging elder abuse. Particularly in India, 'abuse' was mostly understood as an extreme form of physical violence and its existence was denied; "abuse" supposedly did not exist but elder mistreatment was mostly construed as disrespect, loss of dignity, lack of emotional support and neglect by family members.

Very few studies have, however, focused on the narratives and perceptions of older adults' victimisation experience (Erlingsson et al., 2005; Lafferty, Treacy, Fealy, Drennan, & Lyons, 2012; Mysyuk et al., 2016b; Pritchard, 2000). Qualitative research design is often employed within such studies, since it allows exploring the perception and subjective experiences of victims as to causes, consequences and coping strategies (Lafferty et al., 2012; Mysyuk et al., 2016b; Pritchard, 2000). Considering that elder abuse often includes a dyad victim-perpetrator whose relationship has evolved throughout time, finding the dynamics, changes and events that lead to or increase susceptibility to abuse are

important aspects to consider. Qualitative data collection allows the researcher to adjust the in-depth questions to each informants' viewpoints when discussing details about elder abuse (Mysyuk et al., 2016b). For instance, the dynamics of the relationship between victim and abusive individual can largely be approached within qualitative research. In a study in the Netherlands with victims of abuse, the results indicated that victims saw mutual dependency and power and control imbalances as some of the causes of elder abuse (Mysyuk et al., 2016b).

Elder abuse is also a social constructed phenomenon, which needs to be considered within research (Brammer & Biggs, 1998). Not only collective perceptions of elder abuse affects the fields' development, as our understanding of the problem is affected by individuals' perceptions and attributed (cultural) meanings.

Chapter II *Conceptualising elder abuse*

1. Definition

The definition used as a reference in this thesis is the one adopted by the WHO (World Health Organization & The International Network for the Prevention of Elder Abuse, 2002) as it is one of the most commonly used and recognised definitions (Biggs & Haapala, 2010; Goergen & Beaulieu, 2013; Mysyuk et al., 2013). The definition includes behaviours of omission or commission that occur with any type of frequency ("a single or repeated act, or lack of appropriate action") with consequences to the older adult ("which causes harm or distress to an older person"). It is widen enough to include the five more common types of abuse (e.g., financial, psychological, physical and sexual abuse and neglect), though some have argued ambiguity about the value of single or repeated acts as baseline criteria (Biggs, Doyle, & Erens, 2009). Other argument points to the subjective elements included and the difficulties to operationalize (Biggs & Haapala, 2010; Goergen & Beaulieu, 2013; Mysyuk et al., 2013).

As Biggs and Haapala (2010) noted, increasing awareness of elder abuse promoted the public expectation that the numbers of abused elders were greater than scientific evidence showed, which along with the definitional inflation interacted with theoretical development. In fact, the need for thresholds in elder abuse definitions had been discussed by the late 1980s. Particularly, in what concerns psychological abuse and neglect, some researchers argued that one-time event could be characterising normative family conflicts and not elder abuse (Pillemer & Finkelhor, 1988). This issue was brought by prevalence research studies where the period considered was the past twelve months, which resulted in older adults reporting having been "yelled once in the past year" as a positive response to psychological abuse.

Other aspect that has render discussion within elder abuse definition relates to the concept of "expectation of trust". Trust is linked to risk, vulnerability, and to imbalance of power (Goergen & Beaulieu, 2013). However, even though dependency and diminishing autonomy may potentiate elder abuse, as they enhance the need for trust, not all relationships where elder abuse takes place presuppose asymmetric relationships and unequal power distribution (Goergen & Beaulieu, 2013). On the other hand, breach of trust and the use of trust have been documented in other forms of violence against older adults, namely, scams and frauds perpetrated by strangers (Goergen & Beaulieu, 2013). Expectation of trust seems to be employed to better distinguish elder abuse from other abusive behaviours perpetrated by strangers and to limit it to close relationships (Biggs & Haapala, 2010; Goergen & Beaulieu, 2013). It is important to frame elder abuse within adult-adult relationships, which does not imply considering that coercive imbalances in

power cannot exist (Biggs & Haapala, 2010). Limiting elder abuse to interpersonal relationships permits consider adult-adult relations as “complex interaction of expectations of independence, interdependence, and culturally and historically contingent values” (Biggs & Haapala, 2010, p. 168).

Despite the critical aspects of the adopted WHO definition, one may argue that it enables a broader range of different forms of abuse and of several kinds of relationships and therefore, widens the context covered (Mysyuk et al., 2013). Considering that research has shown how different victimisation experiences might be characterised by different risk or protective factors, determinants and even explanatory theories, elder abuse definition must be sufficiently broad to cover all variations and at the same time help to distinguish it from other phenomena. Elder abuse can be assumed to be the construct defining in a comprehensive and uniform way the problem, that can be further divided into more specific and concrete operational definitions (e.g., community vs. institutional settings; types of abuse; informal or formal perpetrators; family violence or non-family violence).

There is general agreement on the scope of actions that fall under elder abuse (Pillemer et al., 2016). These are usually described within a five category typology: (a) physical abuse as the infliction of pain or injury, physical coercion, physical/chemical restraint; (b) psychological abuse as the infliction of mental and emotional anguish; (c) sexual abuse as non-consensual contact of any kind with an older person; (d) financial abuse as the illegal or improper exploitation and/or use of funds or resources; and (e) neglect as the intentional or unintentional refusal or failure to fulfil a care-taking obligation (World Health Organization & The International Network for the Prevention of Elder Abuse, 2002, p. 3). Each described type can include several distinct behaviours. For instance, physical abuse can include being pushed, hit or administered too much tranquillising or neuroleptic medication. Because studies cannot inquire all possible abusive behaviours, the items chosen to be assessed vary greatly (de Donder et al., 2011; Gil et al., 2015). The type and number of abusive behaviours included in the studies impacts findings and results comparability. In addition, several studies have shown the co-occurrence of more than one abuse type, characterising victimisation experiences as one or more abusive behaviours within two or more types of abuse (Pillemer et al., 2016; Roberto, 2017). Overall, there is great variability in operational definitions and thresholds for abuse and abuse severity (Burnes, Pillemer, et al., 2017; de Donder et al., 2011; Fitzpatrick & Hamill, 2010), which underscore the importance of considering not only overall abuse types, but also abusive behaviours.

Because of the variation between frequency and types of abusive behaviours, some authors suggest going beyond the binary operational and analyse abuse types as dimensional variables considering a continuum in terms of frequency and severity (Burnes, Pillemer, et al., 2017).

2. The victim-abuser relationship

Elder abuse perpetrators include anyone with special access to older adults, including family members, relatives, friends, neighbours, and professional caregivers (National Center on Elder Abuse, 1998; Roberto, 2017). The majority of perpetrators have an ongoing relationship with the older adults long before elder abuse occurrence (Jackson & Hafemeister, 2012; Krienert, Walsh, & Turner, 2009). Prevalence studies of elder abuse in the community indicate spouses or partners and offspring as the main perpetrators, even though the predominant type of victim-offender relationship appears to vary by abuse type (Jackson & Hafemeister, 2014).

In the USA, Israel and Europe the spouse or partner are the most common perpetrators of elder psychological and physical abuse (Amstadter et al., 2011; Burnes et al., 2015; Laumann, Leitsch, & Waite, 2008; Lindert et al., 2013; Lowenstein, Eisikovits, Band-Winterstein, & Enosh, 2009; Manthorpe et al., 2007; Pillemer & Finkelhor, 1988) and of sexual and physical abuse in the UK and Israel (Lowenstein et al., 2009; Manthorpe et al., 2007). Offspring were found to be the most common perpetrators of emotional and physical abuse in Asia (Chokkanathan & Lee, 2005; Oh, Kim, Martins, & Kim, 2006) and of financial abuse in the USA, Israel and Ireland (Laumann et al., 2008; Lowenstein et al., 2009; Naughton et al., 2012). These results suggest differences by type of abuse and by culture. Furthermore, data from Spain also suggests possible differences according to victims' functional status - the main perpetrators of older people who are dependent or have disabilities were adult offspring, whereas partners were identified as the main perpetrators for independent older people (Marmolejo, 2008). Even with several studies reporting non-relatives and formal caregivers as perpetrators (Lowenstein et al., 2009; Manthorpe et al., 2007; Marmolejo, 2008; Podnieks, 1993), elder abuse within community setting takes place, for the most part, within the family.

Different conceptual approaches privilege distinct aspects when it comes to the relationship between victim and abuser. The feminist theory and the family violence approach suggest a gendered-base analysis of elder abuse (Penhale, 2003; Spangler & Brandl, 2007). The abusive relationship is seen as the product of gender and age

inequalities, where the perpetrator uses a pattern of coercive tactics to gain and maintain his/her power and control (Spangler & Brandl, 2007).

Part of elder abuse is Intimate Partner Violence (IPV) in later life (Penhale, 2003). IPV in older adults can be conjugal violence grown old, where abuse that has begun earlier in life continues into older age, or a new experience of abuse (Goergen & Beaulieu, 2013; Montminy & Straka, 2006; Penhale, 2003; Roberto, 2016). The first, probably, presents risk and protective factors and determinants more similar with IPV at younger ages, whereas the last one reflects the specific dynamics of growing old (Goergen & Beaulieu, 2013). Even though family violence often explains abusive relationships as stemming from a power imbalance between the genders, it can also manifest in the parent–child relationship (Band-Winterstein, 2015; Lin & Giles, 2013). The unbalance of power might be particularly felt when dependency and care needs increase over time and the older adult must depend on the offspring in their day-to-day living (Band-Winterstein, 2015; Lin & Giles, 2013). While a family violence perspective adds to our understanding of elder abuse in community setting, placing it exclusively within this framework runs the risk of confining it as an issue of families and individuals, dismissing specificities related to age (Harbison et al., 2012).

The life-course perspective, on the other hand, values the history of the relationships and changes that can be brought in old age between both spouses/partners and adult-adult child (Band-Winterstein, 2015; Walsh et al., 2007). In the case of IPV in old age, social and family structure changes in older age, and as such retirement, becoming a caregiver, or starting new relationship can be precipitating factors for elder abuse (Walsh et al., 2007). New and unexpected disability may be related with the beginning of an abusive situation, but also with changes in the abusive experiences already occurring. For instance, victims of IPV in younger age may become perpetrators if the previous abuser becomes dependent on their former victim (Kinnear & Graycar, 1999; Sengstock, 1991).

Parent–child relationships throughout the life span is an important aspect within elder abuse (Band-Winterstein, 2015). The quality of present intergenerational relationships relates to the history and experiences between children and their parents. There is not enough evidence on the importance of the relationship to elder abuse occurrence (Band-Winterstein, 2015; Lin & Giles, 2013). However, people's lives are interdependent and as such are affected by one another, and transitions in one person's life often leads to transitions for the other people as well (Elder & Johnson, 2002; Schiamberg & Gans, 2000; von Heydrich, Schiamberg, & Chee, 2012; Wang, Kang, & Schiamberg, 2014). In a review on dementia care, previous or current poor relationships characterised by conflict

and aggression were found to be a risk factor for psychological abuse (Downes et al., 2013). Overall, the existence of longstanding conflict between parents and children and the quality of the relationship prior to the occurrence of elder abuse may be an important predictive factor (World Health Organization, 2011).

Because the causes or motivations behind individual acts of abuse, and the environments in which they occur are infinitely variable, no single theoretical model or perspective will be enough to predict the behaviour. Nevertheless, there are identifiable risk factors and similar patterns across settings and abuse types, particularly regarding the elderly victim, the perpetrator and the relationship between these two parties.

3. Risk and protective factors – applied ecological framework

The ecological approach provides a useful framework to the multi-dimensions perspective and variability of elder abuse, because it promotes the inclusion of variables at the individual (victim and perpetrator) and the relationship levels, and variables related to broad ideological values and norms of a culture (Burnight & Mosqueda, 2011; Schiamberg & Gans, 1999).

Bronfenbrenner's human ecological perspective (Bronfenbrenner, 1979) considers the individual within four levels of environments: individuals and family (microsystem); the relationships between the family and other principal settings (mesosystem); the level that is removed from the individual but linked to other family members (exosystem) and the broad ideological values, norms and institutional patterns of a culture (macrosystem) (Schiamberg & Gans, 1999). An ecological approach can be applied to elder abuse, where consideration is given to how an individual interacts with informal network and within the wider community and society to which they belong. Considering that abusive situations often occur on an individual level (between two people) and in the privacy of the family, this approach can be bi-focal, focusing on the older person and the person of trust (perpetrator) as a familial dyad (Schiamberg & Gans, 1999). The ecological approach refuses the linear "adding up" version of other conceptual approaches to elder abuse (e.g., caregivers stress) as it proposes that the degree or impact of each risk and protective factor is mediated by individual, community and social level characteristics (Sev'er, 2009). Both individuals are influenced in their behaviours by various other relationships, the communities to which they belong, and societal beliefs around ideas of age, family violence and conflict, intergenerational wealth, caregiving and parents and

children roles. However, this approach does not offer an overall explanation and therefore does not establish any set of predictions to test (Burnight & Mosqueda, 2011).

Fifty risk factors on elder abuse where identified, although only 13 were found consistently across studies (Johannesen & Logiudice, 2013). Of these, eight concerned the older adult: cognitive impairment; behavioural problems; psychiatric illness or psychological problems; functional dependency; poor physical health or frailty; low-income or wealth; trauma or past abuse and ethnicity. For the perpetrator the authors identified two major risk factors: caregiver burden or stress and psychiatric illness or psychological problems. At the relationship level the suggested risk factors were the family disharmony, poor or conflicting relationships, while at the environment level the 2 appointed risk factors were low social support and cohabitation (Johannesen & Logiudice, 2013).

Living arrangements is strongly associated with distinct types of abuse. While living alone seems to diminish the risk of psychological and physical abuse, it is linked to an increased risk of financial abuse (Jackson & Hafemeister, 2012; Pillemer et al., 2016). Financial abuse appears to be more common in the elderly living alone, without children and without a family history of violence (Jackson & Hafemeister, 2011b). In the case of the perpetrators, Johannesen and Loguidice (2013) found mental health problems and dependency on the older adult.

The impact of social support on health and quality of life has been recognised before, and often associated with social isolation (Dong & Simon, 2008; Lachs et al., 2016). The association between social support and abuse is not yet clear, because it might also be a result of the abuse itself. Nevertheless, social support is a protective factor because not only decreases older adults' vulnerability, but also because it acts as a buffer against stressful situations (Melchiorre et al., 2013), while also implies greater social control, which can reduce the risk of violence occurrence (Dong & Simon, 2008).

For psychological and physical abuse, different studies have indicated that older adults' depression or depressive symptoms are specifically associated with these types of abuse (Manthorpe et al., 2007; Podnieks, 1993; Wu et al., 2012). The perpetrators history of mental illness is more strongly associated with physical abuse (Acierno et al., 2010), while substance abuse is linked to increase risk of psychological abuse (Hwalek, Neale, Goodrich, & Quinn, 1996; Liu, Conrad, Beach, Iris, & Schiamberg, 2017).

Overall, evidence reflects victimisation experiences diversity, namely, that risk factors differ by type of mistreatment (Pillemer et al., 2016; Roberto, 2016) and that key characteristics and behaviours seem to be associated, rather than standing as isolated

risks (National Research Council, 2003). Because it is important not to treat risk or protective factors as orthogonal uncorrelated variables (Jackson & Hafemeister, 2013), the ecological framework may appropriately reflect the interplay of the risk and protective factors at distinct levels.

4. The facets of a multifaceted problem

Elder abuse is a highly complex social, health and legal problem. It can take many forms, including financial, physical, psychological and sexual, as well as neglect. The abusive behaviours can be acts of either omission or commission, deliberate or inadvertent. Victims can be community-dwelling older adults, and abuse can occur within family context or be perpetrated by other informal or formal members of ones' social network. Because the type of victim, the type of abuse, the relationship with the perpetrator and the setting differ markedly and encompass a very wide range of configurations, research evidence is sometimes contradictory and difficult to translate into practice. In addition, much of the literature on elder abuse does not sufficiently distinguish between theoretical explanations and the individual factors related to elder abuse (McDonald, 2011). For instance, while dependency is clearly a risk for elder abuse, it should not be treated as an explanation for abuse occurrence, but as a factor to be incorporated in the broader understanding of the problem (Walsh et al., 2007). At the same time, research shows that while elder abuse describes unique victimisations experiences in older age, there are potentially co-occurring issues within distinct configurations that are influenced by both individual and contextual variables (Mosqueda et al., 2016; Pillemer et al., 2016). In fact, there seems to be increasing consensus as to the multifaceted nature of elder abuse (Goergen & Beaulieu, 2013; Jackson & Hafemeister, 2013; Lachs & Pillemer, 2004; Lowenstein, 2009; National Research Council, 2003; Payne, 2002; Pérez-Rojo & Penhale, 2006), recognizing it as a problem where multiple types of abuse can occur alone or together (Jackson & Hafemeister, 2013; Roberto, 2016), with heterogeneous perpetrators (DeLiema, Yonashiro-Cho, Gassoumis, Yon, & Conrad, 2017; Jackson, 2016; Roberto, 2017) and with the victims characteristics playing or not a role as risk factors depending on the configuration.

The following figure displays this thesis conceptual model. Elder abuse is considered as a multidimensional problem defined by the confluence of three key elements: abusive behaviours, victim and perpetrator (including the nature of their relationship). The interaction between these three elements is framed within a specific context. More than

distinguishing one of these dimensions (e.g., type of abuse or type of relationship between victim and perpetrator), this model highlights the interaction of those three dimensions. The characteristics of the victim and of the abusive individual, the nature of their relationship and the experienced abusive behaviours describe potential varying triggering factors, consequences and responses efficacy, indicating that one theory does not adequately address all the elder abuse configurations.

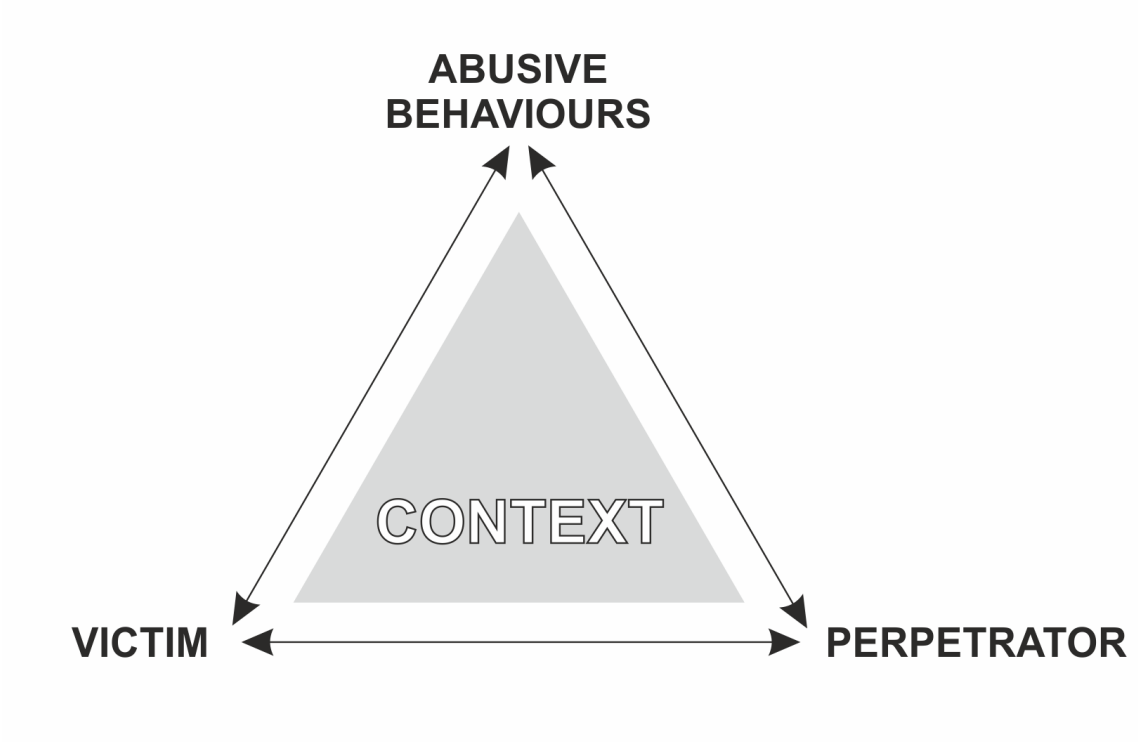

Figure 1. Elder abuse conceptual model

Firstly, the dynamic approach that encompasses both the elderly victim and the abusive individual should be used. Research shows that characteristics of both the victim and the abusive individual predict the occurrence of different forms of elder abuse (Jackson & Hafemeister, 2012; Pillemer et al., 2016). For instance, victims' impairment seems to be more relevant for neglect (Wolf & Pillemer, 1989), whereas some studies suggest perpetrators' financial dependency on the victims to be significantly higher within psychological and financial abuse (Brandl, Heisler, & Stiegel, 2005; Jackson & Hafemeister, 2011a; National Research Council, 2003).

Secondly, the nature of the relationship between victim and perpetrator needs to be identified. Distinct dynamics are probably associated with the elder abuse occurrence, whether it is perpetrated by a family member, by a close non-relative individual or by a

formal service provider. The behaviour and motivations of both the elderly person and the abusive individual will be considerably different according to the nature of the relationship. On one hand, research shows that risk and protective factors are differently associated with distinct types of relationship between victim and perpetrator (Jackson, 2016). On the other hand, consequences and, so, interventions might need different approaches according to the involved dyad victim-perpetrator.

Thirdly, abusive behaviours are associated with specific victims and perpetrators characteristics as well as types of relationship. The variability between frequency and types of abusive behaviours indicates the need to consider abuse as a continuum in terms of frequency and intensity (Burnes, Pillemer, et al., 2017). Hence, abusive behaviours may change over time within an abusive relationship and have distinct patterns.

The model highlights that elder abuse can take several different configurations and that the nature of abuse varies with the victim and the abusive individual characteristics, the nature of the relationship that brings (and keeps) these parties together, and the types of abusive behaviours. These dimensions are all intertwined and constrained by the context in which the relationship arises. Consideration for all these aspects, though challenging, might help to pinpoint configurations and detect patterns, shared commonalities and differences that can help increase our understanding of the phenomenon and develop appropriate responses.

Chapter III *Context of this thesis*

In the preceding chapters, we have reviewed research focusing on elder abuse definitions, types, relationship between victim and perpetrator, theoretical and explanatory models and interventions. The fact that several of these issues remain poorly understood or lacking conceptual development, can, in part, be driven from unidimensional approaches to the problem. Elder abuse is a complex problem that has been researched from different disciplinary perspectives, that usually focus on specific dimensions. This thesis aims to incorporate the multidimensionality on community dwelling elder abuse research and to reflect on what these findings add to our understanding of elder abuse.

The first objective was to, within the major areas of research, analyse different takes on elder abuse, namely, on prevalence, risk factors, consequences and intervention. The question was whether further results can be obtained when we attempt to capture the phenomenon's multidimensionality: what are we missing (if anything at all) when we look into elder abuse within a single dimension in terms of prevalence, risk factors or consequences? The four studies within the first three chapters of the empirical work address this objective (table 3) and attempt to capture elder abuse diversity, focusing on psychological abuse measures (Chapter IV), depressive symptoms as a risk factor for abuse (Chapter V), and emotional reactions to abuse (Chapter VI).

The second objective was to represent elder abuse victimisation experiences, encompassing more than one dimension of the problem (Chapter VII). The question was whether there was any way of capturing a more complex representation of elder abuse, encompassing more than one dimension? The two studies included in Chapter VII attempt to offer a more complex representation of elder abuse victimisation experiences by analysing both abusive behaviours and the victim-perpetrator relationship.

Chapter VIII includes a theoretical review of clinical interventions towards elder abuse, which summarises the different theoretical explanations that have been used to respond to elder abuse. It intends to reflect on how interventions can respond to elder abuse complexity.

Table 3. Outputs and objectives

	Outputs	Objectives
Chapter IV	*Psychological elder abuse: measuring severity levels or potential family conflicts?*	Assess the impact of two different measures on psychological abuse prevalence, ranking of identified perpetrators and victims' characteristics.
Chapter V	*Estudo de validação em Portugal de uma versão reduzida da Escala de Depressão Geriátrica [Portuguese validation study of a short version of the Geriatric Depression Scale].*	Present the psychometric properties of a Portuguese short version of the Geriatric Depression Scale (GDS5).
	Exploring the correlates to depression in elder abuse victims: abusive experience or individual characteristics?	Examine whether individual characteristics and/or characteristics of abusive experiences correlate with depressive symptoms among a convenience sample of older adults who have self-reported elder abuse.
Chapter VI	*Older adults' emotional reactions to elder abuse: individual and victimisation determinants.*	Explore the association between the main evoked emotions and feelings of community-dwelling older adults who have experienced abuse, and individual and abusive characteristics.
Chapter VII	*From appointed perpetrators and abusive behaviours to victimisation patterns: new approaches to elder abuse typologies using two cross-sectional surveys.*	Describe patterns of victimisation experiences using Latent Class Analysis in two samples of older adults: a representative sample of community-dwelling adults and a convenience sample of older adults reporting elder abuse.
	Ageing and abuse: vulnerabilities and limited time	Examine the perceptions of elder abuse held by older adults reporting different victimisation experiences considering the history of elder abuse and ageing.
Chapter VIII	*Maus Tratos e Negligência da Pessoa Idosa: Modelos Teóricos e Intervenção* [Mistreatment and neglect against older adults: theoretical models and intervention]	Review of conceptual approaches to different intervention programs and strategies.

The thesis focuses on elder abuse occurring on community-based setting and involves a secondary analysis of data from the Ageing and Violence research project. The project took place between 2011 and 2014 and was coordinated by Ana Paula Gil of the Department of Epidemiology of the National Heath Institute Doutor Ricardo Jorge. The project commissioned and funded by Fundação para a Ciência e a Tecnologia (FCT) (PTDC/CS-SOC/110311/2009), included the following institutions as partners: Centre for Sociological Studies of the Universidade Nova de Lisboa (CESNOVA); Portuguese Association for Victim Support (Associação Portuguesa de Apoio à Vítima; APAV);

Portuguese Institute of Legal Medicine and Forensic Sciences (Instituto Nacional de Medicina Legal e Ciências Forenses, IP; INMLCF, IP); Social Security Institute (Instituto de Segurança Social; ISS, IP); National Republican Guard (Guarda Nacional Republicana; GNR).

The Ageing and Violence project was the first study to nationally address elder abuse. It allowed for a comprehensive picture of elder abuse in Portugal, by providing prevalence figures, risk factors and characterising the phenomenon. These outcomes, based on sound research of national representative samples, are crucial for any country to grasp such a complex topic. Because it also included qualitative approaches to the problem it advanced on the dynamics and patterns that elder abuse entails.

The project included two surveys:
(a) a population-based survey that aimed to estimate prevalence and characterise situations of elder abuse within the family context experienced by individuals living in Portugal, aged 60 and over; and
(b) a survey targeting self-reporting victims of elder abuse, living in Portugal, aged 60 and over, identified and referred by one of the project partner institutions: APAV; INMLCF, IP; ISS, IP and GNR.

Table 4. Ageing and Violence surveys methods

		Population based survey	**Victims' survey**
Sample	Inclusion criteria	Being 60 or more years of age Living in private households Living in Portugal for the past 12 months Having land or mobile telephone	Being 60 or more years of age Living in private households Living in Portugal for the past 12 months
	Sampling	Nationally representative probability sample (*Random Digit Dialling*) stratified by seven geographic regions with homogeneous allocation of sampling units	Convenience sample of individuals using the services of four institutions: APAV; INMLCF, IP; ISS, IP and GNR.
	Sample size	1123	510 (INMLCF, IP=252; GNR=133; ISS, IP=72 and APAV=53)
Data collection	Method	Telephone interviews	Face-to-face interviews
	Instruments	Structured questionnaire	Structured questionnaire
	Period	October 2012	November 2011 to March 2013

The two surveys employed different methods displayed in Table 4. The prevalence study was a cross-sectional population-based study with data collected through Computer-Assisted Telephone Interviewing (CATI). The sample was designed to be a nationally representative probability sample, with 1123 individuals aged 60 and over. The victims' survey encompassed a convenience sample (n=510) obtained from individuals aged 60 and over reporting to one of the four project partner institutions.

The structured questionnaire employed in the two surveys was very similar (Table 5). The first section characterised the demographic and socio-economic profile of participants (age, gender, civil status, cohabitation and years of schooling) as well as their physical and mental health condition (chronic disease and depressive symptoms), functional status (Activities of Daily Living) and perceived social support (Gil, Kislaya, et al., 2015; Gil, Santos, Kislaya, & Nicolau, 2014).

The second part included questions covering the abusive behaviours, frequency of abuse, characteristics of perpetrators and help-seeking behaviour. For each of the positively answered abusive behaviours, respondents were asked to indicate a perpetrator, which included spouse/partners, children, grandchildren, sons and daughters-in-law, other family members, friends, neighbours, work colleagues, paid professionals and volunteers (Gil, Kislaya, et al., 2015; Gil et al., 2014). If a participant reported more than one abusive behaviour, then he or she could indicate more than one perpetrator. Respondents were also asked about the frequency of occurrence of each of these behaviours during the past twelve months.

Table 5. Variables included in the structured questionnaire of the two surveys of the Ageing and Violence project

Subsections	Variables	Prevalence study	Victims survey
Sociodemographic	Sex, age, civil status, schooling, employment status and profession	√	In addition, *municipality*
Household	How many and whom cohabitates	√	√
Socioeconomic	Type of household (e.g., rented, owned), household monthly income	√	√
Health status	Chronic disease	√	√
	Depressive symptoms (GDS 5)	√	√
Functional status	Activities of Daily Living (ADL), person that helps with ADL, refusal to help with ADL (neglect), frequency of refusal	In addition, *seriousness* of the refusal	√
Social support	Informal	√	√
	Formal	√	√
Abuse Financial, psychological, physical and sexual	Abusive behaviours Perpetrator Frequency	√	√
Abuse and neglect characterization	Characterization of the perpetrator responsible for the most serious event	√	√
	Emotional consequences	Not inquired	√
Help-seeking behaviour	Help-seeking behaviour (yes/no)	√	√
	Whom or where to seek help	√	√
	Reasons not to seek help	√	Not inquired

The project considered twelve abusive behaviours within five main types of abuse (Table 6). The diverse types of abuse were distinctively recorded as positive. The Ageing and Violence project framed the different behaviours based on criteria proposed by Pillemer and colleagues (Lachs et al., 2011; Pillemer & Finkelhor, 1988). In the case of financial, physical or sexual abuse, any incident occurring once in the past twelve months was considered abuse. Neglect and psychological abuse were positively recorded if a person experienced more than ten incidents in the previous twelve months.

Table 6. Abuse types and behaviours

Abuse	Description of behaviours
Physical	▪ Physical aggression (e.g., pushing, pulling, grabbing, tying, cutting, hitting, striking with an object, among others) ▪ Lock the person in a room/apartment or limit the access to the entire household ▪ Hindering of speaking or meeting someone
Psychological	▪ Threats ▪ Verbal aggression, insulting, humiliating (e.g., screaming, offending, insulting) ▪ Ignoring or refusal to talk
Sexual	▪ Unwelcome sexual advances, requests for sexual favours and other verbal or physical actions of a sexual nature
Financial	▪ Forcing to give legal rights ▪ Stealing or using property beyond the consent of its owner ▪ Undue household appropriation ▪ Not contributing to the household expenses
Neglect	▪ Refusal or abstinence from acting or caring for someone resulting in injury, pain, suffering or even death of another person in their care or custody

Adapted from Gil et al., 2015.

The project also conducted in-depth interviews throughout the country in the pilot and exploratory phase (n=13), in 2011, and after the data collection and statistical analysis, in 2013 (n=19). The former interviews sought to gain more detailed knowledge about elder abuse and its origins (Gil, Kislaya, et al., 2015; Gil, Santos, & Santos, 2013), while the last interviews aimed to deepen some dimensions of the typologies resulting from the statistical analysis. The participants were identified and referred by two of the project partner institutions: APAV and GNR (Gil et al., 2015). Participants were community-dwelling older persons 60 years or older, which had experience one or more types of abuse and whom had sought help about the victimisation experience in a non-governmental victims' support institution or the police. Participation was voluntary. Recruitment of participants was through purposeful, convenience sampling. The professionals working in these institutions, who were working or had worked with the older adults, carried out first contacts.

The empirical studies included in the present thesis were conducted with data from both samples according to the objective and the adequacy of the data (Table 7). The study focusing on prevalence (Chapter IV) employed the sample of the population-based prevalence survey. The studies on depressive symptoms as risk factors (Chapter V) and

victims' emotional reactions (Chapter VI) used the sample from the victims' survey. Data from both surveys was employed in the exploratory validation study of the short versions of the Geriatric Depression Scale (Chapter V) and the study using Latent Class Analysis to explore configurations of victimisation experiences (Chapter VII). Within this former chapter, the qualitative study victims' narratives employed the in-depth interviews conducted in the Ageing and Violence project.

Table 7. Studies conducted with data from the Ageing and Violence project

Chapters	Studies	Prevalence study	Victims survey
Chapter IV	[Study 1] Psychological elder abuse: measuring severity levels or potential family conflicts?	√	
Chapter V	[Study 2] Estudo de validação em Portugal de uma versão reduzida da Escala de Depressão Geriátrica [Portuguese validation study of a short version of the Geriatric Depression Scale].	√	√
	[Study 3] Exploring the Correlates to Depression in Elder Abuse Victims: Abusive Experience or Individual Characteristics?		√
Chapter VI	[Study 4] Older adults' emotional reactions to elder abuse: individual and victimisation determinants		√
Chapter VII	[Study 5] From appointed perpetrators and abusive behaviours to victimisation patterns: new approaches to elder abuse typologies using two cross-sectional surveys.	√	√
	[Study 6] Ageing and abuse: vulnerabilities and limited time.	In-depth interviews	

A formal authorisation was obtained for the use of the Ageing and Violence project, and all procedures followed strict ethical standards to guarantee the confidentiality of participants and the correct use of the data.

The secondary analysis of the projects' existing data allows a complementary and distinct perspective from that firstly obtained. This thesis shifts the focus from a more sociological and public health conceptualisation of elder abuse to a psychological assessment by directing the analysis to the impact of different dimensions in elder abuse outcomes. It addresses the relevance of the dyad victim-perpetrator, depressive symptoms as both a consequence and risk factor for elder abuse, the set of emotions that elder abuse may enrol, and the victims' perception of the dynamics between her/him and the perpetrator. The focus on the different dimensions and the variability that characterises elder abuse helps to find patterns and point to hypotheses about the dynamics that further on stem the conceptual development of the field.

Overall, the fact that the data was collected specifically to study elder abuse and the knowledge that procedures data collection used rigorous methodologies enhances the confidence that the information obtained is both reliable and accurate. Furthermore, the participation in the coordinating team of the Ageing and Violence project allows for an in-depth knowledge of the data strengths and limitations.

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Part 2 – Empirical work

Chapter IV

Psychological elder abuse in perspective: measuring severity levels or potential family conflicts?

Psychological elder abuse in perspective: measuring severity levels or potential family conflicts?

Abstract

Purpose – Psychological elder abuse (PEA) assessment is described with different thresholds. The purpose of this paper is to examine how the prevalence of PEA and the phenomenon's characterisation varied using two different thresholds.

Design/methodology/approach – Participants from the cross-sectional population-based study, Ageing and Violence (n=1,123), answered three questions regarding PEA. The less strict measure considered PEA as a positive response to any of the three evaluated behaviours. The stricter measure comprised the occurrence, for more than ten times, of one or more behaviours. A multinomial regression compared cases from the two measures with non-victims.

Findings – Results show different prevalence rates and identified perpetrators. The two most prevalent behaviours (ignoring/refusing to speak and verbal aggression) occurred more frequently (>10 times). Prevalence nearly tripled for "threatening" from the stricter measure (>10 times) to the less strict (one to ten times). More similarities, rather than differences, were found between cases of the two measures. The cohabiting variable differentiated the PEA cases from the two measures; victims reporting abuse >10 times were more likely to be living with a spouse or with a spouse and children.

Research limitations/implications – Development of a valid and reliable measure for PEA that includes different ranges is needed.

Originality/value – The study exemplifies how operational definitions can impact empirical evidence and the need for researchers to analyse the effect of the definitional criteria on their outcomes, since dichotomization between victim and non-victim affects the phenomenon characterisation.

Keywords: Domestic violence, Elder abuse, Older adults, Measures, Psychological abuse, Severity levels

Introduction

Elder abuse and neglect is a difficult construct to measure, with reported variation on methodologies, instruments and measures employed by different prevalence studies (Cooper et al. 2008; de Donder et al. 2011). Most common types of abuse include psychological, financial, physical and sexual abuse, but psychological is the one with less published literature, lacking development from a measuring point a view (Conrad et al. 2009; Dong 2014; Macassa et al. 2013). Notwithstanding, this form of abuse is rather often identified in prevalence studies as the most common. Two recent multi-national European studies found 25.3% psychological abuse among older women (Luoma et al., 2011) and prevalence rates for older adults from seven European countries ranging between 10.5% (Italy) and 29.7% (Sweden) (Soares et al., 2010).

This study examines the impact of employing two different measures to evaluate psychological elder abuse, on prevalence estimates, identified perpetrators and victims' risk factors to explore whether milder psychological abuse behaviours are etiologic predictive forms of psychological abuse or of family functioning?

Psychological abuse comprises verbal assaults, insults, threats, intimidation, humiliation, and harassment, among other abusive behaviours (National Research Council, 2003). Because these behaviours do not always involve tangible violence, evaluation can be difficult, not only in elder abuse, but also in other forms of Interpersonal Violence (IV) (Foran et al., 2014; Karakurt & Silver, 2013). The lack of physical evidences and not so easily identifiable consequences can partially explain the operationalization difficulties (Karakurt & Silver 2013). As Conrad and colleagues stated, "for psychological abuse this maybe because there are fine lines and gray areas in the spectrum of normal bickering and name-calling" (2009, p.157). The lack of a consensual standardized measure reflects the difficulty of assessing a latent social construct that often comprises cultural variations that affect meaning, perception and definition of the phenomenon (Conrad et al., 2009; Kosberg et al., 2003; Pillemer and Finkelhor, 1988; Dong, 2014).

Despite being included in many of the recent prevalence studies, assessment of psychological elder abuse varies widely (de Donder et al., 2011; Gil et al., 2015; Mowlam et al., 2007). Some studies, for example, employ a general question on whether the participant had been victim of psychological abuse, while others ask about specific behavioural acts (de Donder et al., 2011; Fulmer et al., 2004; Gil et al., 2015). Although the need for definitions that include the description of specific behavioural conducts is nowadays acknowledged (Fulmer et al., 2004), the number and type of acts still varies between studies (de Donder et al., 2011; Gil et al., 2015).

Psychological elder abuse comprises behaviours commonly found in interpersonal conflicts (e.g. ignoring or refusing to speak), rendering an often mentioned criticism on the separation between what could be entitled “normal family conflicts” and what constitutes “abusive conducts” (Conrad et al., 2009; Gil et al., 2015; Pillemer and Finkelhor ,1988; Mowlam et al., 2007). Family dynamics encompass a number of conflicts and disputes, as part of the family system, without necessarily reporting to abnormal or unhealthy familiar relationships (Reher, 1998; Astrachan and McMillan, 2003; Pillemer and Wolf, 1986). The interpersonal relationship in which the psychologically abusive act occurs explains the difficulty of drawing a line between abuse and ‘normal’ levels and expressions of conflict in adult relationships (Mowlam et al., 2007; Pillemer and Finkelhor, 1988).

The need to create a threshold, first introduced by Pillemer and Finkelhor (1988) was deemed necessary to overcome the definitional disparities and criticisms of including all family problems under the label psychological elder abuse. These authors, to account for the risk of overestimating prevalence values - that a positive response to a specific conduct might gather (e.g., being yelled once in the past twelve months) - added a frequency criterion, defining psychological abuse as “the elderly person being insulted, sworn at, or threatened at least 10 or more times in the preceding year” (Pillemer and Finkelhor, 1988, p.53). The frequency criterion of psychological elder abuse has been commonly used in recent population-based prevalence studies, applied either to all or to some items of this form of abuse (Naughton et al., 2012; Biggs et al., 2009; Lachs et al., et al., 2011; Cooper et al., 2008).

It is important to establish thresholds and cut-offs that consider the possibility of assessing as abuse normal conflict situations within the family. However, asking about a specific behavioural conduct implies the formative nature of items because answers are “indicative (predictive) for the existence or extent of elder abuse” (Lang et al., 2014). The question is whether that behaviour truly reflects psychological abuse or a manifestation of “normal” interpersonal conflict. The frequency criterion differentiates the measure in terms of sensibility and specificity. The more restricted the criterion more specificity and less sensibility would be attributed to the instrument. In other words, considering the phenomenon as a spectrum of degrees of behaviours, the mild cases (less frequent and/or less serious) would be left out in studies assessing psychological abuse acts with previously determined frequency.

Despite the great variability in specific definitions and thresholds for severity of abuse (Daly and Jogerst, 2001; de Donder et al., 2011), to the best of our knowledge, only one study has analyzed the effect of different measures on elder abuse. This is the case of a

study conducted with Chinese older adults in the Greater Chicago area (USA), which found differences in prevalence rates, but not on sociodemographic characteristics associated with elder abuse (Dong, 2014). Because this study focused on a specific subgroup of the population, with cultural and contextual specificities, the results cannot be generalized to other populations.

The present study focuses on the effect of using two different measures to assess psychological elder abuse. These two measures differentiate from each other by the reported frequency of the experienced abusive behaviours to determine (or not) a positive response to elder abuse.

The study is developed upon a sample of the Portuguese Ageing and Violence study (Gil et al., 2014) conducted between 2011 and 2014 and aimed to estimate the prevalence of violence in community-dwelling adults aged 60 or more years. Psychological abuse was one of the most prevalent types of identified abuse, reported by 6.3% (95% CI [4.7 per cent, 8.5 per cent]) of the target population (Gil et al., 2014). The first purpose of this study is to describe the prevalence according to the two different measures. A second study goal is to portray the perpetrators in each group victims, as defined by the two measures. Thirdly, this study proposes to examine sociodemographic and socioeconomic correlates; examining potential associated factors in each of the two identified victim groups may be particularly informative for appraisal of the resemblance or dissimilarity between these two groups.

Method

Sample

Cross-sectional data comes from the Ageing and Violence study (Gil et al., 2014) - a population-based study that estimated elder abuse prevalence (i.e., physical, psychological, financial and sexual and neglect) within a representative sample of Portuguese community-dwelling individuals aged 60 and over. Participant inclusion criteria were: being 60 or more years of age; having land or mobile telephone; living in private households and living in Portugal for the past 12 months.

The prevalence estimate of overall elder abuse was 12.3 per cent (95% CI [9.9 per cent, 15.2 per cent]). Financial and psychological abuse were the most frequently reported forms of abuse: 6.3 per cent (95% CI [4.5, 8.6]) and 6.3 per cent (95%CI [4.7, 8.5]), respectively. Prevalence of physical abuse was 2.3 per cent (95% CI [1.4, 3.8]), while

neglect (0.4 per cent, 95%CI [0.1, 1.4]) and sexual abuse (0.2 per cent, 95% CI [0.03, 1.1]) were the least frequent abuse behaviours.

Procedure

Data collection was conducted in October 2012 by Computer-Assisted Telephone Interview Technique (CATI). Sixty percent of telephone numbers were randomly selected from directory-listed landline telephone numbers, while the 40% cell phone numbers were generated through random digit dialing (RDD). Sample was obtained through a nationally representative probability sample stratified by the country's seven geographic regions with homogeneous allocation of sampling units.

The telephone interviews were conducted by health or social professionals hired for the survey between September and October 2012. The interviewers were trained on filling rules and questions options of the questionnaire, but also on the topic. Form previously conducted focus groups and victims in-depth interview (for further developments see Gil et al., 2015), the training also focused on making the interviewers more comfortable with the survey topic and by presenting potential reactions to the study. Objective information about respondents' reactions was provided by the researcher's real experiences within the focus groups and interviews. Understanding and respecting the emotional state of a respondent and how to proceed, were incorporated in more active techniques of the training. Instructions were provided to decide when to stop or give time during the interview, how to respect crying and when to suggest a call later, for instance. The interviewers were given a set of contact numbers (Police, victims support organizations and other non-governmental organizations) to provide to older adults' victims of violence in the end of the interview. Supervision was done in real-time (listening to the interview as it happened, without the interviewer being aware) and corrections were done accordingly.

The study scientific protocol was submitted and approved by the National Commission for Data Protection (NCDP) and the Ethics Committee (EC) of the coordinating institution. A short informed-consent was given verbally, where besides the study presentation, the interviewers highlighted the possibility of the older adult not answering a specific question or stopping the interview altogether.

A total of 1123 individuals were included in the study, from 1517 eligible for the interview, encompassing a response rate of 74%.

Measurements

The structured questionnaire included demographic questions (age, sex), health and functional status (chronic diseases and Activities of Daily Living), social and economic

variables (education, living arrangement, housing situation) and perception of social support.

Abuse questions were adapted from the instrument applied in the New York elder abuse prevalence study (Lachs et al., 2011), which presents a very similar structured to the ones employed in the UK (O'Keeffe et al., 2007) and in Ireland (Naughton et al., 2010). Overall, 12 behaviours were distributed within five of abuse types (psychological, financial, physical, sexual abuse and neglect). Participants were asked about the occurrence and the frequency of each of these behaviours during the 12 months preceding the interview. In the questionnaire each of the five types of abuse is operationalized through multiple behaviourally specific questions.

The positive response to neglect and psychological abuse was based on the criterion proposed by Pillemer and Finkelhor (1988) and differs from the definition of financial, physical or sexual abuse because it considers these two forms of abuse only when the frequency of the inquired behaviours occurs more than 10 times in the preceding year. Elder abuse included abusive behaviours perpetrated by: spouse or partner; daughter and granddaughter; son and grandson; other relatives and informal network (not including family members). The instrument was piloted and data from focus group and in-depth interviews was used to evaluate it. Those results helped to choose the words employed in the abuse questions, the ordering of the questions; to redefine and rephrase other questions; and to assure that response options in the closed questions were exhaustive and mutually exclusive (for further developments see Gil et al., 2015).

Psychological abuse was measured by asking about the experience of three specific behaviours ("In the last 12 months, has anyone close to you…"): (i) "threatened to abandon, harm, punish or institutionalize you?"; (ii) "screamed at you, insulted, belittled or humiliated you?"; and (iii) "ignored or refused to talk to you?". The frequency of each of the three behavioural acts was evaluated for the past 12 months: 1-time occurrence; between 2 and 10 times and more than 10 times.

The Ageing and Violence study applied case-description defines psychological elder abuse as a positive response to any of the three evaluated behaviours, experienced more than 10 times in the previous 12 months. To understand the impact of this threshold a less strict measure was developed, comprising the cases excluded from the Ageing and Violence study applied case-description. It considered psychological elder abuse as a positive response to any of the three assessed behaviours experienced once or more in the previous 12 months. Hence, any participant that reported having experienced at least one of the three behaviours more than 10 times in the past 12 months was classified as

victim within the stricter measure. Participants stating to have experienced in the past 12 months, any of the three assessed behaviours between 1 and 10 times, were classified as victims by the less strict measure.

Further developments on study design and instrument development can be found in previous publications (Gil et al., 2014; Gil et al., 2015).

Analytic strategy

To test the effect of the two different measures, prevalence rates were estimated for overall psychological abuse and for the three comprised behaviours composing psychological abuse (to threaten; verbal aggression and ignore/refuse to talk). Prevalence was calculated for any individual that reported any act of psychological abuse independent of the frequency and for all individuals that reported at least one act more than 10 times. For all the participants reporting psychological abuse, univariate analyses were used to describe the frequency of each of the three behaviours (1-time occurrence; between 2 and 10 times and more than 10 times).

The remaining analysis aimed at comparison of perpetrators and correlates in two groups of victims, classified by the two measures: less strict measure (1-10 times) and the stricter (>10 times). Because individuals reporting abuse for more than ten times could also be found in the less strict a victim group, and to accurately compare both victims group, a variable with three categories was used: no abuse, abuse between one and ten times and abuse more than ten times.

The multinomial regression was used to explore the factors associated with i) reporting psychological abuse between 1 to 10 times; ii) reporting psychological abuse more than 10 times and iii) not having reported any psychological abuse. This is a regression model for a discrete outcome variable with more than two response categories, which, in this case, uses two logit functions and produces two conditional probabilities of each outcome measure (Hosmer and Lemeshow, 2000). The advantage of using a multinomial model, rather than fitting separate binary logistic models for each of the psychological abuse measures, is that the effects of individual characteristics on the probability of being a victim between 1 and 10 times and being a victim more than 10 times are evaluated simultaneously and tested for equivalence. Given the purpose of the analysis (to identify risk factors in the two groups of victims as compared to non-victims) the base outcome was defined as not having reported any psychological elder abuse. Hence, the reference category was non-victims and victims in the less strict and victims in the stricter measure

are both compared to that outcome. Relative risk ratios (RRR) were computed to show the relative likelihood of being victim in each group. To observe if the RRR found in both victims group are also significantly different from each of the two victims group, the magnitude of the identified RRR was assessed.

The sampling weights of the Ageing and Violence study were considered and population estimates were weighted by geographic region; sampling weights were calibrated by post-stratification for the Portuguese population distribution by sex and age (Gil et al., 2014).

The confidence interval was established at 95% and statistical analyses were carried out using Stata® and SPSS® software.

Results

The final sample comprised a total of 1,123 respondents (Table I). More than half were women (66.8 per cent). Distribution by the three age groups shows 48.4 per cent in the youngest age group (60-69), followed by individuals age 70-79 (36.9 per cent) and people aged 80 or more years (14.8 per cent). This population were found to be poorly educated: 10.0 per cent had no education and 60.3 per cent reported less than five years of education. The majority (76.5 per cent) was retired and lived as a couple or as a couple with children (64.1 per cent).

Little less than a third (28.5 per cent) reported at least one chronic disease. PEA was calculated by asking older adults about three different abusive behaviours: to threaten, verbal aggression (scream, insult, belittle or humiliate) and ignore or refuse to speak. The less strict measure, which considers PEA as at least one-time occurrence of any of the three behavioural acts, found the prevalence to be nearly the double (12.7 per cent, 95% CI [10.4, 15.5]) as the one found in the stricter measure (6.3 per cent, 95% CI [4.7 per cent, 8.5 per cent]). A higher increase in the prevalence estimates was found for the behaviour “to threaten”, where the prevalence nearly tripled from the stricter (>10 times; 0.9 per cent, 95% CI [0.4, 2.0]) to the less strict measure (⩾1 time; 3.3 per cent, 95% CI [2.1, 5.0]). For the other two abusive behaviours, the increased prevalence rate between the stricter and less strict measure doubled.

Table I. Distribution of the participants according to their sociodemographic characteristics and health variables

	n	%
Sex (N=1123)		
Male	373	33.2
Female	750	66.8
Age Group (N=1123)		
60-69	543	48.4
70-79	414	36.9
80+	166	14.8
Civil Status (N=1121)		
Single	70	6.2
Married/ Civil Union	672	60.0
Divorced / Separated	69	6.2
Widow	310	27.6
Schooling (N=1109)		
No Schooling	111	10.0
Up to 4 years	669	60.3
Between 5 and 9 years	152	13.7
10 or more years	177	16.0
Working Situation (N=1109)		
Employed	69	6.2
Unemployed	20	1.8
Housewife	103	9.3
Retired	848	76.5
Incapacitated (retired)	56	5.1
Other	13	1.1
Cohabitation (N=1117)		
Living with family members other than spouse/ partners or children or with others (non-relatives)	147	13.2
Living alone	254	22.7
Couple or couple with children	716	64.1
Social support (N=1105)		
Lots/enough people I can rely on	853	77.2
Few people I can rely on	166	15.0
No people I can rely on or does not know if people will help	86	7.8
House (N=1106)		
Owned house	845	76.4
Rented house	166	15.0
Relatives house	95	8.6
Chronic Disease (N=1120)		
No	323	71.2
Yes	797	28.8

In both measures, the most prevalent behaviours were: “verbal aggression”, followed by “ignore or refuse to speak” and “to threaten” (Table II).

Table II. Prevalence rates of two measures for three psychological abuse behaviours

Psychological abusive behaviours	N	Stricter measure (>10 times)		Less strict measure (≥1 time)	
		$\hat{p}$	*IC 95%*	$\hat{p}$	*IC 95%*
Scream, insult, belittle or humiliate	1118	4.0	[2.7, 5.8]	7.6	[5.8, 9.9]
Ignore or refuse to speak	1118	3.4	[2.2, 5.1]	6.4	[4.8, 8.4]
Threaten	1120	0.9	[0.4, 2.0]	3.3	[2.1, 5.0]

Considering only the participants who reported some sort of psychological abusive behaviour, Figure 1 shows the distribution of the frequency of occurrence for each of the three-assessed abuse behaviours. More than half of the participants (59 per cent) reporting "ignore/refuse to talk" indicated that they had experienced this act more than ten times in the past year. A similar result is observed for "verbal aggression". Of all the individuals reporting to have experienced verbal aggression, little more than half (53.3 per cent) said to have experienced it more than ten times in the past year.

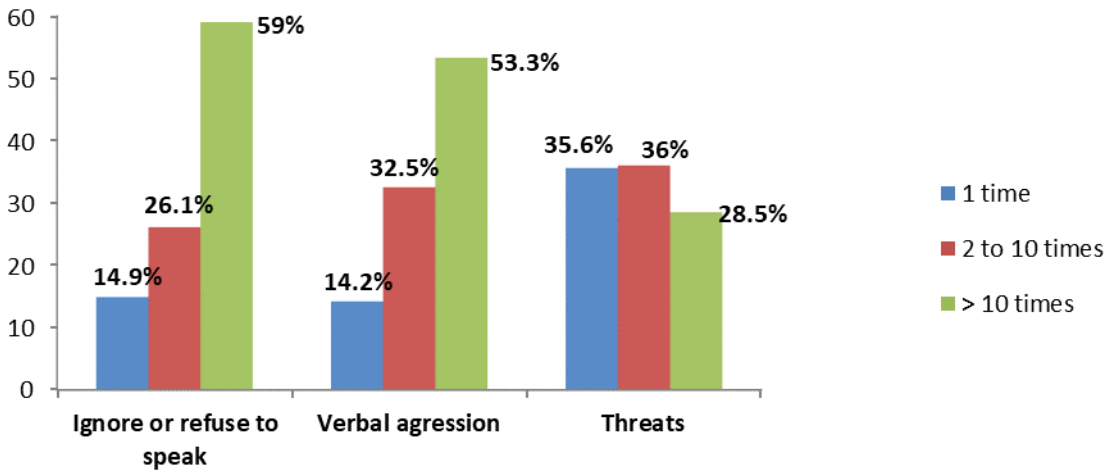

Figure 1. Frequency of the three assessed psychological abuse behaviors

Threatening presents a more evenly distributed frequency – this behaviour was experienced once in last 12 months by 35.6 per cent and between two and ten times by 36 per cent of the self-reported victims. Only 28.5 per cent of the episodes had a frequency higher than ten times.

Individuals from each of the two groups of self-reported victims (psychological abuse between one to ten times and psychological abuse >10 times) appointed similar perpetrators, particularly for two of the three evaluated abuse behaviours. In the case of

"ignore/refuse to speak", the perpetrators' distribution in either group was other family members (e.g. brother, sister, brother or sister-in-law, niece, nephew, cousin), followed by informal social network. A similar pattern is also found in verbal aggression: for both measures, nearly half of the verbal aggression acts were perpetrated by spouses or partners. Differences can be observed, mostly, in the case of "threaten".

When this abusive behaviour occurs between one to ten times, 32.4 per cent of the situations were attributed to children and grandchildren (19.0 per cent female and 13.4 per cent male). However, when only threatening behaviours perpetrated more than ten times are taken into account, spouses and partners are indicated as responsible for about half

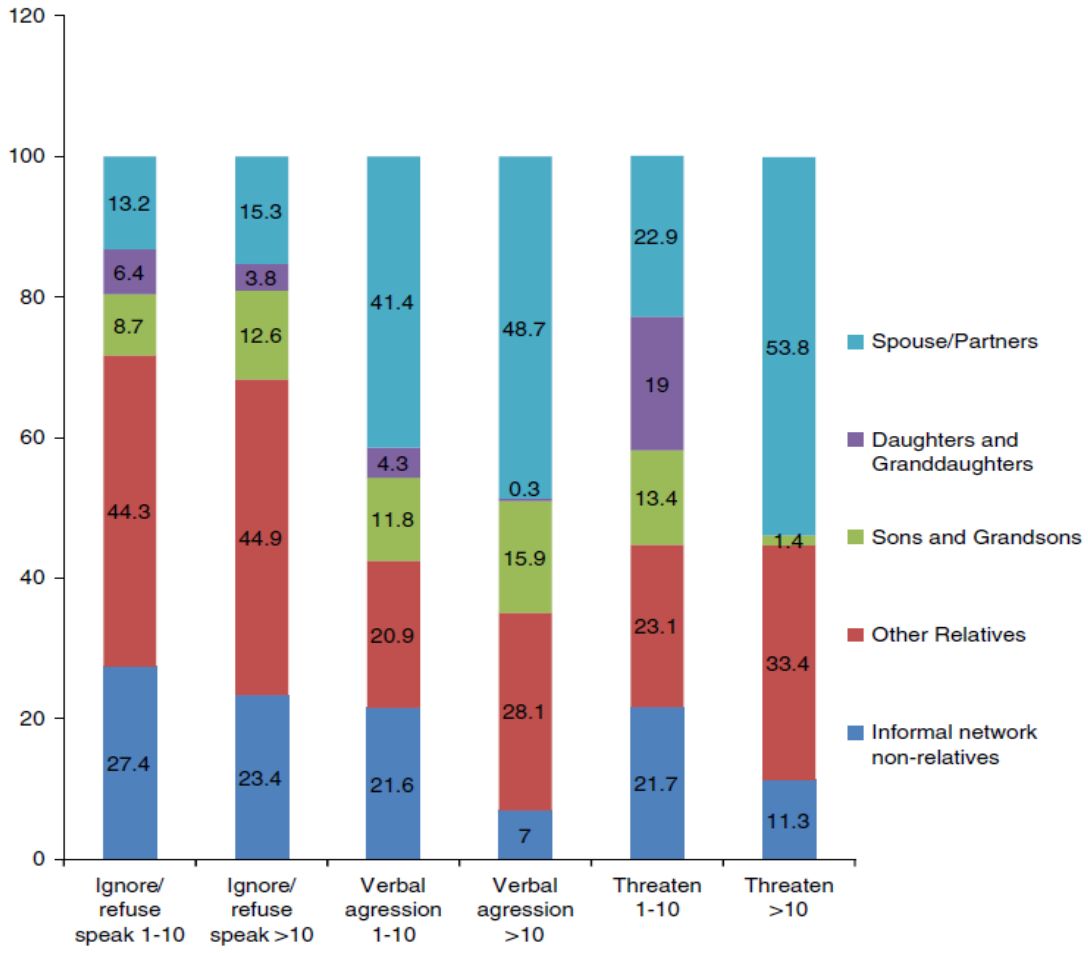

Figure 2. Frequency of three psychological abuse behaviours by perpetrator

A multinomial regression was employed to explore the factors associated with being classified as a victim of psychological abuse by the stricter measure or by the less strict measure. For the dependent variable with three categories (non-victims, victims of psychological abuse between one and ten times and victims of psychological abuse more

than ten times), non-victims were specified as the base outcome, to which the other two categories were compared.

To the development of the multinomial regression model, a bivariate analysis was performed with all key variables selected: sex; age group; chronic diseases; functional status (activities of daily living); income; house type; education; cohabitation and social support. Except for health status variables and education (which were found not to be statistically different), all variables were included in the model. The final model was also tested separately by sex. Despite the fact that the low number of respondents did not allow a stratified model for men/women, an effect of sex and age was observed (RRR were not found to be homogeneous for age) and the interaction between the two variables is included in the final model. The RRR calculated for the three age groups depended and were also modified by sex – being women or being men.

The final model (Table III) includes sex, age group, cohabitation, social support and house type. Men in the younger age group were used as the reference category. In all age groups and in comparison, with non-victims, women are at higher risk than men of experiencing psychological abuse by both measures. Not only are women, rather than men at higher risk, but also women between 60 and 69 years of age, in comparison with women from the two other older age groups (70-79 years and 80+ years), are at higher risk of being victims of psychological abuse, independently of the employed measure. Women from the 70-79 age group were more likely to report abusive behaviours occurring between one and ten times rather than reporting more frequent abusive behaviours (psychological abuse >10 times).

Social support and house situation were relevant variables in both measures, whereas cohabitation was only associated with the stricter measure (>10 times). By comparing older adults stating to have “few people to rely on” with those reporting to have “lots/enough people to rely on” (reference category), we observe that perceived lack of social support increases the risk of being a victim of psychological abuse in both measures. However, perceiving to have no one or not knowing if people will be available to help when needed was only significant in the less strict measure: RRR increased for abusive behaviours occurring between one and ten times.

Table III. Evaluation of RRR in two groups of self-reported victims of psychological abuse

	Less strict measure (≥1 – 10 times)		*p*	Stricter measure (>10 times)		*p*
	RRR	95%CI		RRR	95%CI	
Sex*Age Group						
60-69*Male	1*			1*		
60-69*Female	**5.7**	**[2.25, 14.6]**	**0.000**	**6.1**	**[2.1, 18.0]**	**0.000**
70-79*Male	2.5	[0.6, 11.1]	0.215	1.2	[0.3, 5.8]	0.800
70-79*Female	**5.1**	**[1.8, 14.3]**	**0.002**	1.2	[0.3, 4.4]	0.838
80+*Male	1.1	[0.3, 5.7]	0.907	4.5	[0.9, 22.1]	0.068
80+*Female	1.4	[0.2, 8.1]	0.691	4.1	[0.9, 18.0]	0.060
Cohabitation						
Living with family members other than spouse/ partners or children or with others (non-relatives)	1*			1*		
Living alone	1.9	[0.6, 8.5]	0.212	2.0	[0.8, 5.3]	0.166
Couple or couple with children	0.6	[0.1, 2.8]	0.215	**3.8**	**[1.1, 9.3]**	**0.004**
Social support						
Lots/enough people I can rely on	1*			1*		
Few people I can rely on	**2.7**	**[0.9, 4.4]**	**0.021**	**4.0**	**[1.8, 9.2]**	**0.001**
No people I can rely on or does not know if people will help	**7.7**	**[3.4, 13.2]**	**0.000**	1.9	[0.6, 5.6]	0.246
House						
Owned house	1*			1*		
Rented house	0.5	[0.2, 1.4]	0.202	0.7	[0.2, 1.4]	0.493
Relatives house	**0.3**	**[0.1, 1.0]**	**0.045**	**0.1**	**[0.0, 0.4]**	**0.002**

Note. 1* Reference category.

Regarding the housing situation, living in relatives' house, compared to older adults living in their own house, decreases the risk of being a victim of psychological abuse by the two measures. Cohabitation was found to be a relevant variable only to abuse as assessed by the stricter measure (>10 times). Older adults living as a couple (with spouse/partner) or as a couple with children were at higher risk of reporting psychological abuse occurring more than ten times in the previous 12 months, when compared to older adults living with family members (other than spouse/partners or children) or with non-relatives.

Overall, it is more likely to have experienced less frequent abusive behaviours (1 to 10 times) if you're a woman between 60 and 79 years of age, perceive a low informal social support and live in your owned house. Frequent abusive behaviours (>10 times) are more likely to be experienced by woman between 60 and 69 years of age, perceiving low informal social support and living with spouse or with a spouse and children in their owned house.

Finally, the homogeneity of the categories (cohabiting and social support) - significant variables in one of the two psychological elder abuse measures - was tested to truly evaluate the difference between the two groups of victims. Older adults in the less strict measure (1-10 times) were significantly different from those observed by the stricter measure (>10 times) and more likely to perceive to have no one or not knowing if people would be available to help ($F(1,1084) = 4.50$; $Prob > F = 0.0341$). Conversely older adults in the stricter measure (>10 times) were more likely to live as a couple (with spouse/partner) or as a couple and children than those assigned as cases by the less strict measure (1-10 times) ($F(1,1084) = 2.37$; $Prob > F = 0.0476$). Overall the different correlates found in the two victim groups are significantly different from the non-victim group and significantly different from each other.

Discussion

This study examined two operational definitions and the measurement effect on the characterization of psychological abuse in community-dwelling older adults.

The stricter the applied measurement criterion, the lower the obtained prevalence estimates. The Ageing and Violence study, using the frequency criterion of more than 10 times originally found 6.3% of experienced psychological abuse (Gil et al., 2014); the present study considering a singular positive response to any of the three assessed abusive behaviours doubled such prevalence rate to 12.7%. These results show the influence of the operational definition on prevalence estimates. Considering each assessed question as an abusive behaviour with the discrete outcome, the less strict measure (psychological abuse ≥ 1 time) is capturing the onset of the abuse or a mild form. Looking at prevalence rates found in our study, about half of these numbers could escalate to a more severe form of psychological abuse captured by the stricter measure.

For two of the three assessed abuse behaviours (“ignore/ refuse to speak” and “verbal aggression”) we found a resemblance for the distribution of identified perpetrators in both the less strict (psychological abuse = 1-10 times) and the stricter measure (psychological abuse > 10 times).

Some literature does indicate that the dichotomization between abuse and no abuse of the screening instruments employed in prevalence and other research studies does not comply with assessment and diagnosis of “clinical cases” (Cooper et al., 2009; Foran et al., 2014). In studies with community samples on domestic violence, including elder abuse, mild and severe acts of psychological abuse are usually clustered (Cooper et al., 2009; Foran et al., 2014).

The doubling of the prevalence estimate and the similarity of the perpetrators distribution suggests the same phenomenon capture at different severity levels. The same pattern, however, was not found for the "threaten" behaviour, which included threaten to abandon, harm, punish or institutionalize. This abusive behaviour nearly tripled its prevalence estimate between the two measures; from 0.9% to 3.3%. In addition, it also presented a different distribution of appointed perpetrators. In the stricter measure (psychological abuse > 10 times), spouses and partners were indicated as the main perpetrators, whereas in the less strict measure (psychological abuse = 1-10 times) an evenly distributed frequency of perpetrators is found with children being indicated as responsible for a high portion of the abuse (32.4%). In comparison, almost no children were indicated as responsible for threatening behaviours occurring more than 10 times in the previous 12 months.

It should be regarded that "to threaten" encompasses a wide range of situations (e.g., physical punishment, threaten to institutionalize the older person against his/her will, of refusing to provide care) with diverse impacts (Hudson and Carlson, 1999). Because family in Mediterranean societies is considered as the cornerstone of life for individuals inscribed within the family and the community, "being threatened to be put on the street or moved onto an institution" by a child can be particularly relevant, especially since the care of older adults falls almost exclusively on the family (Laudani et al., 2014; Reher, 1998). In this sense, the threaten behaviour may be particularly relevant and have a serious impact on the elderly in accordance, for instance, with whom perpetrates the abusive behaviour. In Portugal, there are also the older adults' expectations to be cared by the family and grow old in a private setting – own house or relatives' house (Mercurio and Nyborn, 2006). A threat of "being put in a nursing home" could, therefore, have a serious emotional impact on the older adult, whose fear of being displaced and isolated can be particularly relevant in older age. The impact and effect of the abusive behaviour on the victim has taken some authors to apply the frequency criterion only to some items of psychological abusive behaviours, usually excluding threats (Conrad et al., 2009; Lachs et al., 2011).

The regression analysis allowed a closer look at the two groups of victims selected by each of the two psychological elder abuse measures – in comparison with non-victims do the individuals from each group (psychological abuse = 1- 10 times and psychological abuse > 10 times) differentiated from one another? On this matter, differences were found for sociodemographic and contextual variables associated with abuse as defined by the two measures, but not for health-related variables. Most of the same Relative Risk Ratios were found for both groups of victims. Women of the youngest age group, perceiving low social support, and living in their own house are at higher risk of being victims of abusive

behaviours independently of the frequency. These results suggest abuse behaviour with different intensity levels.

Unlike the only known study evaluating measurement effect (Dong, 2014), the results of the present study show a difference in the victims' characteristics associated with elder abuse, as classified by the two psychological elder abuse measures employed. Women between 70 to 79 years of age and perceiving higher lack of social support / unsure of it were more likely to report less frequent abusive behaviours (1-10 times), whereas individuals experiencing more frequent abusive behaviours (>10 times) are more likely to live as a couple or as a couple with children.

The fact that women in the 70 to 79 age group present a higher risk of less frequent abusive behaviours might be representing the onset of abuse for that age group in a milder form. On the other hand, the significance of the cohabitation variable for the increase risk in the more frequent behaviours suggests that the strictest measure might be capturing at greater extent Intimate Partner Violence (IPV) in old age.

Overall results of prevalence estimates, perpetrators distribution and regression analysis are indicative of the same phenomenon with different intensity levels. The difficulty is in determining whether the less strict measure corresponds to a mild form of psychological elder abuse, in which about half never escalates, or to characterise it as part of family conflicts and dynamics.

Some authors have suggested that the employed thresholds in these measures, namely the frequency of the abuse behaviours, do capture abuse however in its mild forms (Cooper et al., 2009; Foran et al., 2014). Cooper and colleagues (2009) observed differences between research screening instruments employing the frequency criterion and clinically diagnose situations of elder abuse; the first were found to have significantly lower thresholds to detect the phenomenon. The authors stated, however, that these do not indicate invalid measurements, since research is aiming at identifying any situation independently of its severity. It should also be considered that even without determining the exact threshold that allows distinguishing relationship conflicts and abuse, complicated and difficult interpersonal relationships are identified risk factors for abuse (National Research Council, 2003). Although little research on violence against older people focus on quality and history of the relationship between victim and aggressor (Fitzpatrick and Hamill, 2010), some authors suggest that familial long-term problems are probably linked to violence. A conflictual relationship might allow the perception on both parts that abuse is an extension of the relationship itself (Fitzpatrick and Hamill, 2010). Even if part of "normal" family dynamics, interpersonal conflicts between family members and other

informal network members should be target for research, especially since early detection and interventions may help prevent abuse (Conrad et al., 2009).

Research and knowledge on elder abuse would benefit from more sensitive measures and the assessment of other dimensions. Elder abuse is a multidimensional phenomenon that encompasses not only the behaviours, but also the context and the history and relationship with the perpetrator (Fulmer et al., 2004). Even the behaviours may not be experienced the same way. The similar patterns found for two of the tree evaluated behaviours suggest this much; verbal aggression and ignoring or refusing to speak are two similar behaviours in terms of identified perpetrators and reported frequency. The big umbrella of psychological abuse reported in different prevalence studies should not treat different behaviours as the same. It is important to consider the etiology of these behaviours separately and in the contextual and relationship history where they have occurred. This is a challenging task for researchers, which require quick and easily applicable instruments to implement large population base surveys (Fulmer et al., 2004; Gil et al., 2015). In fact, research on measuring instruments in elder abuse has not been able to point out an optimal method or tool (Cooper et al., 2009; Fulmer et al., 2004). The combination of different approaches would benefit the findings of research, where quantitative abusive behaviours could be counted and the context where they occurred described.

Except for professionals dealing specifically with elder abuse, the same problem can be found at the clinical level. Professionals dealing with older adults on their day-to-day practices are encouraged to incorporate elder abuse screening and assessment (Cooper et al., 2009; Fulmer et al., 2004) and these professionals would benefit from short and easily applicable instruments for that purpose.

The study has several limitations. The first regards the nature of the data: cross-sectional designs are always subject to response bias and do not provide data on temporal relationships. In true, the worsening of the same conducts in terms of frequency could not be evaluated. Secondly, the frequency criterion employed constitutes only one of several definitional issues portrayed in the literature. Finally, the small number of respondents did not allow exploring differences between men and women.

Conclusion

Results suggest that the usually employed frequency threshold to measure psychological abuse in elder abuse prevalence studies might be separating mild from more frequent and severe forms of abuse; particularly for two of the three evaluated behaviours. The use of

thresholds can be a form of artificial dichotomization for significant abuse, which is a public health target. Even if not all cases as defined in research studies require clinical intervention, the mild forms of abuse or the interpersonal relationship conflicts must also be addressed by research given that they represent potential etiological precursors of (severe forms) psychological elder abuse, namely, observed in women between 70 and 79 years old, with perceived lack of social support.

Data shows how operational definitions can impact evidence and the need for researchers to analyse the effect of the definitional criteria on their outcomes, since distinction on who can be categorized as a victim or not affects the phenomenon characterization. Furthermore, most risks factors derive from prevalence studies and are inevitably reliant on the case definition and employed measures. Further research is needed on the development of a valid and reliable measure for psychological abuse that includes diverse levels of severity.

Practice would benefit of a more comprehensive measure that allows professionals to assess and intervene at different levels of a severity spectrum for psychological abuse. To enhance professionals' capacity to detect and intervene at an early stage of the phenomenon, they should not only be trained in using specific quantitative instruments, but also in the link between these instruments outcomes and the context and interpersonal dynamics of the older adults.

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Chapter V

Estudo de validação em Portugal de uma versão reduzida da Escala de Depressão Geriátrica [Portuguese validation study of a short version of the Geriatric Depression Scale]

Estudo de validação em Portugal de uma versão reduzida da Escala de Depressão Geriátrica

Resumo

As propriedades psicométricas da versão reduzida (5 itens) da Escala de Depressão Geriátrica (GDS), instrumento de avaliação da depressão junto de pessoas idosas, foram examinadas em duas amostras de pessoas com 60 e mais anos.

A validade concorrente, a especificidade e a sensibilidade foram obtidas contra o Inventário de Depressão do Beck (IDB-II) numa amostra de 66 indivíduos (média das idades de 70 anos), enquanto a validade da estrutura fatorial foi observada numa amostra de base populacional de 1023 indivíduos (média das idades de 71 anos). A versão de 5 itens da Escala de Depressão Geriátrica apresenta valores de consistência interna e de correlação com o IDB-II que sugere a sua fiabilidade e valores de sensibilidade e especificidade adequados ao rastreamento de sintomatologia depressiva na população idosa. Os resultados obtidos pela análise fatorial confirmatória sugerem que o modelo unifactorial não apresenta as caracteristicas desejadas, indicando que um dos itens (item 4) poderá ter um menor poder discriminativo, pelo que se observa um melhor ajustamento no modelo obtido pela AFC para 4 itens.

Palavras-chave: Escala de Depressão Geriátrica; validação; depressão; pessoas idosas

Introdução

A depressão é a desordem psiquiátrica mais comum na população idosa com documentado impacto ao nível da qualidade de vida, constituindo um importante preditor da mortalidade (Baldwin, 2004). A par da importância do diagnóstico, para adequada intervenção e tratamento com reconhecidos ganhos em saúde e qualidade de vida, reconhece-se a dificuldade na identificação da depressão (Baldwin, 2004; Roman & Callen, 2008).

Os instrumentos de autorrelato (e.g., escalas) têm vindo a ganhar importância no rastreio da depressão e dos sintomas depressivos também pela sua fácil administração, número limitado de recursos implicados e tempo necessário (Telles-Correia & Barbosa, 2009). Às reconhecidas vantagens, contrapõe-se as dificuldades de avaliação da depressão em

pessoas com outras comorbilidades, pelo facto de o limiar dos níveis de depressão relevantes para a condição psiquiátrica poderem ser diferentes em pessoas com outras patologias (Telles-Correia & Barbosa, 2009).

Em grupos etários mais avançados, acresce ainda o facto da depressão se apresentar, muitas vezes, através de queixas somáticas e funcionais que podem reproduzir outras patologias médicas (Pocinho, Farate, Dias, Lee, & Yesavage, 2009). Além disso, os sinais e sintomas da depressão manifestados pela população idosa podem ser diferentes dos comummente apresentados na população adulta, aspetos que contribuem para a sua subnotificação (Baldwin, 2004; Roman & Callen, 2008).

O rastreio de sintomatologia depressiva na população idosa com os instrumentos de avaliação desenvolvidos para o efeito poderá auxiliar a identificação e tratamento.

A Escala de Depressão Geriátrica

A Escala de Depressão Geriátrica (Geriatric Depression Scale - GDS) é um instrumento de avaliação da depressão que procura superar as dificuldades de rastreio na população idosa, com vantagens demonstradas relativamente a outros instrumentos do mesmo tipo (Baldwin, 2004; Pocinho et al., 2009). Desenvolvida por Yesavage e colaboradores em 1982, a GDS é, segundo os autores, o único instrumento que se conhece elaborado para ser utilizado especificamente com esta população (Yesavage et al.,1982). Procura eliminar a confusão, geralmente presente em outros instrumentos de avaliação da depressão, entre indicadores somáticos da depressão e manifestações físicas “normais” da velhice.

A GDS, na sua versão original e alargada, apresenta-se como uma escala de autorrelato, composta por 30 itens no original, com duas alternativas de resposta (sim ou não), consoante o modo como a pessoa idosa se tem sentido na semana transata.

Esta versão, já traduzida em 30 línguas, apresenta excelentes propriedades psicométricas (a partir de 84% para a sensibilidade e de 95% para a especificidade) (McGivney, Mulvihill, & Taylor, 1994; van Marwijk et al., 1995; Yesavage, 1988). É, segundo Baldwin (2004), o instrumento de rastreio da depressão na população geriátrica mais utilizado e validado em diferentes países. Em Portugal a versão aferida e validada por Pocinho e colaboradores (2009) apresentou uma sensibilidade de 100% (IC=1-1) e uma especificidade de 83% (IC=0.5-1).

Dada a sua extensão, alguns autores indicam que a aplicação da GDS30 pode levar à fadiga das pessoas idosas e interferir no decorrer do atendimento médico (Baldwin, 2004; Rinaldi, Mecocci, Benedetti, & Ercolani, 2003). Além disso a investigação desenvolvida em estudos observacionais obriga à utilização instrumentos de rastreio mais curtos. Para colmatar estas desvantagens, foram desenvolvidas versões mais curtas, nomeadamente de 20, 15, 5, 4 e 1 itens (Hoyl et al., 1999; Kim, DeCoster, Huang, & Bryant, 2013; Pocklington, Gilbody, Manea, & McMillan, 2016; Rinaldi et al., 2003; van Marwijk et al., 1995).

Hoyl e colaboradores (1999) desenvolveram uma das versões curtas da GDS, constituída por cinco itens, mais tarde aferida e validada na população americana (Hoyl et al., 1999; Rinaldi et al., 2003). Os autores, considerando que não se tratando de um diagnóstico de depressão, sugerem que se trata de um bom indicador da presença de sintomas depressivos. Para o desenvolvimento da escala ou autores selecionaram, entre os 15 itens da GDS15, os cinco itens que mostraram maior poder discriminativo (Hoyl et al., 1999). Para isso, numa amostra com 74 pessoas idosas procederam à avaliação clínica de depressão e administraram a GDS15. Os cinco itens com uma correlação mais elevada com o diagnóstico clínico de depressão foram selecionados para integrar a versão curta de cinco itens da GDS.

Esta versão reduzida foi posteriormente validada em três contextos distintos: pessoas idosas da comunidade (consultas externas); pessoas idosas hospitalizadas (enfermaria de cuidados agudos) e pessoas idosas em lar residencial (Rinaldi et al., 2003). O estudo incluiu uma amostra de 181 pessoas sem défice cognitivo (avaliado clinicamente), às quais foi administrada a GDS15, a GDS5; e que foram alvo de uma avaliação neuropsicológica geriátrica incluindo a avaliação clínica da depressão de acordo com os critérios da 4ª edição do Manual Diagnóstico e Estatístico de Transtornos Mentais (DSM-IV) (Rinaldi et al., 2003).

Esta versão mostrou boa sensibilidade (94% dos indivíduos diagnosticadas com os critérios do DSM-IV apresentaram um score indicativo da presença de sintomas depressivos) e boa especificidade (81% dos indivíduos não diagnosticadas com os critérios do DSM-IV apresentaram um score não indicativo da presença de sintomas depressivos) (Rinaldi et al., 2003). Através da validade concorrente (comparando resultados da GDS5, GDS15 e diagnóstico clínico da depressão), Rinaldi e colaboradores estabeleceram o valor de corte em 1/2 como indicativo da presença de sintomas depressivos. Um estudo inicial de validação foi também conduzido em Espanha e os resultados vão ao encontro do que já tinha sido encontrado na amostra americana,

apresentando boa sensibilidade (81%, IC=73.1-89.1) e especificidade (73.2%, IC=66.3-80.1) (de la Iglesia et al., 2005).

A relevância da validação da versão de 5 itens, e do desenvolvimento de versões curtas prende-se com a utilidade de uma ferramenta para a investigação e para o contexto clínico. Se no âmbito da investigação epidemiológica onde o número de perguntas é um aspeto central na participação dos respondentes, no contexto da prática clínica, escalas de rastreio validadas, mas de fácil aplicação, podem auxiliar os profissionais que trabalham com pessoas idosas a identificar situações que requem mais atenção para o diagnóstico clínico. Escalas reduzidas, mas que mantenham validade e capacidade discriminativa, cumprem estes objetivos e deverão ser valorizadas (Hagtvet & Sipos, 2016).

Neste âmbito, o presente artigo apresenta os resultados de dois estudos conduzidos para avaliar as propriedades psicométricas da versão de 5 itens da GDS para a população portuguesa. A partir de uma amostra de conveniência analisou-se a sensibilidade e especificidade contra o Inventário de Depressão de Beck (IDB-II). O segundo estudo, conduzido numa amostra de base populacional, avaliou a fiabilidade e a estrutura fatorial.

A escolha do IDB-II decorreu da necessidade de selecionar uma escala de autorrelato para avaliação da sintomatologia depressiva, dado não haver possibilidade, no âmbito do estudo, de inclusão de uma avaliação para diagnóstico clínico. Esta escala, desenvolvida por Aaron Beck em 1961, é um instrumento de medida construído segundo a metodologia proposta por Likert, com vinte e um itens referentes a sintomas ou grupos sintomatológicos medidos numa escala de quatro pontos (de 0 a 3 consoante o grau de gravidade) (Campos & Gonçalves, 2004; Canavarro, Pereira, Simões, Pintassilgo, & Ferreira, 2008; Oliveira-brochado & Oliveira-brochado, 2008).

Apesar de ser preferencial a utilização de diagnóstico clínico enquanto gold standard na avaliação da validade concorrente de doenças e síndromes, a utilização de um instrumento que avalia o mesmo constructo é também comum quando se deseja substituir um instrumento por outro mais simples, mais barato ou menos invasivo (Streiner & Norman, 1995). Adicionalmente, alguns estudos têm vindo a demonstrar a aplicabilidade do IDB-II junto da população idosa (Argimon, Paloski, Farina, & Irigaray, 2016). A sua adequabilidade para o objetivo proposto, prende-se também com o facto de ser uma das escalas de autorrelato que melhor reflete os critérios de diagnóstico do DSM-V, sendo considerada como o gold standard entre as escalas de autorrelato para avaliação da depressão (Wang & Gorenstein, 2013). Utilizada anteriormente em estudos

de validade da GDS, na sua versão original, os resultados mostraram correlações elevadas entre o IDB e a GDS (Olin, Schneider, Eaton, Zemansky & Pollock, 1992), bem como valores de sensibilidade e de especificidade aceitáveis (Ferraro & Chelminski, 1996; Kiernan, Wilson, Suter, Naquin & Meltzen, 1986; Scogin, 1987). Estes valores tendem a decrescer em populações clínicas, sugerindo que ambas as escalas funcionarão melhor junto da população em geral (Olin et al., 1992).

Os dois estudos apresentam resultados relativos ao ponto de corte mais favorável da GDS5, de acordo com os valores de sensibilidade e de especificidade, relativos à fiabilidade e à estrutura fatorial da escala.

Métodos

Desenvolveram-se dois estudos, que se apresentam em seguida. O estudo 1 teve como objetivo avaliar a validade concorrente da GDS5 utilizando o IDB-II como gold standard. Junto de uma amostra de conveniência (Amostra A) avaliou-se o ponto de corte mais favorável, a sensibilidade e a especificidade. O estudo 2, conduzido numa amostra de base populacional (Amostra B) permitiu examinar a fiabilidade e a estrutura fatorial da GDS5.

Participantes

A população-alvo dos dois estudos realizados foi constituída por pessoas com idade igual ou superior a 60 anos residentes em Portugal, em domicílios particulares, há pelo menos 12 meses. A amostra A (Estudo 1) foi constituída por pessoas com 60 e mais anos e incluiu 71 participantes (Tabela 1), sendo mais de metade mulheres (70% mulheres e 30% homens), com idades compreendidas entre os 60 e os 82 anos (M=70.16, DP=6.24). Considerando apenas os indivíduos sem valores omissos em todos os itens das 2 escalas avaliadas obteve-se um total de 66 participantes.

A amostra B (Estudo 2) obteve-se a partir do inquérito via telefone a uma amostra representativa da população portuguesa de pessoas a residir na comunidade com 60 ou mais anos, A amostra foi composta por 1123 participantes, dos quais 67% eram mulheres e 32% eram homens, com idades compreendidas entre os 60 e os 92 anos (M=70.92, DP=7.06). Considerando apenas os participantes sem valores omisso na GDS5, obteve-se um total de 1030 participantes.

Tabela 1. Distribuição do sexo e idade nas duas amostras

		Amostra A (N=71)	Amostra B (N=1123)
Sexo	Mulheres % (n)	69.6% (49)	67.3% (693)
	Homens % (n)	30.4% (22)	32.7% (337)
Intervalo de idades (M, Dp)		60-82 (70.16; 6.24)	60-92 (70.92; 7.06)

Instrumentos

Para o desenvolvimento da versão reduzida da GDS5 para Portugal, os autores utilizaram os itens que integraram a versão original de 5 itens em língua inglesa (Hoyl et al., 1999). Os cinco itens correspondentes em português (itens 1, 4, 10, 12 e 17) à versão desenvolvida em língua inglesa foram selecionados a partir da versão portuguesa da GDS30 já traduzida e validada para o contexto nacional (Barreto, Leuschner, Santos, & Sobral, 2008). Aos participantes foi lida a seguinte introdução: "Por favor responda Sim ou Não a cada uma das seguintes frases quanto à forma como se tem sentido de há uma semana para cá": (1) Satisfeito(a) com a sua vida?; (2) Muitas vezes aborrecido(a)?; (3) A sentir-se muitas vezes desamparado(a)?; (4) A preferir ficar em casa, em vez de sair e fazer coisas novas?; e (5) A sentir-se inútil?. O score total corresponde à soma de cada um dos itens, sendo 1 ponto atribuído para a resposta "sim" e 0 pontos para a resposta "não", exceto nos itens invertidos.

No caso do IDB-II considerou-se o valor de corte superior a 13 para a presença ou de sintomatologia depressiva, uma vez que em estudos de validação em Portugal, os resultados sugerem valores inferiores ou iguais a 13 para os indivíduos sem sintomatologia depressiva e valores superiores a 13 para indivíduos com sintomatologia depressiva (Campos & Gonçalves, 2004; Oliveira-brochado & Oliveira-brochado, 2008).

Procedimento

Os dois estudos foram realizados enquanto parte do projeto de investigação Envelhecimento e violência (Gil et al., 2015), que decorreu entre 2011 e 2014. Os participantes que aceitaram colaborar na fase piloto do projeto foram convidados a preencher um pequeno questionário onde se incluíram a GDS e o IDB-II (Estudo 1). Esta amostra, a partir da qual se desenvolveu o estudo 1, foi recrutada através de pontos focais de uma universidade sénior, de um centro de dia e de uma junta de freguesia da área metropolitana de Lisboa.

O estudo 2 obteve-se a partir do inquérito via telefone a uma amostra representativa da população portuguesa de pessoas a residir na comunidade com 60 ou mais anos

(Amostra B), tendo-se administrado um questionário em que se incluiu também a versão curta de 5 itens da GDS (Gil et al., 2015). A amostra utilizada no estudo foi estratificada pelas 7 regiões NUTS II e regiões autónomas, com alocação homogénea das unidades de amostragem. A recolha de dados teve em conta a existência de telefones fixos e de telefones móveis nos alojamentos e a utilização de cada uma das redes (fixa e móvel) pela população idosa (60% da amostra recrutada através de telefones fixos e 40% recrutada através de telefones móveis). O questionário foi aplicado através de entrevistas telefónicas assistidas por computador (CATI – Computer Assisted Telephone Interview) a 1123 pessoas com 60 e mais anos, que forneceram o consentimento verbal após terem sido informadas sobre o estudo. De acordo com as definições normalizadas pela American Association for Public Opinion Research (American Association For Public Opinion Research, 2011) a taxa de resposta ao inquérito telefónico foi de 74.03% e de recusa 25.97%.

Resultados

Estudo 1. Validade concorrente

O estudo sobre a validade de critério, conduzido na Amostra A (N=66), foi obtido através do IDB-II. O poder discriminativo foi avaliado a partir da área sob a curva ROC (AUC – Area Under the Curve). Considerou-se valores aceitáveis quando se obteve curvas ROC com valores superiores a .70 (Aguiar, 2007; Hosmer, Lemeshow & Sturdivant, 2013). A sensibilidade e a especificidade foram calculadas considerando o nível de confiança de 95%, utilizando o IDB-II como critério (gold standard). O ponto de corte foi selecionado de acordo com a maximização dos valores obtidos tanto para a especificidade, como para a sensibilidade (Hosmer et al., 2013).

Os resultados indicam que, com uma precisão de 85%, o valor de corte mais adequado em termos de sensibilidade (70.0%) e especificidade (85.3%) é de igual ou superior a 2.

Tabela 2. Sensibilidade e especificidade da GDS5 face ao IDB-II

	GDS5 * IDB-II	
Valor de corte	Sensibilidade	Especificidade
(>= 0)	100.00%	0.00%
(>= 1)	90.00%	52.94%
(>= 2)	**70.00%**	**85.29%**
(>= 3)	50.00%	97.06%
(>= 4)	30.00%	100.00%
(>= 5)	20.00%	100.00%
(> 5)	0.00%	100.00%
Área ROC (IC95%)	84.41 (69.9-93.4)	

Nota: Estudo 1, Amostra A (N=66).

Estudo 2.

Fiabilidade

A fiabilidade da GDS5, através da consistência interna foi obtida junto da Amostra B (N=1030). O Alfa de Cronbach foi de .69, valor abaixo do usualmente utilizado para classificar a fiabilidade como adequada (α=.70). Note-se, ainda, no que respeita aos diferentes itens que compõem a escala, o valor do Alfa de Cronbach para escala é ligeiramente superior (α>.71) no caso de eliminação do item 4 (“A preferir ficar em casa, em vez de sair e fazer coisas novas?”).

Validade

A avaliação da validade fatorial do instrumento foi realizada com uma Análise Fatorial Confirmatória (AFC), considerando o modelo unifatorial, uma vez que a unidimensionalidade da escala pode ser encontrada consistentemente em estudos da GDS5 para outros países (Hoyl et al., 1999; de la Iglesia et al., 2005; Rinaldi et al., 2003). Optou-se pela análise fatorial das correlações tetracóricas por ser a mais apropriada para avaliar variáveis dicotómicas e pelo grande número de participantes na amostra (N=1030) (Wherry, 1984; Savalei, Bonett & Bentler, 2015).

Na tabela 3 são apresentadas as intercorrelações entre os itens. As correlações variam entre .37 e .80 sendo o item 4 aquele que apresenta valores de correlação menos elevados, o que vai ao encontro da análise da fiabilidade obtida através do Alfa de Cronbach. Os valores de correlação dos itens da GDS5 são todos positivos, uma vez que

o único item com uma cotação invertida (“Satisfeito com a sua vida?”) foi corrigido antes da análise.

Tabela 3. Correlações tetracóricas dos itens da GDS5

	GDS_1	GDS_2	GDS_3	GDS_4	GDS_5
GDS_1 Satisfeito(a) com a sua vida?	1				
GDS_2 Muitas vezes aborrecido(a)?	.8004	1			
GDS_3 A sentir-se muitas vezes desamparado(a)?	.5514	.7351	1		
GDS_4 A preferir ficar em casa, em vez de sair e fazer coisas novas?	.3738	.3763	.3982	1.	
GDS_5 A sentir-se inútil?	.4590	.5786	.4684	.4305	1

N=1030

Na análise da estrutura fatorial, foram utilizados os 5 itens do instrumento, numa AFC, recorrendo à versão 15 do programa estatístico Stata. Conforme indicado por alguns autores, foram utilizados três índices para verificar o ajustamento do modelo (Bentler & Bonnet, 1980; Pilati & Laros, 2007). O índice absoluto - $\chi 2$ do ajustamento ($\chi 2/gl$); índice relativo - CFI (Comparative Fit Index) e índice de discrepância populacional – RMSEA (Root Mean Square Error of Aproximation). Os indicadores de ajustamento do modelo permitem perceber um fraco ajustamento do modelo ($\chi 2/gl$=10.824, CFI=.942 e RMSEA=.117). Os coeficientes de ponderação fatorial dos itens para o modelo original (GDS5) mostram o menor peso do item 4, que apresenta uma variância única de 84%, sendo que os restantes apresentam coeficientes elevados (Tabela 4). Considerando-se o potencial menor poder discriminativo deste item e de modo a encontrar um modelo com ajustamento adequado, procedeu-se à sua eliminação.

O novo modelo apresentou valores de ajustamento adequados ($\chi 2/gl$=4.210, CFI=.991 e RMSEA=.055), sobretudo considerando o tamanho amostral. Este modelo sugere a utilização de 4 itens, com valores de variância única de cada um dos itens menores, sendo o item 5 aquele que apresenta um coeficiente de ponderação fatorial mais baixo.

Tabela 4. Coeficientes de ponderação fatorial e variância de dois modelos confirmatórios da Escala de Depressão Geriátrica

	GDS5		GDS4	
	β (ep)	Var	β (ep)	Var
GDS_1	1	.341	1	.127
GDS_2	1.211(.034)***	.034	1.152(.075)***	.001
GDS_3	.919(.038)***	.442	.723(.053)***	.135
GDS_4	.492(.036)***	.839		
GDS_5	.729(.032)***	.649	.492(.045)***	.128
$\chi^2(5)=54.12$, p<.0001			$\chi^2(5)=8.42$, p<0.05	

Note: Estudo 2, Amostra B (N=1030); β = coeficiente de ponderação fatorial; *** p<.0001; **p<.005; Var= variância única explicada

Discussão

Existem, atualmente, uma grande quantidade de escalas de avaliação de depressão disponíveis quer para efeitos de investigação, quer para efeitos de rastreamento na prática clínica. A necessidade de um instrumento rápido, sensível, específico e o mais possível destituído de interferência cultural são fatores potenciadores do contínuo estudo no âmbito das escalas de avaliação de depressão ou da sintomatologia depressiva (Almeida & Almeida, 1999). A Escala de Depressão Geriátrica tem sido amplamente utilizada, tanto em contextos clínicos, como de investigação e está disponível em vários idiomas de países europeus, países latino-americanos e países asiáticos, o que sugere uma consistência entre diferentes países (Almeida & Almeida, 1999) e a facilidade da sua utilização para estudos internacionais comparativos.

Este estudo pretendeu examinar as características psicométricas da versão curta da Escala de Depressão Geriátrica (GDS5), utilizando duas amostras distintas para avaliar a validade concorrente, a fiabilidade e a validade da estrutura fatorial.

A sensibilidade (70%) e especificidade (85%) da versão com 5 itens não sendo elevada é aceitável considerando não só o número de itens, como o número de participantes da amostra (A, N=66). Outras versões obtiveram, contra diagnóstico clínico (DSM-IV ou CID-10) valores de sensibilidade entre os 81% e os 94% para a GDS5 e de especificidade entre 73% e 81% (de la Iglesia et al., 2005; Rinaldi et al., 2003). Estes resultados sugerem uma capacidade discriminativa semelhante entre as versões curtas desta escala em diferentes países.

Em relação ao valor de corte escolhido (2), de acordo com o valor máximo de sensibilidade e especificidade, este é igual ao que tem sido proposto por outros estudos (Almeida & Almeida, 1999; Hoyl et al., 1999; de la Iglesia et al., 2005; Pocklington et al., 2016; Rinaldi et al., 2003).

O resultado de consistência interna (α=.69) não vai ao encontro do desejado, ainda que se aproxime do que é usualmente considerado um valor aceitável na literatura em termos de confiabilidade da escala (α >.70). Porém, importa referir que, dado que o valor da correlação poderá ser influenciado pelo número de itens, se a escala for constituída por um número reduzido os valores acima dos .60 podem ser considerados aceitáveis (Ribeiro, 2010). Do mesmo modo, na mensuração de constructos complexos, um Alfa de Cronbach de 0.60 pode ser considerado aceitável, ainda que requerendo uma interpretação cautelosa (DeVellis, 2003).

Outros estudos de validação tendem a apresentar valores mais elevados nas versões com um maior número de itens (GDS 30, 15 e 10), tanto em Portugal (Apóstolo et al., 2014; Pocinho et al., 2009) como noutros países (Kim et al., 2013; Pocklington et al., 2016). No caso das versões mais curtas, os valores de fiabilidade obtidos são, usualmente, mais baixos (Kim et al., 2013; Pocklington et al., 2016).

Com o recurso a procedimentos de análise confirmatória, os resultados de validade sugerem um modelo de ajustamento fraco (χ2/gl=10.824, CFI=.942 e RMSEA=.117), ainda que os valores de correlações entre os itens sejam aceitáveis. Também os coeficientes de ponderação fatorial mostram a elevada contribuição da grande maioria dos itens para a dimensão, sendo o item 4 (A preferir ficar em casa, em vez de sair e fazer coisas novas) aquele que apresenta uma saturação menos elevada e um valor de variância única mais elevado. Assim, um novo modelo eliminando o item 4 apresentou valores de ajustamento mais aceitáveis (χ2/gl=4.210, CFI=.991 e RMSEA=.055). Este item apresentou valores de correlação menos elevados e na escala, o valor de consistência interna é mais elevado com a sua eliminação. Apesar de estes resultados irem ao encontro do que já foi observado num estudo espanhol, em que das duas versões avaliadas (de 4 e 5 itens), a GDS de 4 itens sugeriu melhores resultados (de la Iglesia et al., 2005), há que considerar que existem sempre fatores aleatórios nos dados que podem promover o comportamento flutuante de alguns itens. Além disso, é importante considerar que estes resultados podem decorrer de algumas limitações do próprio estudo.

Em primeiro lugar os itens utilizados no desenvolvimento da versão curta foram extraídos da versão original e não validados através de um estudo exploratório de uma versão portuguesa mais longa do instrumento. De facto, têm sido desenvolvidas várias versões diferentes relativamente aos itens incluídos, sendo que nenhuma versão é exatamente igual entre si, relativamente aos itens selecionados a partir da GDS15 ou da GDS10 (Pockington et al., 2016). Além disso os diversos estudos utilizam diferentes tipos de

populações (por exemplo, clínicas e não clínicas) o que dificulta a comparabilidade dos resultados e tem levado alguns autores a afirmarem maior evidência da GDS15 face a versões mais reduzidas e a necessidades de futuros estudos para as versões mais curtas (Pocklington et al., 2016).

Também a amostra de conveniência obtida além das implicações implícitas, é pequena e requer alguma cautela na leitura dos resultados. Ainda assim, a análise do comportamento da escala junto de uma amostra representativa desta população permite analisar a adequabilidade dos resultados encontrados, nomeadamente, no que respeita ao valor de corte aceitável e que vai ao encontro do que tem sido observado noutros países.

Conclusões

A versão de 5 itens da Escala de Depressão Geriátrica apresenta valores de consistência interna e de correlação com o IDB-II que sugere a sua fiabilidade e valores de sensibilidade e especificidade adequados ao rastreamento de sintomatologia depressiva na população idosa. Os resultados obtidos pela AFC apesar de não sugerirem um modelo bem ajustado, não põe em causa as propriedades da medida. Os resultados indicam ainda que um dos itens (item 4) poderá ter um menor poder discriminativo e que se observa um melhor ajustamento no modelo obtido pela AFC para 4 itens. Tendo em conta a existência de versões mais curtas (de 4 e 1 itens) noutros países, serão necessários mais estudos, utilizando diagnósticos clínicos como gold standard, para se determinar se as propriedades psicométricas de versão de 4 itens são melhores que as da versão de 5 itens.

Em suma, os estudos mostram que em Portugal, a versão curta da GDS (5 itens), apresenta resultados semelhantes aos obtidos noutros países e noutras versões. Por ser de fácil administração, simples de entender e requerer tempo mínimo, esta versão poderá ser uma ferramenta de grande utilidade na prática clínica, mas sobretudo, para a investigação na população idosa portuguesa.

Notas

[1]Na página oficial da GDS, os autores consideram que se trata de um instrumento no domínio público (https://web.stanford.edu/~yesavage/GDS.html).

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Exploring the correlates to depression in elder abuse victims: abusive experience or individual characteristics?

Exploring the correlates to depression in elder abuse victims: abusive experience or individual characteristics?

Abstract

Depression and depressive symptoms have been studied both as risk factors and consequences of elder abuse, even though the most common crosssectional design of the studies does not allow inferring cause or consequence relationships. This study estimates the proportion of older adults who screened positive for depressive symptoms among those self-reporting elder abuse and examines whether individual characteristics and/or abusive experience aspects are associated with self-reported depressive symptoms. Participants were 510 older adults self-reporting experiences of abuse in family setting enrolled in the cross-sectional victims' survey of the Aging and Violence Study. Depressive symptoms were assessed through the abbreviated version of the Geriatric Depression Scale (GDS-5). Poisson regression was used to determine the prevalence ratio (PR) of screening depressive symptoms according to individual and abusive experience covariates: sex, age group, cohabitation, perceived social support, chronic diseases, functional status, violence type, perpetrator, and number of conducts. Women (PR = 1.18, 95% confidence interval [CI] = [1.04, 1.35]) individuals perceiving low social support level (PR = 1.36, 95% CI = [1.16, 1.60]) and with long-term illness (PR = 1.17, 95% CI = [1.02, 1.33]) were found to be associated with increased risk for screening depressive symptoms. In regard to abusive experience, only the number of abusive conducts increased the PR (PR = 1.07, 95% CI = [1.05, 1.09]). Routine screening for elder abuse should include psychological well-being assessment. Interventions toward risk alleviation for both mental health problems and elder abuse should target women perceiving low social support level and with long-term illness.

Keywords: elder abuse, vulnerability to abuse, depressive symptoms, domestic violence

Introduction

Elder abuse has for the past 40 years been gaining public, state and scientific attention (Lachs & Pillemer, 2004). It refers to "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 & INPEA, 2002, p. 9). Common types of elder abuse include physical, emotional, sexual and financial abuse, and neglect

(Acierno et al., 2010; Biggs, Manthorpe, Tinker, Doyle, & Erens, 2009; O´Keeffe et al., 2007).

Recognized as an important public health issue, elder abuse has been associated with adverse health and social outcomes (Acierno et al., 2010; Biggs, Manthorpe, Tinker, Doyle, & Erens, 2009; Comijs, Penninx, Knipscheer, & van Tilburg, 1999; Dong, Beck, & Simon, 2010). Often studied correlates include psychological wellbeing, of which depression or depressive symptoms are assumed to be of importance (National Research Council, 2003; Roepke-Buehler, Simon, & Dong, 2015; Sirey et al., 2015).

Elder abuse prevalence studies show an association between elder abuse outcome and depression/depressive symptoms. Prevalence estimates of clinically diagnosed depression has been found to be higher in victims in comparison to non-victims. In a study by Dyer and colleagues (2000), the proportion of older adults diagnosed with depression (based on DSM-IV criteria) was significantly higher for abused older adults (5.6%) compared with non-abused (4.0%).

Depression or depressive symptoms, measured by standardized scales have also been studied as correlates to elder abuse. In a study by Roepke-Buehler and colleagues (2015), the proportion of older adults with a record of documented abuse and/or neglect who were “depressed” (defined by a score ≥ 4 in the Center for the Epidemiological Study of Depression Scale, CES-D) ranged from 28% to 37%, compared to 18% to 20% of older adults without any documented abuse or neglect. In a population of three Chinese rural communities 72.5% of abused older adults screened positively (score ≥ 5 in the fifteen-question Geriatric Depression Scale, GDS-15) compared with 29.4% non-abused older adults (Wu et al., 2012). Similar results were observed in a community-dwelling Chinese population, where 24.8% of abused older adults were found to be depressed (score ≥ 3 in the GDS 5) compared with 6.8% of non-abused older adults (Dong, Simon, & Gorbien, 2007).

Other cross-sectional studies have compared the proportion of depressed older adults whom reported elder abuse, compared with non-depressed. A national elder abuse study in the United Kingdom found that abuse was more prevalent among older adults indicated as suffering from depression (score ≥ 3 in the CES-D 8) for both men (3.6% vs. 0.6%) and women (7.8% vs. 2.2%) (Manthorpe et al., 2007). Another study targeting older adults from eight rural villages in Spain found that participants with suspected depression (score ≥ 2 in the GDS-5) presented a higher percentage of suspected psychosocial (19.7% vs 12.0%) and financial abuse (7.1% vs 3.0%) (Garre-Olmo et al., 2009).

The only longitudinal study examining depression as a risk factor for elder abuse did not find depression to be significantly associated with increased risk for reported elder abuse and neglect (Lachs, Williams, O'Brien, Hurst, & Horwitz, 1997).

Overall, the studies´ results present a higher proportion of individuals screening positively for depressive symptoms in comparison with depression. A higher prevalence of depressive symptoms, without fulfilling a psychiatric disorder diagnosis, has been reported within the older adult population (WHO, 2012).

Other research findings also show an association between the presence of abuse and higher rates of self-reported emotional distress (Cooper et al., 2006), psychological distress (Comijs, Penninx, et al., 1999), poorer mental health (Naughton et al., 2012) and feelings of loneliness (Lowenstein, Eisikovits, Band-winterstein, & Enosh, 2009) in victims.

Depressed older adults may be more susceptible to vulnerability and dependence, which can increase the risk of abuse, whereas non-depressed older adults may also be at risk of developing the disorder if they experience some form of abuse (Dong et al., 2010; Sirey et al., 2015).

Additionally, abuse can have a more serious impact in victims already experiencing depression/depressive symptoms. Even though effects of abuse and neglect on older adults vary according to individuals' resources and coping strategies (Comijs, Penninx, et al., 1999), depression or depressive symptoms increase the vulnerability to emotional or psychological consequences (Choi & Mayer, 2006; Sirey et al., 2015).

The cross-sectional nature of most research hinders the development of causal inferences, given that only the association between these two variables is studied. Notwithstanding, researching correlates of elder abuse are an important first step, and available data clearly present elder abuse and depression/depressive symptoms conjoint presence as something common (Johannesen & LoGiudice, 2013; National Research Council, 2003).

This study proposes to an in-depth analysis of the relationship between depressive symptoms and elder abuse, by examining both characteristics of the individuals and characteristics of the abusive experience. Focusing the analysis only on older adults self-reporting abuse, results can indicate which of those characteristics relate, more specifically, with the presence of depressive symptoms.

The present study was designed to (a) estimate proportion of older adults self-reporting elder abuse that screened positive for depressive symptoms in accordance to abbreviated version of the Geriatric Depressive Scale (GDS-5); and (b) examine whether individual

characteristics and/or characteristics of abusive experiences aspects correlate with self-reported depressive symptoms among a convenience sample of older adults who have self-reported elder abuse.

Methods

A secondary data analysis of the Aging and Violence (2011-2014) cross-sectional study (Gil et al., 2015) was performed. The study included a survey targeting self-reported older adult victims who were identified and referred by project partner institutions. Data was collected between November 2011 and March 2013.

Setting and Sampling

Data was collected from a convenience sample and was obtained from four institutions: a non-governmental organization aimed at the support of domestic violence victims; the welfare state organization; the security police institution and a forensic and legal medicine institute[1]. Trained professionals working in these institutions implemented a structured questionnaire to all eligible older adults who were willing to participate in the study and wanted to report their abusive experience to a competent organization. Between November 2011 and March 2013, participants completed face-to-face interviews conducted in one of four different institutions. The institutions' professionals carried out the interviews. Further developments on study design can be found in previous publications (Gil et al., 2015; Gil, Santos, & Kislaya, 2015)

Participants

Participants were victims of elder abuse who were enrolled in a victims' survey in the Portuguese Aging and Violence study. The target population comprised community-dwelling individuals aged 60 and over who had been living in Portugal for at least 12 months and who came to one of the partner institutions to report violence perpetrated by someone close. Inclusion criteria was age (>59 years of age); living in Portugal for the past 12 months; living in private households (i.e., not being institutionalized); reporting violence perpetrated by family members, caregivers or members from the informal social network; and being able to understand and answer questions. The final sample consisted of a total of 510 individuals who reported being victims of abuse.

[1] Portuguese Association for Victim Support (Associação Portuguesa de Apoio à Vítima); Portuguese Institute of Legal Medicine and Forensic Sciences (Instituto Nacional de Medicina Legal e Ciências Forenses, IP); Social Security Institute (Instituto de Segurança Social); National Republican Guard (Guarda Nacional Republicana).

Study variables

The structured questionnaire included demographic questions, health and functional status, social and economic variables and questions assessing physical, sexual, psychological or financial violence and neglect.

The questionnaire was structured as a series of questions on the diverse topics and included three standardized measures on functional status, depressive symptoms and violence.

Perceived social support was assessed by asking participants, “do you have enough people who you may ask for help and support when you encounter problems?” using a five-point scale: 1) lot people I can rely on; 2) enough people I can rely on; 3) I do not know if people will help when I´m in need; 4) few people I can rely on and 5) no one I can rely on.

Self-reported functional status was assessed through The Katz Activities of Daily Living (ADL) scale that measures limitations in an individual’s ability to perform basic selfcare tasks (Katz, 1983). It consists of six items and an ADL score is created by adding the individual items (range 0–6).

Depressive symptoms were assessed with the short version of the self-report screening scale Geriatric Depression Scale. The GDS, originally developed with 30 different items by Yesavage (1991), has been validated in shorter versions. The GDS-5 has been validated in USA (Rinaldi, Mecocci, Benedetti, & Ercolani, 2003) and Spain (Martínez de la Iglesia et al., 2005) with reported high sensitivity (94% in the USA and 81.1% in Spain) and specificity (81% in the USA and 73.2% in Spain) values. Respondents are asked to indicate whether they have experienced the described symptoms during the past week using the yes/no format. It consists of 5 dichotomous response items assessing mood and social behavior. Depressive symptoms were defined as two or more positive answers to the five screening questions: (i) feelings of satisfaction with life; (ii) feelings of often getting bored; (iii) feeling a sense of helplessness; (iv) wanting to stay home often instead of going out; (v) and feelings of worthlessness. Similarly, to the Spanish and American studies of the scales validity, the cut-off point was taken as 2 or more positive responses (to items 2 to 5) and/or negative response to item 1.

The violence questions were adapted from the instrument of the New York Elder Abuse Prevalence Study (Lachs et al., 2011). Violence encompassed 12 violent behaviours distributed within distinct types of violence and one open question that covered other actions not covered in the questionnaire. Respondents were asked about the occurrence

(yes/no), frequency (1 time, 2-10 times and >10 times) and perpetrator of each of these behaviours during the past 12 months. Financial abuse included a) forcing to give legal rights; b) stealing or using property beyond the consent of its owner; c) undue household appropriation and d) not contributing to the household expenses. Physical abuse was assessed through three different behaviours: a) physical aggression (e.g., hitting, pushing, etc.); b) locking or limiting the access to the household and c) hindering of speaking or meeting with other persons. Three concepts were also encompassed in the evaluation of psychological abuse: a) threatening; b) verbal aggression, insulting, humiliating and c) ignoring or refusal to talk. Sexual abuse and neglect were each evaluated by one single question. The measurement of sexual abuse included any unwelcome sexual advances, requests for sexual favors and other verbal or physical actions of a sexual nature. Neglect was measured by the refusal or absence of acting or caring for someone, to whom help was usually given. While a onetime occurrence of financial, physical or sexual conduct was considered a positive response to abuse; neglect and psychological abuse was recorded if a person experienced more than ten incidents in the previous 12 months. The three included abuse variables are: violence type (financial, physical, psychological and polivictimization); perpetrator (partner/spouse; descendants and other relatives and non-relatives); and number of abusive behaviors.

Focus group and semistructured interviews were used to evaluate and design the questionnaire, namely, in terms of ordering of the questions, redefine and rephrase the questions and assure that response options in the closed questions were exhaustive and mutually exclusive. For further developments please see Gil and colleagues (2015).

Data analysis

To assess the GDS-5 scale validity and reliability, Chronbach Alpha and exploratory factorial analysis by tetrahoric correlations was conducted. Tetrahoric correlations were used since they are more appropriate to evaluate dichotomous variables (Wherry, 1984). Exploratory factorial analysis was done for the five items of the scale, followed by the unrotated (one-factor) extraction, considering the unifatorial structure of the scale.

Descriptive analyses of depressive symptoms are presented, namely frequencies and percentages for the individual questions and for the overall scale score. Sociodemographic, socioeconomic, health variables and abuse variables are described for the depressed and non-depressed victims of elder abuse.

For the analysis, a dichotomous variable was created for functional status (not reliant on help with ADL and reliant on help with ADL for at least one activity) and social support

variable was defined in three categories (plenty; few or enough and no one available *to help if needed*).

Pearson's chi-square test or Fishers exact test were conducted to examine the relationship between depressive symptoms and both the victims and the abuse experience characteristics. Finally, analysis of self-reported depressive symptoms using dichotomous outcomes was conducted. Some authors in the medical and the public health literature indicate that, when evaluating not so rare outcome events, it is better to estimate prevalence ratio (PR) because a high prevalence rate could overestimate the odds ratios (OR) and increase the difference between PR and OR (Aguiar & Nunes, 2013; Deddens & Petersen, 2008). Hence, prevalence ratio estimation by Poisson regression with robust error variance was conducted. Depressive symptoms were examined as the dependent variable. The independent variables were 1) individual characteristics and 2) abusive experience characteristics. Individual characteristics included sex, age groups, civil status, cohabitation, perceived social support, chronic disease and functional status. Abuse experience characteristics included violence type, perpetrator and number of abuse occurrences.

To select the covariates for the regression model, the significance-testing approach was employed (Greenland, Daniel, & Pearce, 2016). A bivariate analysis was performed for all the independent variables and these were included in the final model if the p-value was less than 0.051. The final model controlled for abuse experience and individual characteristics variables as confounders. Statistical analyses were all carried out using Stata®.

Ethical considerations

Ethical approval was obtained for the survey protocol from the ethics commission of the Portuguese National Health Institute Doutor Ricardo Jorge and the National Data Protection Commission. All participants were required to sign an informed consent after the interviewer (institutions trained professionals) presented the study's aims, methods and potential risks and benefits.

Results

Sample Characteristics

Characteristics of the Aging and Violence victims' survey sample are presented in Table 1. Most participants were female (76.1%) and 49.8% were aged between 60 to 69 years

old. More than half were married (61.5%), lived in their own house (66.5%) with partner or with partner and children (75.9%).

Table 1. Distribution of the participants according to their sociodemographic characteristics, health variables and reported violence types

		%
Sex	**Women**	**76.1**
	Men	23.9
Age groups	**60-69**	**49.8**
	70-79	35.3
	80 +	14.9
Civil status	Single	3.0
	Married/Civil Union	**61.5**
	Divorced/Separated	11.6
	Widow	23.9
Cohabitation	Alone	10.4
	Couple or couple with children	**75.9**
	Relatives	12.7
	Only non-relatives	1.0
House type	Rented	22.7
	Own house	**66.5**
	Relatives House	8.1
	Other situation	2.7
Perceived social support (enough people to rely on)	Plenty	14.7
	Few or enough	**65.5**
	No one available	19.8
Chronic disease	**Yes**	**76.3**
	No	23.7
Help in Activities of the Daily Living	**Yes**	**77.0**
	No	23.0
Depressive symptoms	**Yes (GDS5 ≥ 2)**	**78.7**
	No (GDS5 < 2)	21.3
GDS-5 items	Feeling dissatisfied with life[2]	68.7
	Feeling bored	79.3
	Feeling helpless	65.1
	Prefer to stay home, rather than going out and doing new things	53.5
	Feeling worthless	35.4
Violence types	Financial	47.5
	Physical	87.8
	Psychological	69.2
	Neglect	6.5
	Sexual	7.8
	Multiple types	74.1

[2] Inverted item

Depressive Symptoms (GDS-5)

Table 1 also shows the prevalence of depressive symptoms accordingly to the GDS-5 cut-off score. The GDS5 scale presented acceptable psychometric properties. Cronbach's alpha coefficient was 0.72. The tetracoric correlations presented positive values ranging

between 0.47 and 0.72. Using principal factor analysis, one factor emerged (eigenvalue of 1.83) accounting for 62% of overall variance. All five items loaded above 0.53.

Of the 510 self-reported victims of elder abuse, 351 answered positively to two or more items on the scale, indicating the presence of depressive symptoms of 78.7% of the sample. More than half of the sample (66.3%) reported 3 or more depressive symptoms, and almost half (46.8%) screened positive for 4 or 5 depressive symptoms. Most common depressive symptoms were: feeling bored (79.3%), feeling dissatisfied with life (68.7%) and feeling helpless (65.1%). The two least frequent items were: prefer to stay home rather than going out and doing new things (53.5%), and feeling worthless (35.4%).

Violence

Of all the five types of violence assessed, older adults referred more frequently physical abuse (87.8%), followed by financial (47.5%) and psychological abuse (69.2%), neglect (6.5%) and sexual abuse (7.8%) (Table 1). Most of the older adults reported the co-occurrence of multiple types of abuse (74.1%), followed by only physical abuse (18.8%), only psychological abuse (5.3%), only financial abuse (1.6%) and only neglect (0.2%).

Co-occurrence of abusive behaviors could be positively reported up to 12 - the total number of abuse experienced questions. The higher number of co-occurring behaviors reported by the same older adult was 10 occurrences. Violence seems to be essentially perpetrated by both partners/spouses (48.2%) and descendants (children and grandchildren - 50%). Other relatives and non-relatives were only appointed as responsible in 1.8% of the cases.

No significant differences were found (p=0.242) for the distribution of reported abuse types by gender: 76% women and 68% men reported multiple types; 16.8% women and 25% men reported only physical; 5.2% women and 5.7% men reported only psychological and 1.8% women and 0.8% men reported only financial abuse. Looking at the individual distribution of each type of abuse, differences were only observed for psychological and sexual abuse. Women reported to have experience more frequently psychological abuse (72.7% vs. 52.8%) and only women reported any occurrence of sexual abuse (9.8% vs. 0.0%).

Prevalence Ratio for Positively Screening Depressive Symptoms

Table 2 presents the prevalence ratios and p-values for the individual models predicting positive screening for depressive symptoms for each of the possible independent variables assessed. Of the seven individual characteristics evaluated (sex, age groups, civil status, cohabitation, perceived social support, chronic disease and functional status),

only three were found to be significantly related to depressive symptoms. Women, individuals perceiving not having anyone available to rely on if they need help and individuals reporting at least one chronic disease were more likely to report depressive symptoms. All three violence variables were related with depressive symptoms. The likelihood of screening positive for depressive symptoms was higher in victims of multiple types of violence, and lower in older adults indicating descendants as perpetrators. An increase on the number of experienced abusive occurrences increased the likelihood of older adults reporting depressive symptoms.

Table 2. Bivariate analysis for predicting positive screening for depressive symptoms

Independent variables	Categories (including reference)	PR		*p*
Sex	Men	1		
	Women	**1.25**	**[0.89-1.45]**	**0.002**
Age groups	60-69	1		
	70-79	0.99	[0.89-1.10]	0.801
	80 and more	1.03	[0.90-1.18]	0.701
Civil status	Single	1		
	Married/Civil Union	1.59	[0.90-2.81]	0.111
	Divorced/Separated	1.59	[0.89-2.85]	0.111
	Widow	1.58	[0.89-2.82]	0.117
Cohabitation	Alone	1		
	Couple or couple with children	1.12	[0.98-1.77]	0.097
	Relatives	1.08	[0.81-1.46]	0.359
	Only non-relatives	1.12	[0.72-1.88]	0.556
Perceived social support (people to rely on)	Plenty	1		
	Few or enough	1.12	[0.93-1.33]	0.082
	No one available	**1.40**	**[1.19-1.65]**	**0.000**
Chronic disease	No	1		
	Yes	**1.22**	**[1.09-1.52]**	**0.007**
Needs help in Activities of the Daily Living	Yes	1		
	No	0.99	[0.84-1.18]	0.954
Violence Type	Financial	1		
	Physical	1.19	[0.58-1.44]	0.625
	Psychological	1.23	[0.58-2.60]	0.528
	Multiple types	**1.71**	**[1.02-2.17]**	**0.048**
Perpetrator	Partner/spouse	1		
	Descendants	**0.89**	**[0.73-0.99]**	**0.043**
	Others relatives and non-relatives	0.97	[0.60-1.01]	0.107
Number of occurences	1 or 2	1		
	3 or 4	**1.38**	**[1.21-1.57]**	**0.000**
	5 or 6	**1.45**	**[1.26-1.66]**	**0.000**
	7 or more	**1.56**	**[1.37-1.77]**	**0.000**

For the final model, all significant individual characteristics and significant violence variables were added: gender, chronic disease, social support, violence type, perpetrator and number of occurrences. From this last set, only the number of abuse occurrences remained statistically significant. Hence, the final model (table 3) includes four variables: gender; chronic disease; perceived social support and number of abuse occurrences. The likelihood of screening depressive symptoms increased for women (20%), for those perceiving not having anyone available to rely on if they need help (33%), and for individuals reporting at least one chronic disease (16%). The increase of two violent behaviors experienced between 37% to 50% the PR for depressive symptoms.

Table 3. Final model: covariates predicting the prevalence ratio of depressive symptoms

		PR	95%CI	p
Sex	Men	1		
	Women	**1.20**	**[1.04-1.36]**	**0.007**
Chronic disease	No	1		
	Yes	**1.16**	**[1.02-1.38]**	**0.021**
Perceived Social support (people to rely on)	Plenty	1		
	Few or enough	1.08	[0.91-1.28]	0.385
	No one available	**1.33**	**[1.14-1.58]**	**0.000**
Number of conducts	1 or 2 conducts	1		
	3 or 4	**1.37**	**[1.20-1.56]**	**0.000**
	5 or 6	**1.42**	**[1.23-1.62]**	**0.000**
	7 or more conducts	**1.50**	**[1.32-1.70]**	**0.000**

Discussion

Most of respondents screened positive for depressive symptoms considering both the GDS-5 cutoff of 2 (78.7%) and of 3 (66.3%). These estimates are higher than the usually indicated prevalence of depressive symptoms among community-dwelling older adults. Different studies indicate that clinically significant depressive symptoms are present in approximately 8% to 15% of community-dwelling older adults (Beyer, 2007; Blazer, 2003; Kraaij, Arensman, & Spinhoven, 2002).

The prevalence found in this study is easily accountable by the fact that the target population comprised only older adults self-reporting some form of domestic violence, group that usually presents higher rates of both depressive symptoms and depression (Beach et al., 2010; Burnes, Rizzo, & Courtney, 2014; Comijs, Pot, Smit, Bouter & Jonker, 1998; Cooper et al., 2006; Dong, Simon, Gorbien, Percak, & Golden, 2007; Manthorpe et al., 2007). A recent systematic review on elder abuse risk factors indicated older adult's psychiatric illness or psychological problems as a risk factor in five general population

studies (Johannesen & LoGiudice, 2013). Furthermore, in most prevalence research studies depressive symptoms incidence and prevalence tend to be higher in studies using cutoffs on rating scales than in those using diagnostic criteria (Cole & Dendukuri, 2003). Similarly, on elder abuse studies, the prevalence of depression or depressive symptoms is higher when the outcome is measured by rating scales (Dong et al., 2007; Roepke-Buehler et al., 2015), rather than clinical diagnosis (Dyer et al., 2000).

The second objective was determining whether variables linked to individuals' characteristics or variables linked to an abuse experience would show the strongest PR for screening depressive symptoms among elder abuse self-reported victims. The obtained results show an association between individual sociodemographic and health status variables and self-reported depressive symptoms. Specifically, gender, perceived low social support, and the presence of at least one chronic disease all increased the risk of experiencing depressive symptoms. In the case of violence variables, the bivariate analysis showed that all three variables (type, perpetrators and number of abuse occurrences) were associated with positively screening depressive symptoms.

Results from the final model demonstrated that the relationship between individual characteristics and depressive symptoms remained significant after controlling for the other covariates. This suggests that the relationship between elder abuse and depressive symptoms may be better accounted by individual characteristics (i.e., gender, perceived low social support, and the presence of at least one chronic disease). Of the several factors associated with an increased risk of developing depression among older adults, gender (women), perceived social isolation, and comorbidities are among the usually identified variables (O'Neil, 2007). On the contrary, although violence variables were all significant in the initial bivariate analysis, only the number of abusive occurrences remained significant in the final model. In this study, the high density of violence (multiple occurrences), rather than abuse types or perpetrator, was found to be associated with the depressive symptoms of self-reported elder abuse older adults. Even though also including the frequency of each of the different occurrences (intensity), other studies suggest severity to be as key component of elder abuse (Burnes, Pillemer, & Lachs, 2017; De Donder et al., 2016). In these studies, severity differentiates factors associated with elder abuse. It would be expected that different consequences are also related (Burnes et al., 2017; De Donder et al., 2016).

Furthermore, results indicate that the number of occurrences may have a stronger and direct effect on older adults' psychological well-being, whereas abuse type and perpetrator

effects are shared with other individual factors, such as gender, social support, and having a chronic disease.

The results indicate the preponderance of individual characteristics on the likelihood of screening positive for depressive symptoms. All three variables have been linked consistently with the risk or vulnerability to elder abuse.

The possible relationship between abuse, depression, and evaluated variables could be conceptualized as a complex array of relations. Gender, poor physical health, and low social support have consistently been associated with increased risk of elder abuse (Johannesen & LoGiudice, 2013).

In the case of gender, women are found to be at greater risk for depression (Cole & Dendukuri, 2003) and in some studies more at risk of reporting abuse (Johannesen & LoGiudice, 2013). Dong and colleagues (2010) examined the effect of social support on the association between depression and elder abuse and found that in men depression was no longer associated with increased risk, but remained a significant factor for women. Social support has been a recognized variable associated with quality of life and psychological well-being in older adults, and some studies have even suggested this variable to be an important buffer for the negative impact of elder abuse (Dong et al., 2010).

Overall, the results established that women with poor physical health status perceiving low social support and reporting several abuse occurrences had a higher risk of positively screening depressive symptoms. These results support the appointed gender inequalities in both elder abuse and in mental health; women with low social support and poor physical health are at risk for both outcomes. This might be particularly detrimental for women, since they have increased vulnerability with aging and associated lowering status (Brozowski & Hall, 2004).

Elder abuse and depressive symptoms can increase the vulnerability to each of the other occurrences, given that elder abuse is associated with an increased risk of developing emotional and psychological distress and depression, whereas psychological distress and depression have been consistently associated with elder abuse.

In sum, independently of depressive symptoms being a cause, a consequence of elder abuse or both, these findings highlight that depressive symptoms may be more relevant among specific groups of abused older adults in comparison with others, and attention is to be paid to the number of occurrences involved in the abuse situation.

This study is not without limitations. First, this is a convenience sample of older adults reporting to four state and NGO institutions and may not be representative of the general, community-dwelling population. This may be particularly relevant, because the sampling method only captured victims asking for help in victim support services or presenting criminal complaints in judicial and criminal institutions. A population-base prevalence study has found that only a third of older adults reporting abuse at the hands of someone close have sought help (Gil et al., 2015). Second, the assessment of depression was not comprehensive and one cannot infer a depression diagnosis. Even though crucial to the development of epidemiological research studies, screening standardized instruments lack the rigorous approach of clinical diagnoses. The GDS-5 scale is one of the several short versions commonly used in studies targeting older adults (Almeida & Almeida, 1999; Rinaldi et al., 2003; van Marwijk et al., 1995), even though its results tend to present higher incidence and prevalence rates than those employed by other measures (Cole & Dendukuri, 2003).

In addition, due to the cross-sectional nature of the study, the assessment of the direction of the relationship between depressive symptoms and elder abuse cannot be determined. Third, the study excluded older adults with cognitive impairment, and fourth, it was based on self-report of older adults, which can be subject to recall bias.

Conclusion

Our findings expand prior studies in a number of ways. This study examines a population of self-reported domestic violence victims to evaluate depressive symptom outcomes with respect to both individual and violence characteristics. This information contributes to the global understanding of the relation between depressive symptoms and elder abuse.

Individuals' characteristics already known to be associated with higher prevalence rates of depressive symptoms of community dwelling older adults, may be more relevant to screen for depressive symptoms than violence type or perpetrator. The high density of abuse occurrences might better account for depressive symptoms in elder abuse.

This has important implications for research and elder abuse targeted detection, management and prevention strategies.

Research focusing on elder abuse consequences, must consider the severity of the phenomenon. Also, it should be further explored how individual characteristics might increase or decrease individuals vulnerability to emotional and psychological consequences of elder abuse.

Women perceiving low social support levels with long-term illness should be targeted specifically as a risk group for both elder abuse and mental health problems. Routine screening for elder abuse should include screening of depressive symptoms and psychological wellbeing, and intervention should be concomitantly adjusted. In addition to increasing vulnerability to abuse, depressive symptoms may also impact the decision-making capacity of older adults experiencing violence. Intervention programs must therefore be aware of the need to address the phenomenon as well as the older adults' ability to successfully respond to it.

Empowering women, promoting active ageing strategies and combating social exclusion could help lessen the risk of both elder abuse and depressive symptoms among older adults.

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Chapter VI

Older adults' emotional reactions to elder abuse: individual and victimisation determinants

Older adults' emotional reactions to elder abuse: individual and victimisation determinants

Abstract

Elder abuse has been gaining public, state and scientific attention for the past 40 years, but research focusing on emotional reactions of older adults to victimization is still scarce. The study describes the emotions and feelings of older adults that experienced abuse in a community setting, and the association between these emotions and individual or abuse characteristics. The cross-sectional study comprises 510 older adults who were identified and referred by four institutions. Participants answered a questionnaire on elder abuse experiences, including the emotion or feeling brought out by the act of abuse that was perceived to be the most serious. Fear and sadness comprised 67.1% of all provided responses. Emotional reactions were associated with functional status, the presence of depressive symptoms, relationship with the perpetrator and, to a limited degree, to the experience of multiple types of abuse. The most significant and meaningful variable was the relationship with the perpetrator. This study demonstrates that older adults present very similar patterns of emotional reactions, but individual characteristics and the established relationship with the perpetrator might mediate the emotional response. Implications for prevention and intervention of elder abuse are discussed.

Keywords: Elder abuse, Abuse types, Emotions, Mental Health, Perpetrator

What is already known about this topic:

- Elder abuse is recognised as an important public health problem.
- Emotional reactions to other forms of family violence have been associated with individuals' characteristics, willingness to report it and intervention engagement.
- Despite studies suggesting several mental health consequences, namely, psychological distress, including anxiety and depression, studies on older adults' emotional reactions to abuse are scarce.

What this paper adds':

- Similar emotional pattern among community-dwelling older adults reporting elder abuse: fear and sadness were the most common responses.
- Reported emotions are differently associated to both individual and abuse characteristics.
- The perpetrator was the most significant and meaningful variable to distinguish reported emotions.

Introduction

Presently recognised as an important public health problem, elder abuse has received increasing attention worldwide (Acierno et al., 2010; Lachs et al., 2011; Laumann, Leitsch, & Waite, 2008; Pillemer, Burnes, Riffin, & Lachs, 2016). The past four decades have witnessed the development of a high number of prevalence and risk factor studies (Biggs & Goergen, 2010), but considerably less attention has been given to emotional reactions triggered by elder abuse (Daly, Merchant, & Jogerst, 2011; National Research Council, 2003; Ploeg, Fear, Hutchison, MacMillan, & Bolan, 2009). The importance of emotional reactions have been addressed, namely, associated to individuals' engagement in the intervention (Anetzberger, 2005; Cornijs, Penninx, Knipscheer, & van Tilburg, 1999; Desmarais & Reeves, 2007; Ploeg et al., 2009; Quinn & Tomita, 1997).

Qualitative studies have found that older adults experiencing abuse usually reported despair, fear, shame, grief, anger, stress or disappointment (Comijs et al., 1999; Dong et al., 2011; Mysyuk, Westendorp & Lindenberg, 2016; Nerenberg, 2006; Wolf & Pillemer, 2000; Yan, 2014). However, as already acknowledged in Intimate Partner Violence (IPV) literature "there is also no single health or mental health presentation of abuse and no standard sequelae for reacting to it" (Jordan, 2009, p. 395).

Similarly to IPV literature, elder abuse studies have highlighted a reduced sense of mastery over the environment and feelings of powerlessness as emotional consequences (Parker, 2007; Quinn & Tomita, 1997; Spangler & Brandl, 2007). Seligman's (1975) "learned helplessness" describes how individuals experiencing abuse that perceives themselves helpless to change the situation they are in, can give up seeking or accepting help, given that a motivation to respond to a situation is weakened if the individual feel's nothing can be done to affect the outcome (Quinn & Tomita, 1997).

Individuals manage differently abusive relationships, and specific emotional profiles and psychosocial traits mediate the coping strategies employed to handle abuse (Al-Nsour, Khawaja, & Al-Kayyali, 2009; Avdibegovic, Brkic, & Sinanovic, 2017; Comijs et al., 1999). Hence, emotional reactions may be particularly informative, by increasing our understanding of why some individuals remain in potential harmful abusive relationships while others seek or accept help (Burnes, Lachs, Burnette, & Pillemer, 2017).

The emotional reaction to stressors depends on the appraisal, which in turn depends on the event threatening assessment, its perceived controllability, and one's ability to cope with it (Dong et al., 2013; Park, 2014; Parker, 2007; Roepke-Buehler & Dong, 2015). Therefore, varying appraisals will account for different emotional reactions. In elder abuse, the array of possible configurations (e.g., age and personal vulnerability, type of

relationship with the perpetrator and type of abuse) suggests an array of emotions (Burnes et al., 2017; Mysyuk et al., 2016).

A recent qualitative study observed different consequences of the victimization experience associated with the type(s) of abuse, but also with the relationship with the perpetrator (Mysyuk et al., 2016). Others have suggested a particularly detrimental impact when abusers are the adult offspring whom individuals' raised themselves (Yan & Tang, 2004); indicating that older adults may be more disposed to keep up the family relationship (Vladescu, Eveleigh, Ploeg & Patterson, 2000).

Given that research indicates emotions as a key component in decision-making processes (Salerno & Bottoms, 2009), the emotions elicited by the victimization experiences possibly mediate older adults' engagement in interventions and potentiate (or not) therapeutic and counselling effects (Santos & Ribeiro, 2014).

Furthermore, because emotional reactions may be differently elicited according to older adults' characteristics, contexts, and types of abuse experienced (Avdibegovic et al., 2017; Kaspiew, Carson, & Rhoades, 2016; Mysyuk et al., 2016), it is important to understand which characteristics of the abusive event are associated to specific emotions.

Although there is growing acknowledgment on the importance of knowing the emotional responses of older adults experiencing abuse to tailor intervention, the literature examining such responses is still sparse (Cisler, Begle, Amstadter, & Acierno, 2012; Dong, Chang, & Simon, 2013).

This paper intends to add to the available body knowledge on this topic by describing the main evoked emotions and feelings of community-dwelling older adults who have experienced abuse, and by exploring the association between these emotions and individual and abuse event characteristics (types of abuse, the occurrence of multiple types, identified perpetrators and severity).

Methods

The study relies on data from the Aging and Violence project (2011-2014), conducted in Portugal (Gil et al., 2015; Gil, Santos, & Kislaya, 2015). The project included two surveys targeting elder abuse in community-dwelling older adults. One was a population-based survey that aimed to estimate prevalence and other was a survey targeting older adults' reporting elder abuse at one of the four institutional partners. The present study employs data from the victims' survey, which aimed to describe older adults that sought institutional help after an abuse event.

Design and Sampling

The cross-sectional survey was implemented between November 2011 and March 2013 in four institutions with national catchment areas (see supporting material figure 1): the Portuguese Association for Victim Support (APAV); the Institute of Social Security (ISS); the National Republican Guard (GNR) and the National Legal Medicine Institute (INMLCF).

APAV is a private non-profitable organisation, with a statutory objective to inform, protect and support citizens who have been victims of crime, providing free and confidential services. ISS is responsible for assessing and applying the national policies of social protection and inclusion. The GNR is one of the three police forces in Portugal. The INMLCF is a Portuguese government-owned organization under the direct supervision of the Portuguese Ministry of the Justice, which provides forensic science services to the police forces and government agencies.

Recruitment of participants was through purposeful, convenience sampling (Polit & Hungler, 1999). The study non-probabilistic sample was obtained by the identification of older adults' reporting in one of the four institutions. Participants and procedures

The target population of the study comprised individuals aged 60 or more years; living in Portugal for the past 12 months in private households; reporting violence perpetrated by someone close (spouse/partners, children, grandchildren, sons and daughters-in-law, other family members, friends, neighbours, work colleagues and paid professionals); and being able and willing to answer to the questionnaire.

Participants were community-dwelling older persons, which had experience one or more types of abuse and whom had sought help regarding the victimisation experience in these institutions. Participation was voluntary. The professional service providers implemented the recruitment and data collection. Professionals working in these institutions (victim support offices managers, police officers, medical legal examiners and social workers) were specifically trained to apply a structured questionnaire to all eligible older adults who were willing to participate in the study. Participants completed face-to-face interviews conducted in one of four different institutions.

All participants were required to sign an inform consent after the interviewer (trained professionals) presented the study's aims, methods and potential risks and benefits. Ethical approval was obtained for the survey protocol from the review board of the Portuguese National Public Health Institute and the National Data Protection Commission (legal state authority).

More information on the Portuguese Ageing and Violence study's methodological procedures can be found elsewhere (Gil et al., 2015; Gil, Santos, & Kislaya, 2015).

Participants and procedures

The target population comprised individuals aged 60 or more years; living in Portugal for the past 12 months in private households; reporting abuse perpetrated by someone close (spouse/partners, children, grandchildren, sons and daughters-in-law, other family members, friends, neighbours, work colleagues and paid professionals); and being able and willing to answer to the questionnaire.

Each institution nominated a focal point to coordinate the fieldwork procedures with the research team. Despite the similarity of recruitment and data collection procedures, the fieldwork was adapted to the institutions' structure and organization.

APAV and INMLCF collected the data between November 2011 and March 2013, whereas ISS and GNR collected the data between March 2012 and March 2013.

In each of these institutions, professionals who were assisting the public carried out the recruitment and data collection: psychologists and social workers in APAV; physicians in INMLCF; social workers in ISS and police officers in GNR. Every older adult, which complied with the inclusion criteria and reporting elder abuse in one of these institutions would be asked by the professionals to participate. If accepted, the participants completed face-to-face interviews conducted in the institution. Interviews took between 15 and 40 minutes long.

The selected institutions received training for carrying out the survey, supported by several standardised materials (questionnaire, informed consent, questionnaire manual, and project leaflet). The protocol for services referral was different according to the aim of the institution. For the most part, given their expertise in responding to elder abuse cases, the institutions had already in place specific referral protocols.

The methodological challenges came mainly from the scope and nature of the partner institutions. Information (which data did we have access and how) and communication to professionals applying varied from institution and institution. The main result from these organisational constraints was the fact that we were not able to collect data on the number or characteristics of eligible individuals that refused to participate.

All participants were required to sign an informed consent form after the interviewer (trained professional) had presented the study aims, methods, and potential risks and benefits. The informed consent was safely stored in each of the institutions, and the

anonymous questionnaires were sent regularly (about once a month) to the research team. Participant' safety, privacy, and confidentiality were regarded also by the method employed to identify potential participants. The professionals knew the older adult's story and were known by the participant. The interview took place in the private offices of the institutions, scheduled within the routine appointments of the institutional framework.

Ethical approval was obtained for the survey protocol from the ethics review board of the Portuguese National Public Health Institute and the National Data Protection Commission (legal state authority).

More information can be found elsewhere on the Portuguese Aging and Violence project methodological procedures (Gil et al., 2015; Gil, Santos, & Kislaya, 2015) and ethical issues (Gil, Santos & Santos, 2013).

Measures

All the institutions applied a similar standardised questionnaire with few variations (see supporting material table 1). In the first phase of the Ageing and violence project, focus group and victims' interviews were conducted, also, to assess the questionnaire's adequacy, clarity and comprehensiveness (Gil, Santos & Kislaya, 2015). We also conducted a pilot with 96 older adults aged 60 and over, which allowed us to assess the validity and reliability of key measures, including the two scales: The Katz Activities of Daily Living (ADL) and the five-item Geriatric Depression Scale.

Sociodemographic and social support. The questionnaire included information on sex; age group; civil status; cohabitation (alone; couples and couples with children; other family members or others), schooling and perceived social support.

Schooling was evaluated by asking participants the highest level of education attended, according to the current national levels of education: no schooling; up to 4 years of schooling; between 5 and 9 years; between 10 and 12 years and 12 or more years. Given the low variation of the older adults' population distribution for the considered education levels, schooling was categorised into three levels: no schooling, up to 9 years and 10 or more years.

Perceived social support was assessed through a single question developed for the project questionnaire, asking participants if they had enough people to ask for help and support when they encountered problems. The questions' facial validity was evaluated in the pilot of the study (Gil, Santos & Kislaya, 2015). The response categories included: a

lot of people I can rely upon, enough people I can rely upon, I do not know if people will help when I am in need, few people I can rely upon and no one I can rely upon. For analysis purposes, and because some categories presented low frequencies' distribution, three categories were considered: plenty people to rely upon, few or enough people to rely upon, and do not know and no one is available.

Functional and health status. Functional status was assessed by the need for assistance into Activities of the Daily Living (Katz, 1983), which were divided into personal and instrumental activities (Arriola, Yanguas, & Leturia, 2001). In this study, only two categories were considered: not reliant on help with ADL and reliant on help with ADL for at least one activity. Health variables included chronic health conditions (yes/no) and depressive symptoms. Depressive symptoms were evaluated with the five-item version of the Geriatric Depression Scale (Hoyl et al., 1999; Yesavage, 1988). It consists of five dichotomous response items assessing mood and social behaviour: feelings of satisfaction with life; feelings of often getting bored; feeling a sense of helplessness; wanting to stay home often instead of going out; and feelings of worthlessness. Depressive symptoms were defined as two or more positive answers to the five screening questions (Santos, Nunes, Kislaya, Gil, & Ribeiro, 2017).

Abuse measures. Abuse questions were adapted from the instrument of the New York Elder Abuse Prevalence Study (Lachs et al., 2011). The questionnaire included the measurement of 12 abuse behaviours, distributed within five subtypes of elder abuse: financial, psychological, physical, sexual abuse and neglect. Because the National Legal Medicine Institute (INMLCF) did not include neglect, these questions were excluded. The remaining types of abuse were operationalised through multiples behaviourally specific items (Table 1).

Table 1. Types of abuse and abusive behaviours included

Abuse types	Abusive behaviours included
Financial	1) Forcing to give legal rights
	2) Stealing or using property beyond the consent of its owner
	3) Undue household appropriation
	4) Not contributing to the household expenses
Physical	5) Physical aggression (e.g., hitting, pushing, etc.)
	6) Locking or limiting the access to the household and
	7) Hindering of speaking or meeting with other persons
Psychological	8) Threatening
	9) Verbal aggression, insulting, humiliating
	10) Ignoring or refusal to talk
Sexual	11) Any unwelcome sexual advances, requests for sexual favours and other verbal or physical actions of a sexual nature

For each of the positively answered abusive behaviours, respondents were asked to indicate a perpetrator, which included spouse/partners, children, grandchildren, sons and daughters-in-law, other family members, friends, neighbours, work colleagues, and paid professionals. The perpetrator variable was categorised as spouse/partner, children and grandchildren, and others. The others category included relatives (other than nuclear family, 5%), friends or neighbours (1.6%) and paid professionals (0.2%). Other relatives were included in this category because some of the participants' characteristics distribution was similar to the characteristics of participants indicating non-relatives as perpetrators.[2]

Abuse frequency was evaluated for the past 12 months as a one-time occurrence, between two and ten times, and more than ten times. The present analysis also includes a severity indicator, based on the "level of severity" developed by Donder and colleagues (2016) in the context of the EU-funded Abuse and Violence against Older Women (AVOW) study. The authors by combining the information about density (positively answered abusive behaviours) and intensity (frequency by which they occurred) conceived of a typology with four quadrants. In this study, density and intensity were combined into three different levels:

- Level 1: one abusive behaviour, once in the past twelve months;
- Level 2: one abusive behaviour two or more times in the past twelve months or more than one abusive behaviour occurring once in the past twelve months;
- Level 3: more than one abusive behaviour occurring two or more times in the past twelve months.

Emotions. Respondents were asked to state the main emotion or feeling brought out by the act of abuse that was perceived to be the most serious ("From what you reported having happened to you in the previous questions, indicate the act of abuse, mistreatment and/or neglect which most afflicted you?"). A numeric variable was developed according to the emotion or feeling stated by participants. For emotions with a high frequency, a specific category was created, namely, fear, sadness, anger, shame, and outrage. Another category, denominated others, was included for the responses with low frequency (less than 10 absolute counts): loneliness, despair, heartbreak, disillusion, helpless, humiliation, nervous, hatred, pity, and surprise.

[2] While 54% of other relatives was cohabitating with the victim, about 80% of children and grandchildren and 86% of spouses/partners lived in the same household as the victim (compared to 22% of perpetrators from the social network). Perpetrators from the nuclear family were more often identified as having a difficult relationship with the victim (about 70% of children and grandchildren and 83% of spouses/partners), compared to other relatives (44%) and social network members (23%). A higher proportion of victims of a single type of abuse indicated other relatives and social network members as perpetrators, compared to victims reporting multiple types (17% vs. 6%).

Analysis

Statistical analysis includes descriptive analysis of all the categorical variables by frequencies and percentages for the sociodemographic, health status, abuse, and emotions. Pearson's chi-square test or Fisher's exact test were conducted to examine the relationship between the elicited emotions and all other individual or violence characteristics. A significance level of < .05 was considered for the employed tests. The analysis was performed with Stata® (version12).

Results

The final sample encompassed 510 self-reporting victimization experiences in four institutions: non-governmental organization for the support of domestic violence victims (APAV, n=53); the welfare state organization (ISS, n=72); police force (GNR, n=133) and National Legal Medicine Institute (INMLCF, n=252). Sample characteristics are presented in Table 2. Overall, 510 individuals reported having experienced some sort of abusive experience at the hands of someone close to them. Participants in the sample were mostly female (76%), younger than 80 years (85%) and married/partnered (61%). The majority lived with the nuclear family (couple or couple with children, 76%) and had up to 9 years of education (69%). In terms of the health condition, the majority reported at least one chronic disease (76%), was independent in their Activities of Daily Living (ADL, 77%) and screened positive for the presence of depressive symptoms (GDS5≥2, 79%).

Table 2. Demographic and health variables distribution

		%(n)
Sex (n=510)	Women	76.1(388)
	Men	23.9(122)
Age groups (n=510)	60-69	49.8(254)
	70-79	35.3(180)
	80 or more years	14.9(76)
Civil status (n=501)	Single	3.0(15)
	Married/Civil Union	61.5(308)
	Divorced/Separated	11.6(58)
	Widow	23.9(120)
Cohabitation (n=510)	Alone	10.4(53)
	Couple or couple with children	75.9(387)
	Other	13.7(70)
Schooling (n=499)	No education	22.9(114)
	Up to 9 years	69.3(346)
	10 or more years	7.8(39)
Perceived social support (n=504)	Plenty	14.7(74)
	Few or enough	65.5(330)
	No one available	19.8(100)
Chronic disease (n=490)	No	23.7(116)
	Yes	76.3(374)
Help in ADLs (n=509)	No	77.0(392)
	Yes	23.0(117)
Depressive symptoms (n=451)	No (GDS5 < 2)	21.3(96)
	Yes (GDS5 ≥ 2)	78.7(355)

Table 3 presents participants' distribution according to the type of abuse experienced, the occurrence of different abuse types, abuse severity level and identified perpetrators. Physical abuse was the most frequent (88%), followed by psychological (70%), and financial (48%). Most participants reported having experienced more than one type of abuse (74%). The majority of the experienced abuse was within the medium severity level (76%). Perpetrators were mostly spouses and partners (48%) followed by children and grandchildren (42%).

Table 3. Distribution of abuse variables: abuse type, polyvictimisation, severity and perpetrator

		%(n)
Abuse type	Financial (n=505)	47.5(240)
	Psychological (n=510)	69.6(355)
	Physical (n=510)	87.8(448)
	Sexual (n=495)	7.8(37)
Polyvictimisation (n=510)	No	25.9(132)
	Yes	74.1(378)
Severity*(n=510)	Low	18.6(95)
	Medium	76.3(389)
	High	5.1(26)
Perpetrator (n=504)	Spouse or partner	48.2(243)
	Children or grandchildren	42.3(213)
	Other	9.5(48)

* Low = 1 abusive behavior 1 time in the past 12 months; medium = 1 abusive behavior 2 or more times in the past twelve months or >1 abusive behaviors 1 time in the past twelve months; and high = >1 abusive behavior 2 or more times in the past twelve months.

A total of 454 participants (missing values=3.1%) reported the emotions and feelings elicited by the most serious abuse incident as perceived by the participant (Table 4). Fear (34%) and sadness (33%) were the most frequently elicited emotions, whereas outrage was not so commonly indicated (6%). There were nine other emotions and feelings with very low absolute frequencies, namely: loneliness (n=8); hatred (n=3); heartbreak (n=2); humiliation (n=2); hurt (n=2); despair (n=1); disillusion (n=1); nervous (n=1); pity (n=1).

Table 4. Frequencies of the reported emotions and feelings elicited by the most serious violence incident

Emotions and feelings	%(n)
Fear	34.1 (155)
Sadness	33.0 (150)
Anger	11.2 (51)
Shame	11.2 (51)
Outrage	5.3 (24)
Others	5.1 (23)
Total	100 (454)

Table 5 presents the distribution of the participants' characteristics (demographic, social, and health variables) and the abuse event characteristics (types of abuse, occurrence of multiple types, abuse severity and identified perpetrator) by the six emotion and feeling categories.

As for the individuals' characteristics, participants reporting abuse mainly referred fear and sadness as their emotional reaction. However, differences between the proportions of reported emotions and feelings were found for need of help to perform at least one of the ADLs ($\chi 2(5) = 11.71$, $P = 0.039$) and the presence of depressive symptoms ($\chi 2(5) = 16.40$, $P = 0.006$). Fear and anger were emotions more commonly reported by participants who were independent in their ADLs (34.9% and 12.2%, respectively) and did not screened positive for depressive symptoms (37.6% and 14.5%, respectively). On the contrary, individuals who were more dependent in ADLs (44.6%) and indicated depressive symptoms (44.6%) reported more frequently sadness. Shame and outrage present a similar pattern, as these emotions were more common among individuals who were functionally independent (12.2% and 6.3% respectively), and with a positive screen for depressive symptoms (13.3% and 7.2%, respectively).

In what regards the abuse event characteristics, only the occurrence of multiple types of abuse (Fisher's exact test, $P = 0.049$) and perpetrator ($\chi 2(10) = 31.92$, $P < 0.001$) were significantly associated with different emotions and feelings reported by participants. Fear was more commonly evoked by participants reporting multiple types of abuse (35.9%) and abuse perpetrated by individuals outside the nuclear family (38.5%) or by the spouse or partner (36.0%). Sadness was more common among participants indicating single abuse types (43.2%) and abuse perpetrated by children and grandchildren (44.9%). Regarding anger and shame, differences are more relevant in the case of the perpetrators' variable. Individuals indicating their children and grandchildren as responsible for the abuse reported less frequently anger (7.1%), shame (10.1%) and outrage (4.1%). All these three emotions were more commonly found in participants reporting abuse perpetrated by a spouse or a partner (14.5%, 13.1% and 7.0%, respectively). The category "other", which includes a wide diversity of emotions and feelings, was more commonly reported (15.4%) by the perpetrators category "others", which included individuals outside the nuclear family.

Table 5. Association between individual and abuse characteristics and evoked emotions

		Fear %	Sad %	Anger %	Shame %	Outrage %	Other %	Total %	p
Sex	Men	27.2	34.0	12.6	16.5	5.8	3.9	100	0.317[a] ($\chi2$(5)=5.88)
	Women	36.2	32.8	10.8	9.7	5.1	5.4	100	
Age groups	60-69	30.9	32.6	11.3	13.9	5.2	6.1	100	0.177[a] ($\chi2$(10)=13.90)
	70-79	38.9	28.4	11.7	9.9	6.8	4.3	100	
	80 and more	33.9	46.8	9.7	4.8	1.6	3.2	100	
Civil status	Single	25.0	41.7	25.0	0.0	8.3	0.0	100	0.117[b]
	Married/Civil Union	32.6	32.6	12.0	12.7	4.4	5.8	100	
	Divorced/Separated	47.2	15.1	13.2	11.3	7.6	3.7	100	
	Widow	33.3	41.9	5.7	8.6	6.7	3.8	100	
Cohabitation	Alone	42.2	24.4	13.3	8.9	8.9	2.2	100	0.707[a] ($\chi2$(10)=7.20)
	Couple/ with children	34.2	33.9	10.1	11.3	5.2	5.2	100	
	Others	28.1	34.4	15.6	12.5	3.1	6.3	100	
Schooling	No schooling	39.6	39.6	7.7	8.8	1.1	3.3	100	0.080[b]
	Up to 9 years	33.1	30.0	11.4	12.9	6.6	6.0	100	
	10 or more years	27.8	41.7	19.4	2.8	5.6	2.8	100	
Perceived social support	Plenty	33.3	37.9	13.6	9.1	3.0	3.0	100	0.150[a] ($\chi2$(10)=14.54)
	Few or enough	33.0	30.3	12.3	13.7	6.3	4.3	100	
	No one available	37.4	39.8	6.02	4.8	3.6	8.4	100	
Chronic disease	No	36.2	32.4	12.4	13.3	1.0	4.8	100	0.202[b]
	Yes	31.8	34.2	10.8	10.8	6.9	5.4	100	
ADL	No	34.9	29.8	12.2	12.2	6.3	4.6	100	**0.039**[a] ($\chi2$(5)=11.71)
	Yes	30.7	44.6	7.9	7.9	2.0	6.9	100	
Depressive symptoms	No	37.6	28.0	11.2	11.2	5.6	6.5	100	**0.006**[a] ($\chi2$(5)=16.40)
	Yes	18.1	44.6	14.5	13.3	7.2	2.4	100	
Psychological abuse	No	30.2	37.3	15.9	10.3	4.0	2.4	100	0.141[a] ($\chi2$(5)=8.30)
	Yes	35.7	31.4	9.5	11.6	5.8	6.1	100	
Physical abuse	No	26.3	49.1	8.8	8.8	5.3	1.8	100	0.136[a] ($\chi2$(5)=8.38)
	Yes	35.3	30.7	11.6	11.6	5.3	5.5	100	
Financial abuse	No	32.2	33.9	12.9	10.7	5.2	5.2	100	0.882[a] ($\chi2$(5)=1.76)
	Yes	35.8	32.1	9.6	11.9	5.5	5.1	100	
Sexual abuse	No	33.3	33.3	8.3	11.1	8.3	5.6	100	0.964[a] ($\chi2$(5)=0.92)
	Yes	34.2	32.8	11.3	11.6	5.2	4.9	100	
Multiple abuse types	No	28.8	43.2	12.6	10.8	1.8	2.7	100	**0.049**[b]
	Yes	35.9	29.7	10.8	11.4	6.4	5.8	100	
Severity	Low	26.9	44.9	9.0	14.1	2.6	2.6	100	0.314[a] ($\chi2$(10)=11.59)
	Medium	35.6	30.5	12.0	10.8	5.4	5.7	100	
	High	36.0	32.0	8.0	8.0	12.0	4.0	100	
Perpetrator	Partner/spouse	36.0	23.8	14.5	13.1	7.01	5.6	100	**0.000** [a] ($\chi2$(10)=31.92)
	Children and grandchildren	31.1	44.9	7.1	10.2	4.1	2.6	100	
	Others	38.5	23.1	12.8	7.7	2.6	15.4	100	

Note: % percentage; [b] Fisher's exact test; [a] Chi-square, it includes the test statistics and degrees of freedom ($\chi2$(dg)=x).

Discussion

In this sample of older adults self-reporting financial, psychological, physical or sexual abuse, three main outcomes are noteworthy. First, that two specific basic emotions (fear and sadness) were reported by most participants; second, the reported emotions are differently associated to both individual and abuse event characteristics; third, that the perpetrator was the most significant and meaningful variable to distinguish reported emotions.

By means of an open question, we found that older adults reported very similar emotions on what is regarded as the most serious incident of abuse. Fear and sadness comprised 67.1% of all responses. While fear is commonly reported by elder abuse (Comijs et al., 1999; Dong, Chang, & Simon, 2013) and domestic violence research (Campbell, 2002), sadness is not so frequently reported (Comijs et al., 1999; Mysyuk et al., 2016; Yan & Tang, 2001).

Fear has also been described as an emotion associated with health outcomes. Studies on older women experiencing abuse have described the presence of panic attacks and acute anxiety (McGarry, Simpson, & Hinchliff-Smith, 2011) in addition to feelings of terror (Lazenbatt, Devaney, & Gildea, 2010) as consequences of the abuse. Feeling fear, although being a normative reaction to an abuse experience, can increase older adults' perception of vulnerability due to the possible presence of numerous underlying medical problems and functional dependencies (National Research Council, 2003). Furthermore, fear can exist as a long-term threat in long-lasting abusive relationships and is associated with worse psychological and health outcomes (Begle et al., 2009; Cisler et al., 2012; Dong et al., 2013; Quinn & Tomita, 1997; Lazenbatt et al., 2010; McGarry et al., 2011).

In what regards sadness, it must be distinguished from fear since it corresponds to an internalizing response to whatever initiated it (Busfield, 2008; Steimer, 2002). An important difference between the two is that fear relates to impulsive actions and to dispositional attributions (Keltner, Ellsworth, & Edwards, 1993), whereas sadness comprehends a more internalizing feeling related to situational attributions (Keltner et al., 1993), i.e., to the environmental or situational features, something that is beyond one's control. The internalization of the aggression can also lead to a lower sense of self-efficacy, learned helplessness, and an external locus of control, being that all these three psychological features can be associated with worst outcomes as depression and anxiety (Begle et al., 2009).

Overall, both these negative normative emotional reactions to abuse are triggered by events appraised as difficult to control by immediate actions and, at the same time, with

perceived diminished coping potential (Busfield, 2008; Keltner et al., 1993; Steimer, 2002). In fact, perceptions of agency become an important aspect (Keltner et al., 1993). Fear and sadness are both negative emotions that develop from a person's perception of impersonal circumstances beyond human control to be the cause of their misfortune (Keltner et al., 1993). Unlike anger that results from the perception of some other person to be the cause of one's misfortune (Keltner et al., 1993). Anger was the third most common emotion elicited, along with shame. A study on the emotional reactions to the norm violation characterizing episodes of interpersonal harm indicated that perceived intent of the perpetrators to harm and the target's blaming of the perpetrator is more associated with anger (Kam & Bold, 2009). Because the agency has been put in the perpetrators, feeling angry about being abused might have the capability of acting as a motivating force, unlike fear, sadness or even shame.

Violence, particular within a trusted relationship, disrupts a person's autonomy rendering him or her powerless to maintain control of their emotions, thoughts, finance, and welfare. Literature in IPV has described Seligman's phenomenon of learned helplessness as an outcome of the abuse (Rakovec-Felser, 2014). Similarly, elder abuse studies report many older people come to believe that events are beyond their control, which derives into feelings of impotence and perceived helplessness (Parker & Lee, 2007; Quinn & Tomita, 1997; Spangler & Brandl, 2007).

Overall for about two-thirds of the older adults who reported some type of abuse, the emotional response of the most serious incident resulted from the assessment of an event or situation as uncontrollable and as something, they were unable to handle.

The self-perception of being in a powerless position can be enhanced by structural issues as the inequalities of power within relationships (Penhale, 2003; Spangler & Brandl, 2007). Given that the majority of older adults reporting elder abuse were women, it is also important to recognise socialization, and cohort effects. Studies observe that, in comparison to their younger counterparts, older women may view themselves as more submissive, perceive abuse as a private matter, and believe in a higher responsibility and loyalty to family and in the duty to protect them at all costs (Lazenbatt et al., 2010; Wilke & Vinton, 2005; Zink, Jacobson, Regan, Fisher, & Pabst, 2006). All these aspects may promote more passive emotional reactions.

Despite the high frequency of the elicited emotions (fear and sadness), we found significant differences regarding individual and abuse event characteristics. In comparison to sadness, fear was more frequently reported among more independent and potentially less vulnerable older adults, as they were independent for their ADLs and screened

negative for the presence of depressive symptoms. The most vulnerable individuals (with higher dependency levels and presence of depressive symptoms) may be more prompt to display an internalised feeling related to situational attributions, such as sadness. However, the presence of depressive symptoms might be a confounder and one of these symptoms can likely be sadness since the individuals that screened positive for depressive symptoms also reported more frequently sadness.

The different emotions triggered by less and more vulnerable individuals relate to other studies on domestic violence that highlight the importance of individual or contextual characteristics for different abuse consequences (Avdibegovic et al., 2017; Cisler et al., 2012; Comijs et al., 1999; Dong, Chang, & Simon, 2013; Parker, 2007). Not focusing specifically on the emotions evoked by the abuse, these studies indicate that the impact of victimization might be different according to gender, personality and coping traits, functional status, and social support (Avdibegovic et al., 2017; Cisler et al., 2012; Comijs et al., 1999; Dong, Chang, & Simon, 2013; Parker, 2007). It is conceivable that the emotional reaction may also be associated with specific individual characteristics and that functional dependent older adults may be more prompt to react with sadness rather than with fear.

Our results also showed that emotional reactions were associated with the relationship with the perpetrator and to a limited degree, the experience of multiple types of abuse. The association between abuse and the triggered emotional response may be better accounted by the relationship with the perpetrator rather than by the type of violence experienced, and this relates to the importance of considering the relationship as a key component when addressing elder abuse. Older adults victimised by their children or grandchildren elicited more frequently sadness, in comparison to fear or anger. Despite the correspondence areas between IPV and abuse within adult and adult-child relationships, namely, the consequences and effects of violence and abuse (Penhale, 2003), older adults victimised by offspring may feel a heightened sense of responsibility, while being more protective of the perpetrator (Harbison & Morrow, 1998; Jackson & Hafemeister, 2014; Luo & Waite, 2011; Moon & Benton, 2000; Nahmiash, 2004). The ambivalent feelings of parents abused by children, namely, commitment, love, along with affection and pain have been recorded (Lüscher & Pillemer, 1998). Some of these situations may even be characterised by an interdependency between the older person and the perpetrator (Band-Winterstein, 2015; Pickering & Rempusheski, 2014; Roberto, 2016), given they know and share memories, experiences, and feelings that include but are not limited to abuse (Band-Winterstein, 2015). In addition, the bond between adult and adult-child also hinders the recognition of the situation and the development of self-

protective measures (Begle et al., 2009; Gil, Santos & Kislaya, 2016; Luo & Waite, 2011; Nahmiash, 2004; Spangler & Brandl, 2007).

Despite the identification of two specific basic emotions (fear and sadness) as more commonly reported by older adults experiencing abuse, individual characteristics and the relationship between older adult and perpetrator can be important to account for the emotional reaction triggered by the victimisation experience. These results, particularly the importance of the type of abusive relationship, note specificities of elder abuse, relevant for the development of both prevention and intervention policies, programs and strategies.

In Portugal, this is particularly relevant, as Portuguese policy concretely directed at older adults' abuse has been developed within the large umbrella of domestic violence and even legislatively Portuguese law does not cover it directly (Ferreira-Alves & Santos, 2011). Elder abuse is subsumed to the domestic violence legislation if perpetrated against someone particularly vulnerable due to age, by a direct relative or other relatives that lives in the same household (Ferreira-Alves & Santos, 2011). This implies that most of the developed services and responses have been developed within the domestic violence framework, which could effectively be adapted to some cases of elder abuse, but not all.

It is important to understand the dynamics involved in abusive situations for the development of proper interventions. Even though the goal of all interventions is to halt the abuse, whatever form it takes, the conceptualisation of the relationship and the way abuse takes place might help tailor intervention efforts.

Limitations

Challenges associated with accessing older adults experiencing abuse through service provider institutions include a possible biased sample, which may not be representative of the general, community-dwelling population. It is possible that older adults reporting their situation to a non-governmental institution of victims' support or proceeding with a criminal complaint will be experiencing more severe forms of abuse. The sample might under-represent men, disabled people and people with cognitive impairment. While the incidence of abuse may be lower in older men than in older women, evidence also suggests that more women are aware of the available services and are generally more likely to seek help (Kaye, Kay & Crittenden, 2007). Considering the catchment areas of the different institutions collecting data the results may be indicative of the population that actually seeks help in Portugal.

Conclusion

Elder abuse can present itself within a wide range of configurations (e.g., impaired/not impaired older adult; the wide range of perpetrators relationship, community, and institutional setting) and older adults' emotional reactions can vary widely. To understand how and what factors mediate the different emotional reactions can be particularly important to policies development. This study demonstrates that overall older adults present a very similar pattern of emotional reactions to elder abuse, not only among themselves but also regarding other forms of family violence. Hence, programs and strategies already developed for other forms of family violence can be adapted to this population. However, because IPV interventions focus on partner and spouse relationships, these interventions might not accurately describe the parent-child relationship or other configurations of elder abuse.

The results indicate that different configurations of elder abuse affect older adults differently; considering the subjective perspective of victims can contribute to a more informed discussion and effective responses to the problem. The emotional and coping strategies employed by older adults to deal with abuse and its consequences can be distinct and therefore require distinct responses.

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Chapter VII

From appointed perpetrators and abusive behaviours to victimisation patterns: new approaches to elder abuse typologies using two cross-sectional surveys

From appointed perpetrators and abusive behaviours to victimisation patterns: new approaches to elder abuse typologies using two cross-sectional surveys

Abstract

Background: Research on elder abuse has defined it as a multidimensional construct that encompasses a set of different abusive behaviours, victims, perpetrators and settings. The array of possible elder abuse configurations is difficult to capture. This study sought to identify victimisation patterns that represent distinct elder abuse configurations based on specific abusive behaviours and on the relationship with the perpetrator; it also sought to determine the association between these latent classes with victims' characteristics.

Method: Data comes from two elder abuse surveys: a representative sample of community-dwelling adults and a convenience sample of older adults reporting elder abuse to four state and NGOs institutions. Latent Class Analysis (LCA) was used to categorize victimisation in the population-based (N=245) and in the victims' sample (N=510) using 7 items measuring physical, psychological and financial abuse, and appointed perpetrators. Association tests were conducted to determine differences and similarities of victims' characteristics between the different obtained classes.

Results: The LCA procedure identified six different latent classes of victimisation experiences in each of the samples, which were statistically and plausibly distinct. In the population-based survey: verbal abuse by others (29%); psychological abuse from children/grandchildren (18%); overlooked by others (18%); stolen by others (15%); verbal IPV (14%) and physical and psychological IPV (6%). In the victims' survey: physical abuse by children/grandchildren (29%); physical IPV (26%); psychological abuse by children/grandchildren (18%); polyvictimisation by others (16%); physical abuse by others (6%) and physical and psychological IPV (4%). In the victims survey the 6 groups significantly differ in age, gender, civil status, cohabitation, perceived social support and functional status.

Conclusions: The results support the possibility of the multidimensionality of elder abuse not being accounted by the "classical" abuse typologies. Elder abuse victims seeking help may represent a distinct group from that included in population-based prevalence studies. The appointed perpetrators may be the most meaningful and relevant aspect in distinguishing victimisation experiences. Further research is needed to develop tailored interventions to specific elder abuse cases and enhance successful outcomes.

Keywords: Elder abuse; victimisation; perpetrators; Latent Class Analysis (LCA)

Background

Elder abuse has been gaining public, state and scientific attention for the past 40 years[1,2]. Research has proliferated in the nineties with prevalence studies developed at regional and national levels [3, 4]. At the same time, even though not at the same rate, some conceptual and theoretical framework has been advanced [4]. Within a decade, two major reviews disclosed a wide variation between the phenomenon's prevalence estimates, ranging from 1% to 36.2% [5, 6]. The difference between studies on conceptual and operational definitions, number and types of abuse included, study designs, and data collection methods could account for such variation [3, 5, 6].

Some of the differences on the conceptual and operational definitions of elder abuse can be attributed to the phenomenon's complexity, which includes different victims, perpetrators and contexts [1, 7]. The definition of elder abuse by itself has not been consensual [1, 6]. Current approaches have evolved to include not only physical abuse and neglect against older vulnerable women, but also other forms of abuse, victims, and settings [1]. Presently two different definitions are more common according to the geographic region. In Europe, the World Health Organization's adopted definition [8] has been widely used, which states that "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" (p. 152). In the USA The Panel to Review Risk and Prevalence of Elder Abuse and Neglect [9] developed another definition that includes: "(a) intentional actions that cause harm or create a serious risk of harm, whether or not intended, to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder; (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm" (p. 39).

These definitions are comprehensive enough to include the usually considered four types of elder abuse (psychological, physical, financial, sexual) and neglect, different settings (community and institutional) and different perpetrators (e.g., family members, close friend, colleagues, paid workers). However, such broadness also represents difficulties in defining, characterizing and explaining a phenomenon that has many possible configurations.

Aware of this issue, studies have developed approaches according to specific types of elder abuse rather than focusing on the overall construct [10–14]. Some authors have suggested that the "monolithic" perspective which tries to assess a multidimensional

problem as a unit has hampered the development of appropriated theories [9, 15]. In fact, recent research indicates elder abuse to be a set of disparate events that are not always related [15], and Bonnie and Wallace [9] had even proposed that in some cases it can correspond to independent occurrences with different determinants and explanations.

The multidimensionality of elder abuse recognises abusive behaviours, victims, perpetrators and contexts as elements that define victimisation experiences, all of which are necessary to characterise and explain its occurrence. Some studies showed also other dimensions to be of influence when it comes to identify similarities, trends and patterns in elder abuse: variation in appraisals [16]; severity [2]; and the relationship between victim and perpetrator [17]. Despite these findings, we can consider elder abuse as a unique social phenomenon, distinct of other forms of domestic violence. It sheers similarities with other types of victimisation (e.g., Intimate Partner Violence) [18, 19], but also includes neglect as one possible form, and relates to critical concepts such as vulnerability [7].

Recognizing elder abuse as a complex construct that defines a series of potential different occurrences allows researchers to try to refine the differences and commonalities between all possible configurations. Existing typologies do not properly address the different victimisation experiences in terms of risk factors, determinants and perpetrators [10, 20, 21]. The present study focuses on configurations of victimisation experiences considering both abusive behaviours and appointed perpetrators. Drawing on data from two elder abuse surveys, it uses Latent Class Analysis (LCA) to categorize abuse occurrence into subgroups. Based on the individuals' shared characteristics or behaviours, LCA uses observed data to group individuals into latent classes, in this case the positive or negative answer to specific abusive behaviours and indication (or not) of a specific perpetrator. We selected this approach because we believe that there might be diverse victimisation experiences, even within the same abuse type, and because empirical data on the phenomenon presentation might help underpin the variation across these different types of elder abuse. We hypothesize that victimisation experiences will classify differently from the traditional abuse type typology and that these will be distinctively associated with victims' characteristics.

Methods

Study design and setting

This paper involves a secondary analysis of data from two cross-sectional surveys conducted as part of the Aging and Violence study [22], which targeted community-dwelling elder abuse. One of the surveys was a population-based study aimed at estimating elder abuse prevalence (i.e., physical, psychological, financial and sexual and neglect) within a representative sample of Portuguese community-dwelling individuals aged 60 and over. The second survey intended to characterise adults aged 60 or more years reporting the abuse to governmental and non-governmental institutions [23]. This last survey encompassed a convenience sample obtained from individuals reporting to one of four institutions: a non-governmental organization aimed at support of domestic violence victims; a welfare state organization; the public security police; and the national forensic and legal medicine institute. The summary of the sampling, setting and data collection procedure of these two surveys is presented in table 1; a more complete description has been reported elsewhere [22, 23].

Table 1. Population-based and victims' surveys description (sample and data collection)

		Population based survey	Victims' survey
Sample	Inclusion criteria	Being 60 or more years of age Having land or mobile telephone Living in private households Living in Portugal for the past 12 months	Being 60 or more years of age Living in private households Living in Portugal for the past 12 months
	Sampling	Nationally representative probability sample stratified by seven geographic regions with homogeneous allocation of sampling units	Convenience sample of individuals using the services of four institutions
	Sample size	1123	510
Data collection	Method	Telephone interviews	Face-to-face interviews
	Instruments	Structured questionnaire	Structured questionnaire
	Time period	October 2012	November 2011 to March 2013

The present analysis focused on older adults self-reporting experiences of psychological, physical or financial abusive behaviours in the two surveys. From the population-based survey, 245 older adults answered positively to at least one of the questions assessing these three forms of abuse. In the victims' survey, all individuals (N=510) reported having experienced at least one physical, psychological or financial abuse behaviour.

Measures

Both surveys employed a standardized questionnaire that included sociodemographic information, health and functional status, social and economic variables in addition to questions assessing physical, sexual, psychological, financial abuse and neglect.

Self-reported demographic variables included age, gender, civil status (single or divorced, married or currently cohabiting, widowed), cohabitation (alone, cohabiting) and years of schooling (up to four years of schooling, five or more years).

Health variables included reporting of at least one chronic disease and functional status. We used a typology of Activities of Daily Living (ADL) [24], divided in personal and instrumental activities, and assessed the need of assistance. In this specific study, only two categories were considered: not reliant on help with ADL, and reliant on help with ADL for at least one activity.

Perceived social support was assessed by asking participants “do you have enough people who you may ask for help and support when you face problems?”. From the five-possible close-ended responses (I have a lot people I can rely on; I have enough people I can rely on; I do not know if people will help when I´m in need; I have a few people I can rely on and I have no one I can rely on), we recoded the variable into two response categories: 1) plenty or enough people to rely on, and 2) few and no one available to rely on.

Abuse and neglect were assessed by means of 12 behaviours [22]. Because of low frequencies of some of the evaluated items [22], the present study included a total of seven abuse behaviours: 1) stealing or using property without consent; 2) undue household appropriation and not contributing to household expenses; 3) physical aggression; 4) hindering of speaking or meeting someone; 5) threatening; 6) verbal aggression, insulting, humiliating and 7) ignoring or refusal to talk.

For each of the positively answered abusive behaviours, respondents were asked to indicate a perpetrator, which included spouse/partners, children, grandchildren, sons and daughters-in-law, other family members, friends, neighbours, work colleagues, paid professionals and volunteers. If a participant reported more than one abusive behaviour, then he or she could indicate more than one perpetrator. In this study, the perpetrators variable was recoded into three main categories: spouse/partner; children/grandchildren and others. Respondents were also asked about the frequency of occurrence of each of these behaviours during the past 12 months.

Statistical analysis

In each of the considered samples, we applied Latent Class Analysis to investigate whether seven behaviourally specific abusive behaviours and the three categories of perpetrators cluster together and enable a plausible characterization of co-occurrence patterns capturing the phenomenon variation. An exploratory approach of the latent class measurement model was conducted on 245 participants from the population-based survey and on 510 participants from the victims' survey.

We used the LCA Stata® Plugin (version 11 or higher) [25] to identify the number of distinct abuse subtypes (classes, k), the relative size of each subtype (proportion of self-reported victims within each class), and the distribution of characteristics within each subtype (probability of each of the items based on class membership, ρ) [26]. For the LCA analysis we used 10 binary items: 7 abusive behaviours and 3 perpetrators categories.

The number of classes was determined by the entropy measure, the log likelihood, the parsimony indices and the bootstrapped likelihood ratio test (BRLT) [27, 28]. The best model has higher entropy, lower values of Akaike information criterion (AIC), Bayesian information criterion (BIC) and SSABIC, a larger log likelihood and a G^2 value that is significantly smaller than the G^2 value of the k − 1 model based on the BLRT results. In addition, because victimisation experience groups should be plausible, the conceptual suitability and precision of the classes was qualitatively assessed. Following these procedures, the computed membership probability allowed assigning each participant to one of defined classes. Optimal fit considered average posterior probabilities above 70% [29].

Using the chi-square and exact Fisher tests for significance, the final latent groups were compared in terms of age groups, civil status, cohabitation, schooling, perceived social support, chronic disease and functional status. The significance level for all analysis was set at 5%.

Results

Samples description

Table 2 lists the characteristics of both samples. The distribution of these characteristics was rather similar for both surveys. Most of participants were women (75.1% for the population-based; 77.2% for the victims' surveys). Approximately half was in the youngest age group (53.1% for the population-based and 50.3% for the victims' surveys in the 60 to 69 years old age group) and was married or living in civil

union (58.2% and 61.9%, respectively). Cohabitation was the most common situation for participants in both surveys (73.2% for the population-based and 89.6% for the victims' surveys), as was having up to 4 years of schooling (80.2% and 85.9%, respectively). The majority reported at least one chronic health condition (82.0% for the population-based and 76.3% for the victims' surveys), but no need of assistance in ADL (80.4% and 77.0%, respectively).

Table 2. Sociodemographic and health variables distribution of the participants from the two surveys

		Population-based survey N=245	Victims' survey N=510
		%(n)	%(n)
Sex	Women	75.1(184)	76.1(388)
	Men	24.9(61)	23.9(122)
Age groups	60-69 years	53.1(130)	49.8(254)
	70-79 years	31.8(78)	35.3(180)
	80 or more years	15.1(37)	14.9(76)
Civil status	Single	5.3(13)	3.0(15)
	Married/Civil Union	58.2(132)	61.5(308)
	Divorced/Separated	8.2(20)	11.6(58)
	Widow	28.3(69)	23.9(120)
Cohabitation	Alone	26.8(65)	10.4(53)
	Cohabiting	73.2(178)	89.6(457)
Schooling	Up to 4 years of schooling	80.2(190)	85.9(429)
	5 years or more	19.8(47)	14.1(70)
Social support	Plenty/ enough	58.8(137)	55.7(281)
	Few/ No one	41.2(96)	44.3(223)
Chronic disease	Yes	82.0(201)	76.3(374)
	No	18.0(44)	23.7(116)
ADL	Yes	19.6(48)	23.0(117)
	No	80.4(197)	77.0(392)

In table 3 the different abusive behaviours and indicated perpetrators distribution are presented for both surveys, which consist of the 10 items selected for the LCA Model. Two behaviours encompassed in psychological abuse were the most frequently reported by participants in the population-based survey: verbal aggression (46.5%) and ignoring or refusing to talk (43.6%). In the victims' survey, the most often reported behaviour was physical aggression (84.7%), followed by verbal aggression (62.0%). In the population-based survey the most common appointed perpetrators were individuals outside the nuclear family (62.5%), whereas the nuclear family was reported as being responsible for most abusive experiences in the victims' survey (48.2% for spouse or partners and 42.3% for children/grandchildren).

Table 3. Abusive behaviours and perpetrators distribution reported by the participants from the two surveys

		Population-based survey		Victims' survey	
		%(n)	Missing %	%(n)	Missing %
Physical	Physical aggression	14.8(36)	0.2	84.7(430)	0.4
	Hindering of speaking or meeting someone	7.8(19)	0	22.5(113)	1.4
Psychological	Threaten to abandon, harm, punish or institutionalize	19.7(48)	0.2	38.6(194)	0.6
	Verbal aggression, insulting, humiliating	46.5(113)	0.4	62.0(315)	0.4
	Ignoring or refusal to talk	43.6(105)	1.6	36.6(182)	2.4
Financial	Stealing or using property without consent	26.5(65)	0	36.4(180)	3.1
	Undue household appropriation	7.8(19)	0	25.8(129)	3.7
Perpetrator*	Spouse/ partner	26.8(60)	8.6	48.2(243)	1.2
	Children/grandchildren	21.0(47)	8.6	42.3(213)	1.2
	Other	62.5(140)	8.6	9.5(48)	1.2
	N	245		510	

* Multiple perpetrators could be reported

LCA application to population-based survey

The six-class solution was the chosen model for classifying victimisation experiences in the population-based sample. Classification certainty (entropy) was marginally greater for the three and the six-class solution (92%). AIC, G^2 values and SSABIC values decreased from three to six-class solution. Also, the BLRT results showed a statistically significant improvement in model fit ($p < .05$) from the three to the six-class solution and it was not significant when comparing the six to the seven-class solution (fit statistics for models 3 through 6 are presented Additional file 1). The six-class model not only had the best fit and highest level of separation, as it was also interpretable and presented distinctive patterns. The results of the six-class solution are presented in Table 4. Victimisation experiences were assigned descriptive labels based on the predominant abusive behaviours and main perpetrators.

Verbal abuse by others was the largest class (29.0%), with a high probability of individuals reporting to have experienced verbal aggression (0.77) from someone other than their nuclear family (0.99). Psychological abuse from children/grandchildren (Class 2) comprised 18.0% of the sample. In this class, abuse is characterised by verbal aggression (0.82) and ignoring or refusing to talk (0.71) perpetrated by children/grandchildren and almost no probability of physical aggression (0.09). Being overlooked (Class 3) and being stolen (Class 4) comprise only one abusive behaviour

each and were perpetrated outside the nuclear family. Being overlooked by others included individuals with a high probability of being ignored or refused to be talked to (0.99) and very low probability of any other abusive behaviour (<0.07), whereas Class 4 included individuals with very high probability of being stolen (0.99) and, again, very low probability of any other abusive behaviour (<0.09). Intimate Partner Violence (IPV) in older age was found for two classes: verbal IPV (15.0%) and physical and psychological IPV (6.0%). The last comprised individuals with a high probability of reporting both physical and verbal aggression (0.78 and 0.73, respectively) and being threatened (0.98) by their partner/spouse.

Table 5 presents sociodemographic and health characteristics of participants from the population-based study, when each victim is assigned to their best-fitting class. The only significant difference was in age group distribution. Psychological abuse from children/grandchildren and stealing by others presented a higher proportion of individuals from the oldest age group (25.0% and 29.0%, respectively). Due to small sample size and cells frequencies count with zero, the association test wasn´t performed for sex, civil status and schooling. However, we observe a higher proportion of women in all classes, and a lower proportion of men specifically in the two classes characterising IPV in old age. Both these groups also present a higher proportion of married/living in civil union individuals and no single individuals. No other variable was found to be significantly associated with class membership. In all classes, most individuals lived in cohabitation, reported at least one chronic disease, and were independent in ADLs. Half or little more than half reported having plenty or enough people to rely on.

Table 4. Items response probabilities (population-based survey)

	Verbal by others		Psychological by children/ grandchildren		Overlooked by others		Stolen by others		Verbal IPV		Physical and psychological IPV	
	29%(N=70)		18%(N=44)		18%(N=44)		15%(N=38)		14%(N=35)		6%(N=14)	
	P	SE	P	SE	P	SE	P	SE	P	SE	P	SE
Physical aggression	0.18	0.05	0.09	0.04	< 0.005	< 0.005	< 0.005	< 0.005	0.23	0.07	0.78	0.14
Hindering of speaking/meeting	0.03	0.02	0.05	0.03	0.03	0.03	0.06	0.04	0.13	0.06	0.50	0.14
Threaten	0.29	0.06	0.29	0.07	0.01	0.02	< 0.005	0.01	0.01	0.05	0.98	0.05
Verbal aggression	0.77	0.06	0.82	0.08	0.01	0.02	0.01	0.03	0.71	0.08	0.73	0.14
Ignoring or refusing to speak	0.38	0.06	0.73	0.08	0.99	0.03	0.08	0.11	0.15	0.07	0.30	0.13
Stealing	0.12	0.04	0.35	0.07	0.02	0.09	0.99	0.02	0.03	0.03	0.21	0.11
Undue household appropriation	0.16	0.05	0.07	0.04	0.06	0.04	< 0.005	0.00	0.06	0.04	< 0.005	0.01
Spouse/partner	0.17	0.05	< 0.005	0.01	< 0.005	0.01	0.02	0.01	0.99	0.01	0.99	0.03
Children/ grandchildren	< 0.005	0.01	0.99	0.01	< 0.005	< 0.005	< 0.005	0.01	< 0.005	0.01	0.22	0.11
Other	0.99	< 0.005	0.18	0.06	0.99	0.01	0.99	0.01	0.02	0.06	0.01	0.04

Table 5. Sociodemographic and health variables of victims, conditional on class membership (N=245)

		Verbal by others (n=70)	Psychological by children (n=44)	Overlooked by others (N=44)	Stolen by others (N=38)	Verbal IPV (N=35)	Physical and psychological IPV (N=14)	p-value
Sex	Female	77.1	70.5	70.5	63.2	85.7	100.0	*
	Male	22.9	29.5	29.5	36.8	14.3	0.00	
Age group	60-69	52.9	52.3	50.0	42.1	65.7	64.3	< 0.05
	70-79	41.4	22.7	34.1	29.0	25.7	28.6	
	80+	5.7	25.0	15.9	29.0	8.6	7.1	
Civil Status	Single	11.4	0.0	4.6	7.9	0.0	0.0	*
	Married/ Civil Union	57.1	54.6	52.3	52.6	79.4	57.1	
	Divorced/ Separated	10.0	6.8	6.8	2.6	14.7	7.1	
	Widow	21.4	38.6	36.4	36.8	5.9	35.7	
Schooling	Up to 4 years	80.9	76.2	83.3	75.0	77.1	100.0	*
	5 or more years	19.1	23.8	16.7	25.0	22.9	0.0	
Cohabitation	Alone	33.3	20.9	27.3	36.8	11.4	21.4	0.115
	Cohabiting	66.7	79.1	72.7	63.2	88.6	78.6	
Perceived social support	Plenty/ Enough	64.2	43.9	61.9	63.9	60.6	50.0	0.355
	Few/No one	35.8	56.1	38.1	36.1	39.4	50.0	
Chronic disease	Yes	81.4	86.4	77.3	86.8	77.1	85.7	0.789
	No	18.6	13.6	22.7	13.2	22.9	14.3	
AVD	Yes	24.3	20.5	9.1	29.0	14.3	14.3	0.213
	No	75.7	79.6	90.9	71.0	85.7	85.7	

Note: * Due to cells frequencies count with zero, the association test wasn´t performed

LCA application to the victim's survey

The six-class solution was also the chosen model for classifying victimisation experiences in the victims' sample. Classification certainty (entropy) was marginally greater for the three and four-class solutions (92%). AIC and G^2 values decreased from three to six- or seven-class solution. There was an important drop in the BIC and SSABIC values from three to five-class solution; however, the SSABIC remained similar in the five, six and seven-class solution. The BLRT results showed a statistically significant improvement in model fit ($p < .05$) from three to seven-class solution. Comparing the six to seven-class solution, BLRT was still significant but to a lesser degree ($p = .04$) (fit statistics for models 3 through 7 are presented in Additional file 1). Further inspection showed that for the seven-class solution, one of the classes presented a posterior probability of 0.1. Additionally, the conditional probabilities of the items in the six-class solution were more plausible than the seven-class solution. Given the negligible difference between six and seven-class models in terms of the SSABIC and G^2 Values, and following the parsimonious principle, the six-class model was chosen. The results of the six-class solution for the victims' sample are presented in Table 6. Victimisation experiences classes were assigned descriptive labels based on the predominant abusive behaviours and main perpetrators.

Physical abuse by children/grandchildren was the largest class. It comprised 29.0% of the sample and individuals with high probability of reporting physical aggression (0.87) perpetrated by children/grandchildren (0.99). Physical Intimate Partner Violence (IPV) (Class 2) comprised 26.0% of the sample. In this class, abuse is characterised by physical aggression (0.87) perpetrated by a spouse or a partner. Physical and psychological abuse by children/grandchildren was the third largest class comprising 18% of the sample. Within this class, individuals tend to report physical aggression (0.79), threatening behaviours (0.91) and verbal aggression (0.66) perpetrated by children/grandchildren. For some items, this class has lower homogeneity when compared with others: there is similar probability of individuals reporting to have or not experienced being ignored (0.50), stolen (0.55) or having someone appropriated the household or not contributed to household expenses (0.42). The "polyvictimisation by others" class, which comprised 16.0% of the sample, included physical aggression (0.74), verbal aggression (0.84), and stealing (0.63). It also presented low homogeneity for the other two psychological abusive behaviours. There is similar probability of individuals in this class to have or have not experienced threatening behaviours (0.57) or being ignored (0.48). Class 5 was labelled "physical abuse by others" because victims in this class have a high probability of reporting physical aggression and very

low probability of reporting any other abusive behaviour (<0.31). The last class - physical and psychological IPV – comprise 4.0% of the sample and includes individuals reporting to have experienced physical aggression (0.74), threatens (0.66) and verbal aggression (0.99) by the spouse/partner.

Table 7 presents sociodemographic and health characteristics of participants from the victims' survey when each individual was assigned to their best-fitting class. Regarding sex, all groups presented a higher proportion of female victims: the highest for physical abuse by children/grandchildren and the lowest for physical abuse by others.

There were more victims aged between 60 and 69 in the groups "physical abuse by children/grandchildren" and "physical and psychological by children/grandchildren". These groups also comprised the lowest proportion of individuals aged 80 or more years. The oldest age group (80+ years) was more present in both classes of IPV (physical or physical and psychological IPV).

A higher proportion of married individuals was found in the "physical IPV" (88.9%) and the "physical and psychological by children/grandchildren" (74.7%) groups, whereas the highest proportion of widows was observed in the "physical abuse by children/grandchildren" (48.5%) and "polyvictimisation by others" (39.3%) groups. The highest proportion of single individuals was found in the "physical and psychological IPV" group (31.6%).

A larger proportion of individuals in the "polyvictimisation by others" group lived alone, in comparison with victims in the groups "physical abuse by children/grandchildren" (6.8%) and the "physical IPV" (6.8%). The number of participants having plenty or enough people to rely on was higher in the victims from the "physical and psychological by children/grandchildren" (69.5%) and the "physical and psychological IPV" (63.2%) groups. More individuals from the "physical abuse by others" (48.3%) and "polyvictimisation by others" (47.4%) groups reported limitations in ADLs. People from the "physical and psychological by children/grandchildren" group were mainly independent in their ADLs (91.6%).

Table 6. Items response probabilities (victims' survey), conditional on class membership (N=510)

	Physical by children/ grandchildren		Physical IPV		Physical and psychological by children		Polyvictimisation by others		Physical abuse by others		Physical and psychological IPV	
	29%(N=148)		26%(N=133)		18%(N=96)		16%(N=85)		6%(N=29)		4%(N=19)	
	P	SE	P	SE	P	SE	P	SE	P	SE	P	SE
Physical aggression	0.87	0.04	0.87	0.04	0.79	0.04	0.74	0.12	0.85	0.08	0.79	0.03
Hindering of speaking/meeting	0.10	0.03	0.22	0.05	0.19	0.04	0.33	0.12	0.05	0.05	0.35	0.04
Threaten	0.01	0.03	0.08	0.03	0.61	0.05	0.57	0.16	0.01	0.03	0.66	0.06
Verbal aggression	0.03	0.06	0.25	0.10	0.96	0.04	0.84	0.13	0.08	0.10	0.99	0.01
Ignoring or refusing to speak	0.16	0.04	0.16	0.04	0.50	0.05	0.48	0.15	0.02	0.05	0.56	0.05
Stealing	0.31	0.06	0.20	0.05	0.55	0.05	0.63	0.13	0.31	0.10	0.32	0.04
Undue household appropriation	0.24	0.05	0.15	0.04	0.42	0.04	0.23	0.11	0.10	0.06	0.23	0.04
Spouse/partner	< 0.005	< 0.005	0.99	< 0.005	< 0.005	< 0.005	0.04	0.02	0.02	0.01	0.99	< 0.005
Children/ grandchildren	0.99	< 0.005	< 0.005	< 0.005	0.99	< 0.005	0.03	0.01	0.02	0.01	< 0.005	< 0.005
Other	< 0.005	< 0.005	< 0.005	< 0.005	< 0.005	< 0.005	0.99	0.02	0.99	0.01	< 0.005	< 0.005

Table 7. Sociodemographic and health variables of victims, conditional on class membership (N=510)

		Physical by children	Physical IPV	Physical and psychological by children	Polyvictimisation by others	Physical abuse by others	Physical and psychological IPV	p-value
Sex	Female	88.5	70.7	74.0	69.4	62.1	79.0	<0.001
	Male	11.5	29.3	26.0	30.6	37.9	21.0	
Age group	60-69	71.0	29.3	64.6	36.5	41.4	26.3	<0.001
	70-79	23.0	46.6	32.3	40.0	34.5	47.4	
	80+	6.0	24.1	3.1	23.5	24.1	26.3	
Civil Status	Single	3.1	0.7	1.1	0.0	10.3	31.6	*
	Married/ Civil Union	39.2	88.9	74.7	47.6	44.8	26.3	
	Divorced/ Separated	9.2	9.0	17.9	13.1	10.3	10.5	
	Widow	48.5	1.4	6.3	39.3	34.5	31.6	
Schooling	Up to 4 years	84.5	91.5	76.3	89.0	86.2	94.4	0.038
	5 or more years	15.5	8.5	23.7	11.0	13.8	5.6	
Cohabitation	Alone	6.8	6.8	17.7	9.4	20.7	15.8	0.017
	Cohabiting	93.2	93.2	82.3	90.6	79.3	84.2	
Perceived social support	Plenty/ Enough	57.8	46.9	69.5	47.6	58.6	63.2	0.012
	Few/No one	42.2	53.1	30.53	52.4	41.4	36.8	
Chronic disease	Yes	82.1	72.4	77.2	73.2	72.0	73.7	0.432
	No	17.9	27.6	22.8	26.8	28.0	26.3	
AVD	Yes	16.9	25.6	8.4	47.4	48.3	31.8	<0.001
	No	83.1	74.4	91.6	52.6	51.7	68.2	

Note: * Due to cells frequencies count with zero, the association test wasn´t performed

Discussion

This study sought to describe patterns of victimisation experiences using LCA in two samples of older adults: a representative sample of community-dwelling adults and a convenience sample of older adults reporting elder abuse to four state and NGOs institutions. The LCA procedure identified six different latent classes of victimisation experiences in each of the samples, which were statistically and plausibly distinct, based on the presence or absence of abusive behaviours and appointed perpetrators. The results support the likelihood of elder abuse being a multidimensional phenomenon that is not accounted by the "classical" abuse typologies and highlight three distinct aspects. First, elder abuse victims seeking help and individuals included in population-based studies of elder abuse prevalence may represent quite distinct groups. Second, the appointed perpetrators may be the most meaningful and relevant aspect in distinguishing victimisation experiences. Finally, the victims' survey indicates distinct elder abuse case profiles.

On the first aspect, the two LCA model results underline different victimisation configurations in the population-based and in the victims' surveys. The victims' survey comprised experiences of abuse perpetrated mostly by elements of the nuclear family (e.g., spouse/partner and children/grandchildren). Psychological abuse was more common in the population-based survey, whereas physical abuse was more frequent in the victims' survey. Also, polyvictimisation was only found in this victims' survey LCA model, comprising physical aggression (0.74), verbal aggression (0.84), and stealing (0.63) perpetrated by individuals outside the nuclear family. Both polyvictimisation and physical abuse point out to more severe victimisation experiences in the victims' survey. Differences between population-base studies and studies employing services/clinical samples have been acknowledged in elder abuse research [5, 6]. Burnes and colleagues, for instance, observed that older adults experiencing more types and severe forms of abuse perceived their situation as more serious, suggesting that these victims were more likely to seek support [16]. Victims might undervalue or "perceive" psychological abuse as not being "serious enough" to ask for help [30, 31]. At the same time, services might be more prompt to respond and intervene in cases of physical abuse. In fact, despite being less frequent, physical abuse is often given greater clinical relevance by experts when compared to emotional abuse or neglect [32]. Even studies comparing screening instruments employed by population-based prevalence studies and clinical diagnose of elder abuse have reported differences, usually indicating that less severe thresholds are captured by the first [33, 34]. Overall, the two LCA models presented in our study may represent two distinct groups of abuse

victims that display different victimisations experiences, and this requires distinct responses.

The second noteworthy finding was the perpetrators categories being one of the most distinctive items of the classes (with values close to 1 or close to 0). According to our findings, in either sample, each category of perpetrator was included in more than one class (exception was children/grandchildren in the population-based survey). The occurrence of distinct psychological, physical or financial abusive behaviours by the same category of perpetrators adds specificity to elder abuse characterization. The relationship dynamics between victim and perpetrator may be more accurate if specific abusive behaviours are taken into account [35]. On this matter, a clear distinction is made between abusive behaviours perpetrated by spouses/partners, children/grandchildren or individuals outside the nuclear family. In the population-base survey, abuse within the nuclear family distinguished three classes: psychological abuse from children/grandchildren; verbal IPV; and physical and psychological IPV. Within the victims' survey, we found four different classes relating to abusive behaviours perpetrated by the nuclear family: physical abuse by children/grandchildren; physical and psychological by children/grandchildren; physical IPV; and physical and psychological IPV. This results are somewhat in line with a recent review conducted by Jackson and Hafemeister (2016) who reported differences regarding perpetrators and types of abuse, as well as differences in interpersonal dynamics between perpetrators within the same abuse type [21].

From the application of the LCA model to the victims' sample, the third aspect to be highlighted refers to the six distinct elder abuse case profiles. In the victims' survey, most victims were female, between 60 and 79 years of old, with small number of schooling years, living in cohabitation, reporting at least one chronic disease and relatively independent for their ADLs. However, differences were observed between the identified victimisation groups.

The two groups of older adults victimized by children or grandchildren that emerged presented rather similar characteristics, compared to the other four groups. Victims physically abused and victims both physically and psychologically abused have the lowest proportion of individuals within the oldest age group and the highest proportion of individuals without any need for help on theirs ADLs. However, the group of older adults reporting physical aggression from children/grandchildren presented a higher proportion of women (88.5%), whereas the group reporting physical and verbal aggression reported a higher proportion of married individuals (74.7%). Taken together,

these results suggest different elder abuse case profiles. In the most prevalent group (29%) we mostly found older women living alone (88.3% of women and 48.5% of widowers) being physically abused by their children and grandchildren.

Other two classes obtained in the LCA model applied to the victims' survey sample indicates the expressive proportion of elder abuse between partners in later life, an already observed finding in elder abuse research [18]. Victims in the two groups "physical IPV" and "physical and psychological IPV" present very similar traits. The difference is only regarding civil status - a higher proportion of individuals only reporting physical IPV were married (88.9% vs. 26.3%). The debate about IPV being considered or not as elder abuse is partly based on the assumption that it shares more similarities with conjugal violence than with elder abuse [7, 18, 19]. In fact, IPV as part of elder abuse can be both conjugal violence grown old, where abuse that has begun earlier in life continues into older age and a new experience of abuse [7, 18, 36]. As social and family structure changes in older age (e.g. due to retirement, caregiving or new relationships), ageing can also lead to IPV [19]. Even though the results do not allow us to distinguish from the two discussed forms of IPV, the findings suggest that one of the groups may be more adequate characterizing "new" IPV. The "physical and psychological IPV" group may represent, in part, new relationships that have led to IPV – in this group we found a highest proportion of both single (31.6%) and divorced or separated (10.5%) individuals and widowers (31.6%).

Finally, the remaining two groups indicate profiles of elder abuse outside the nuclear family: polyvictimisation by others and physical abuse by others. Compared to the other groups describing victimisation within the nuclear family, these two groups share more similarities than differences. This suggests that despite the perpetrators category encompassing a very wide range of relationships, being abused by someone from the nuclear family or someone else can represent significant distinctive victimisation experiences. Both groups have the highest proportion of male victims (30.6% and 37.9%) and the highest proportion of individuals needing help for theirs ADLs (48.3% and 47.4%). In addition, a larger proportion of victims physically abused by others lived alone (20.7% vs. 9.4%). Domestic violence and to some extent elder abuse has been defined as a more common feminine experience [18, 37, 38] with a higher proportion of women reporting abuse. In this study, other profile emerged, showing that older males with dependency for their ADLs might be vulnerable to victimisation experiences, particularly by individuals outside the nuclear family.

The study is not without limitations. The first regards the nature of the data of both samples: the cross-sectional designs are always subject to response bias and do not provide data on temporal relationships. Also, the victims' survey was a convenience sample, which may also include a sample bias. Secondly, the data collection methods may not be the more adequate to capture victimisation experiences from the most vulnerable group of older adults, such as those with physical or cognitive impairments. Thirdly, the low frequencies in some items obtained in the population-based sample did not allow exploring the association of the victims' characteristics and class membership. Finally, victimisation experiences groups identified in this study are item and sample dependent. Classifying victimisation experiences using other data or including different indicators in the model may generate additional groups defined by distinct characteristics.

Conclusion

Although elder abuse researchers have noted an association between abuse type and specific perpetrators [17], relatively few have sought to define victimisation configurations according to the abusive behaviours and perpetrators. Our study results show that specific abusive behaviours and the relationship with the perpetrator may distinguish victimisation experiences associated with different victims' characteristics. This is important because available research tend to operationalize these concepts differently, with specific behaviours being employed to characterize the same type of abuse [3, 5]. More research is needed to understand the differences and similarities between different elder abuse configurations to efficiently respond to victims.

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Supplementary material

Latent Class Analysis models fit statistics

The number of classes was determined by the entropy measure, the log likelihood, the parsimony indices and the bootstrapped likelihood ratio test (BRLT) [1, 2]. In addition, because abuse subtypes should be plausible, the conceptual suitability and precision of the classes was qualitatively assessed.

Entropy measures how well individuals are assigned to latent classes (class differentiation). It ranges from zero to one, with values closer to 1 indicating better differentiation. The log likelihood is a function of the observed responses in the sample conditional on the model parameters. The parsimony indices are measures of the goodness of fit of the model that consider number of parameters, the sample size and other factors. These include the Akaike Information Criterion (AIC) and the Bayesian Information Criterion (BIC) or adjusted BIC (SSABIC). The BLRT assesses the relative improvement in fit between a model with k classes versus a smaller model with k − 1 classes. The optimal class solution has high entropy, low AIC, BIC and adjusted BIC values, a larger loglikelihood and a G^2 value that is significantly smaller than the G^2 value of the k − 1 model based on the BLRT results. These criteria allowed for the best model to be selected.

LCA application to population-based survey

The six-class solution was the chosen model for classifying abusive experiences in the population-based sample. Classification certainty (entropy) was marginally greater for the three and the six-class solution (92%). AIC and G2 values decreased from three to six-class solution, except for four-class solution, where they increased. BIC values declined from four- through six-class solutions, while slightly lower in three-class solution. Because, BIC penalizes models with more parameters and thus provides an upper bound indicator for class selection [1], the Adjusted BIC (SSABIC) is, in many cases, recommended instead. In this case, the SSABIC was lower for the six-class solution model (Table 1). Finally, the BLRT results showed a statistically significant improvement in model fit ($p < .05$) from the three to the six-class solution and it was not significant when comparing the six to the seven-class solution. The six-class model not only had the best fit and highest level of separation, but it was also interpretable and presented distinctive patterns.

Table 1. LCA model for the population-based survey

Number of classes	3	4	5	6
Class membership probability	55%, 25%, 20%	18%, 27%, 28%, 27%	15%, 18%, 19%, 28%, 21%	15%, 14%, 18%, 29%, 6%, 18%
Log-likelihood	-1070.64	-1092.14	-1012.31	-995.23
G^2 Values	392.70	435.71	276.07	241.90
Entropy	92%	85%	91%	92%
AIC	456.71	521.72	384.07	371.90
BIC	568.75	672.27	573.14	599.49
SSABIC	467.31	535.96	401.96	393.43
df	991	980	969	958
BRLT (*p*)	3*4 (.01)	4*5 (.01)	5*6 (.01)	6*7 (.08)

LCA application to victim's survey

The six-class solution was also the chosen model for classifying abusive experiences in the victims' sample. Classification certainty (entropy) was marginally greater for the three and four-class solutions (92%) compared to five, six (91%) and seven-class solutions (90%). AIC and G2 values decreased from three to six or seven-class solution. There was an important drop in the BIC and adjusted BIC (SSABIC) values from three to five-class solution; however, the adjusted BIC remained similar in the five, six and seven-class solution. The BLRT results showed a statistically significant improvement in model fit ($p < .05$) from three to seven-class solution. Comparing the six to seven-class solution, BLRT was still significant but to a lesser degree ($p = .04$) (Table 2). Further inspection showed that for the seven-class solution, one of the classes presented a posterior probability of 0.1. The seventh abuse subtype that emerged comprised being threatened and verbal aggression (0.78 and 0.98, respectively), by the spouse or partner (0.72). The other two classes, from the six-solution solution, where the perpetrator was the spouse or partner presented a diminished frequency (from 24% to 15% and from 4% to 3%). Other aspect taken into consideration was the high homogeneity of characteristics/behaviours within each subtype. The conditional probabilities of the items in the six-class solution were more

plausible than the seven-class solution. Finally, given the negligible difference between six and seven-class models in terms of the adjusted BIC and G2 Values, and following the parsimonious principle, the six-class model was chosen.

Table 2. LCA model for the victims' survey

Number of classes	3	4	5	6	7
Class membership probability	24%, 48%, 28%	10%, 20%, 29%, 42%	10%, 20%, 28%, 17%, 26%	6%, 26%, 28%, 17%, 26%, 4%	6%, 18%, 4%, 17%, 26%, 3%, 26%
Log-likelihood	-2571.42	-2480.86	-2417.12	-2399.65	-2383.25
G^2 Values	641.79	460.66	333.19	298.24	265.45
Entropy	92%	92%	91%	91%	90%
AIC	705.79	546.66	441.19	428.24	474.45
BIC	841.29	728.74	669.85	703.48	739.26
SSABIC	739.71	592.25	498.45	497.15	498.03
df	991	980	969	958	947
BRLT (*p*)	3*4 (.01)	4*5 (.01)	5*6 (.01)	6*7 (.04)	7*8 (.07)

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Ageing and abuse: vulnerabilities and limited time

Ageing and abuse: vulnerabilities and limited time

Abstract

Purpose: To examine, through a qualitative lens, how community elder abuse and the ageing process are represented in the older adults' narratives reporting abuse perpetrated by family members.

Methodology: The convenience sample consisted of 22 interviews from 24 older adults (2 couples) aged 60 years or older who had experienced one or more types of abuse and had sought help about the victimisation experience. Thematic content analysis was employed and the interviews transcripts were read. Text segments that could intersect with ageing were compiled and explored with more in-depth categorical and theoretical-substantive coding categories.

Findings: Four main emergent themes relate to the passage of time or the perception of becoming old within the process of abuse: abuse grown old, abuse after entering later life, vulnerability to abuse, and responses to abuse: time to accept it or end it. The first three express a greater intertwining of "ageing" and "abuse" and the last a focus on how the passage of time (and its awareness) influenced the decision of ending (or not) the abuse and the victims' repertoire of responses.

Originality/value: Given the little suitability of chronological age to define and delimit elder abuse, the phenomenon conceptualization may benefit from the inclusion of ageing as a process or as a product (being older) to help explain, identify aetiology processes and develop interventions.

Keywords: Ageing; Parent-child; Intimate Partner Violence; Vulnerability; Qualitative

Introduction

Elder abuse has been the focus of growing concern in recent years. Despite the increasing number of studies on its prevalence, risk factors, determinants, theories and intervention (Pillemer et al., 2016; Yon et al., 2017), descriptions of elder abuse from the victim's perspective are not notable (Mysyuk et al., 2016). This article aims to contribute to the available knowledge on such perspective by specifically examining, through a qualitative lens, how community elder abuse and the ageing process are represented in the victims' narratives.

Prevalence studies on elder abuse in the community show spouses/partners and offspring as the two main perpetrators categories, indicating that elder abuse that occurs in the community takes place for the most part within the family (Pillemer et al., 2016).

Several studies on elder abuse have suggested that within families marked by history of abuse, violence may endure into late adulthood assuming a pattern of continuity (Goergen & Beaulieu, 2013; Walsh et al., 2007). In some other cases, abuse occurs for the first time in later life (Goergen & Beaulieu, 2013; Walsh et al., 2007) inaugurating the existence of new interactions within the family dynamics. In either situation, ageing as a process or as a product (being older) are key aspects when considering the occurrence of elder abuse.

Life transitions and changes in older age have been indicated to increase conflicts and tension between family members, which could increase vulnerability to abuse (Anetzberger, 2000; Penhale, 2003; Walsh et al., 2007). In the case of Intimate Partner Violence (IPV), for instance, several social and family changes in older age, and as such retirement, becoming a caregiver, or starting a new relationship can be precipitating factors for elder abuse (Penhale, 2003; Walsh et al., 2007). In addition, new and unexpected disability may be related to the beginning of an abusive situation, but also with changes in the abusive experiences already occurring (Band-Winterstein, 2015; Penhale 2003).

Parent-child relationships throughout the lifespan are also an important aspect within elder abuse (Band-Winterstein, 2015). The quality of present intergenerational relationships relates to the history and experiences between children and their parents. There is not enough evidence on the importance of the relationship to elder abuse occurrence (Band-Winterstein, 2015; Lin & Giles, 2013). However, people's lives are interdependent and as such are affected by one another. Transitions in one person's life often lead to transitions for the other people as well (Elder & Johnson, 2002; Schiamberg & Gans, 2000).

Some studies show the influence of the ageing process on the development and changes of victimisation patterns (Band-Winterstein, 2015; Brozowski & Hall, 2004; Rennison & Rand, 2003; Wilke & Vinton, 2005; Zink et al., 2005). Particularly, studies focusing on lifelong IPV observe that violence may become less frequent and visible, with distinct patterns of severity throughout the years (Wilke & Vinton, 2005).

Qualitative studies also suggest differences between younger and older victims of family violence on both perception of abuse, and social and contextual constraints (Band-Winterstein, 2015; Eisikovits & Band-Winterstein, 2015; Montminy & Straka, 2006; Pritchard, 2000). The perception of time in one's life narrative is bound to be different from younger and older victims of family violence (Band-Winterstein, 2015), given that social and contextual frameworks differ from younger and older adults (Montminy & Straka, 2006; Wilke & Vinton, 2005).

Older adults, and particularly older women, have probably been socialized with traditional attitudes and values on gender roles, marriage, and family (Montminy & Straka, 2006). Compared to their younger counterparts, older women were taught to be submissive, to respect the privacy on family matters, and to sustain religious traditional values (Rennison & Rand, 2003; Wilke & Vinton, 2005; Zink et al., 2005). They may not have formal education and be more economically vulnerable, and financially dependent on their abusers (Band-Winterstein, 2015; Hightower et al., 2006), have more health problems and a smaller informal network (Wilke & Vinton, 2005).

Asserting that within the ageing process, both the passage of time and temporality influence how individuals experience life and life events (Butler, 1977), we aim to explore how elder abuse perpetrated by spouse/partners or offspring is experienced in the intersection of the ageing process.

Methods

Participants

The sample comprised 22 interviews from 24 older adults with an average age of 71 years. Two of the interviews were of a couple. Most of the informants were women (n=18). About half of the men reported victimisation against the couple (n=6) and the other half reported individual experiences of elder abuse (n=4). Offspring were the most commonly reported perpetrators (n=14), followed by spouses or partners (n=8) (Table 1).

Table 1. Description of participants by gender, age, relationship with the perpetrator, and type of abuse reported

Victim		Perpetrators		Types of abuse
Sex	**Age**	**Relationship**	**Age**	
F	72	Son	45	Psychological, Physical, Financial
F	77	Son and grandson	40, 22	Psychological, Physical
F	75	Son and daughter		Psychological and Financial
F	68	Son	33	Psychological, Physical, Financial
F.M.	70, 71	Son		Psychological, Physical, Financial
M	71	Son	42	Psychological, Physical, Financial
F	65	Son	41	Psychological, Physical, Financial
F.M.	81, 83	Son	44	Psychological, Physical
M	74	Son	43	Psychological, Physical, Financial
F	68	Son	34	Psychological, Physical, Financial
F	71	Daughter	31	Psychological, Physical, Financial
M	80	Son	49	Psychological, Physical, Financial
F	78	Daughter	48	Psychological, Physical, Financial
F	76	Son	35	Psychological, Physical, Financial
F	62	Husband	NI	Psychological, Physical, Financial
F	66	Ex-Husband	NI	Psychological
F	82	Husband	NI	Psychological, Physical, Financial, Sexual
F	75	Husband	NI	Psychological, Physical, Financial, Sexual
M	65	Wife	NI	Psychological
F	67	Husband	NI	Psychological, Physical, Financial, Sexual
F	63	Husband	NI	Psychological, Physical, Financial
F	66	Husband and stepdaughter	71, 43	Psychological, Physical, Financial

Abuse encompassed psychological, physical, financial and, less frequently, sexual behaviours. The psychological abuse involved verbal aggression, such as insulting, blaming, offending and humiliation, and threatening. The physical abuse included hitting, kicking, pushing and throwing objects. The financial abuse involved theft, extortion, property damaging, household appropriation, and not contributing to household expenses. Finally, the sexual abuse encompassed coercion to make victims perform sexual acts and rape. For most cases, abuse ended at the time of the interview (n=15).

Recruitment and procedures

The study relies on data from the Portuguese Ageing and Violence study (2011-2014). This cross-sectional study (Gil et al., 2015) included in-depth interviews to older adults identified and referred by the project partner institutions: the Portuguese Association for Victim Support (APAV) and the National Republican Guard (GNR) (Gil et al., 2015). APAV is a private non-profitable organisation, with a statutory objective of informing, protecting and supporting citizens who have been victims of crime, and to provide free and

confidential services. GNR is one of the three police forces in Portugal. It is the national gendarmerie force and the members are military personnel.

The in-depth interviews took place in two different periods: between May and August 2011, and between January and March 2013. Recruitment of participants was through purposeful, convenience sampling (Patton, 2002). Eligible participants were community-dwelling older persons aged 60 years or older who had experienced one or more types of abuse and had sought help about the victimisation experience in APAV or GNR. Every older adult who complied with the study's inclusion criteria would be asked by the professionals working with them to take part in the research project.

Each interview started with an open question (What have brought you here?), followed a checklist to ensure that all the main topics would be addressed (abuse characterization, abuse leading events, relationship with the perpetrator, help-seeking behaviour, elder abuse consequences, and perceived solutions) and lasted between 15 and 145 minutes.

Analysis

For the present study, thematic content analysis was employed, given that it allows "qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings" (Patton, 2002, p. 453). The analysis was conducted through open coding (Strauss & Corbin, 1998) and included several steps. First, all interviews were read for overall impression. The second step involved sorting each interview using the previously defined core theme as a guiding framework (ageing process within the abuse experience). All the text segments that could intersect with ageing and the passage of time were compiled and further explored with more in-depth categorical and theoretical-substantive coding categories. After coding all text segments, the coded passages were organized according to meaning units. Throughout the process, the coded passages were compared with each other and placed back in the context of the original transcripts in order to verify consistency and explore if there was a need for the development of new codes. All the authors contributed to the development of the emergent categories, and the coding was discussed to ensure that mutually exclusive categories were developed. The chosen quotes that illustrate the identified categories are representing the different narratives.

Ethical considerations

Ethical approval was obtained for the survey protocol from the review board of the Portuguese National Public Health Institute and the National Data Protection Commission (legal state authority). Each participant signed a consent form.

Results

Main emergent themes from the collected interviews relate to the passage of time or the perception of becoming old within the process of abuse. These have been organized in four major themes. The first three express a greater intertwining of "ageing" and "abuse" (abuse grown old, abuse after entering later life, vulnerability to abuse) and the last theme a focus on how the passage of time and its awareness influenced the decision of ending (or not) the abuse and the victims' repertoire of responses (responses to abuse: time to accept it or end it).

Abuse grown old

About half of the interviews reported abuse that started earlier in life and persisted into old age. Longstanding abuse overlapped with the current relationship difficulties and conflicts, and in the interviewees' narratives, past and current history appeared blurred, hampering the identification of when abuse had in fact started. Along with the difficult relationship and identified conflicts, victims referred to the perpetrator as being "always mean" and "a little aggressive". A 72-year-old woman describes the continuous abusive behaviour from her 45-year-old son throughout time:

> "*Uhm ... My son has always treated me badly, you see? Even when my husband was alive, but my husband called his attention and he would stop. Then my husband died, about 15 years ago, and ever since it has been a sheer nonsense* […] *he received a two-years suspended jail sentence, but now there is another police complaint because he hit me. When he gets mad, he kicks me. Well, I get all bruised because of his shoes, you see?*"

Older adults reporting longstanding abuse also highpoint the passage of time. Abuse has been present in their lives for decades, and the time spent within the abusive relationship has brought tiredness and exhaustion. The cumulative effects of abuse were mostly reported as being linked to physical health consequences. A 75-year-old woman reporting a long-lasting history of abuse describes the length of her suffering and the enduring health consequences:

> "*Even if my husband would cry for as long as he lives, he wouldn´t shed as many tears as I have shed throughout my whole life because of him. I cried my entire life, you see? I got tired of living, really, I did! I got tired because I am 75 years old and my whole life was like this* […] *And its 75 years… I cannot keep my nerves in check. I am a very anxious person, due to all this; I just… I became a very nervous and anxious person because of this*."

Abuse is mostly characterized by severe physical violence (e.g., “using a knife”; “kicks in the head”; “pushing down stairs”) along with psychological and financial abuse. Sexual abuse only appeared in longstanding abuse and perpetrated by spouses.

Abuse after entering later life

About half of the interviewees described victimisation experiences that began after they had been retired or perceived themselves to have enter old age. The beginning of the abuse was accurately identified and within this group of interviews, physical abuse was found to be sporadic (in some cases even nonexistent) than in the former category (abuse grown old) whereas psychological and financial abuse was frequent (8 out of 11 interviews). Physical abuse often represented the culmination of continuous and severe psychological abusive behaviours and the progressive increase of conflicts and tension. The following quote is illustrative of such victimisation cases. A 71-year-old-man who suffered psychological, physical and financial abuse by his son and daughter-in-law describes how new cohabitation arrangements worked very well at first and how as time went by, the financial constraints ended up in a physical assault.

> “*It was all wonderful in the beginning. I was the best father-in-law she* [daughter-in-law] *could have.* […] *but I was mistaken. And you know why? Because my pension started to become increasingly shorter… and the months were getting longer, right?* […] *Two arguments had already took place when the abuse occurred, but then he* [son] *grabbed me by my wrists and begun to twist them* […] *Twisting my arms and with the knee he hit me in the belly, in my legs. This was in September, on the 20Th of September. By Christmas I still had broken blood vessels*.”

Vulnerability to abuse

Victims felt vulnerability as increasing the risk of abuse occurrence or triggering its severity (e.g., physical aggression). Those participants who addressed this topic perceived their greater vulnerability as an expression of physical weakness that would limit their capacity to confront the perpetrators and stop the psychological abusive behaviours from escalating to physical aggression. Among older women who were victimised by a male offspring, physical abuse started when they became widows or because the husband has had a medical problem that resulted in some sort of functional incapacity. Before that, physical abuse did not occur because “*the father* [figure] *was there to stop it*”. A similar description was found in the interviews of older men who were

victimised by their male children: their self-perception of being old and having less physical strength or having a medical incapacitating condition increased the awareness for the victims' vulnerability to abuse – "*we become afraid of them*". Despite the previous conflicts between the adult and adult-child, one of the interviewees, a 71-year-old-man, reported that physical abuse had only taken place when his 42-year-old son perceived his physical difficulties: "*Back then I had strength; now I have no strength. I have uh… arthritis and arthroses. That's the way he got me…*".

Other aspects reported as being associated with a greater vulnerability to abuse and its consequences refer to social and contextual factors. Participants who were widowers or lived alone/rather isolated perceived their situation as increasing the odds for victimisation, which were accompanied by feelings of fear. The following citation refers to a 76-year-old woman reporting physical abuse at the hands of her 35-year-old son and describes her geographical isolation:

> "*I would call for the neighbours, but the neighbours wouldn't listen. He* [a male neighbour] *was probably in the coffee shop... Not that he could do anything; my son could just have killed me right there and nobody would listen. We only have that neighbour* […] *Back when I was younger, I would have run, I would have taken my wallet with me and run out the door, but now…"*

Retirement is another feature of ageing that was found to be associated with vulnerability to abuse within the victims' narratives. In cases where the victim cohabited with the perpetrator, extended periods of interaction were perceived as "triggers" for conflicts and tension. On the other hand, retirement implied more limited income and/or fewer possibilities to increase monthly revenues, which its considered when mentioning the decision of putting an end (or not) to the abuse. Illustratively, one 67-year-old woman reporting lifelong IPV refers to the financial difficulties the following way:

> "*He is the one that wants the divorce, not me! He asked for it, but I did not want it. I am old now, and one day I'll be entitled to a pension from him, if he was to die first. It's a way of safeguarding my life because we don´t get to know who dies first, right? I have to assure some security, because I have a disability pension that is quite low* [274 euros]*. It´s horrible to have to live in so tight budget. And really, I find it funny that he would want the divorce, so that if he was to die first I wouldn't be entitled to his pension*."

Within the context of psychological abusive behaviours participants reporting abuse at the hands of children described that getting older was *per se* something perpetrators relied on for acting abusive. On this matter, a 78-year-old woman mimics her abusive daughter

speech to her: "*You have to understand that I'm in charge now, you're rotten, you're worthless.* […] *I'm going to put you into an asylum. You're rotten, you're no good for anything*".

Responses to abuse: from getting along with it to "a time to end"

Seeking help was linked to the perception participants had of a limited time to live. Not only abuse consequences were felt worsen due to their advanced age, but participants also stated they had the right to expect some peace and quiet at such an advanced time of their lives, which was described a time to enjoy retirement. A 71-year-old woman who was a victim of psychological, physical and financial abuse from her daughter mentions this on the following interview extract: "*I don't need anything, I don't want anything anymore. At this age, I just need to have peace of mind. Let me live in peace, that's the only thing I ask for.*"

Some victims of longstanding abuse felt that age was an important aspect for their decision-making process as well. Growing old, the perception of increasing physical vulnerabilities and health problems were stated as factors influencing the decision to seek help and stop the victimisation. In the next interview passage, an 80-year-old man explains why he decided to report the abusive behaviour of his son for the first time:

> "*This was the first time I reported him. I couldn´t bear it anymore* [crying]*. Because I am 80 years old, ma'am. I have always worked. I worked until I was 78 years.* […] *He* [son] *tells me that I won't make it until Christmas* [crying]. *He´s sick and tired of yelling at me and threatening... He continues with the threats and they're pretty real…*"

Confronted with the difficulty to end the abuse, a small number of interviews (5 out of 22 interviews) reported acceptance of the situation because of their lack of ability to change it. The following citation refers to a father who describes coming to terms with the abusive episodes perpetrated by his son with severe mental health problems. This 74-year-old man explains that he and his wife must endure the situation because there was no prospect of changing the situation: "*We have to take it. He won't get any better. She knows* [wife]*. She knows all this. She's my age, she's 70, 72. I'm 74 and she's 72. This has always been our life*.".

Also, some interviewees mentioned that they felt age had influenced positively the way they handled abuse. A 66-year-old woman reporting current psychological abuse from her ex-husband (from whom she was divorced 20 years ago) felt that the impact of the abuse

was lessened because she became older: *I was over 60 years old and that feeling of rejection was no more a concern of mine. It was fear, not the same reaction as when I was 40. That's right, it was different. It was quite different. Back then it was a feeling of loss*".

Victims report distinct ways to try to end or ameliorate the abusive situation. Older adults reporting IPV sought help within the social and legal services of the state. For the most part the feedback obtained from social and legal services was positive; however, some victims felt these institutions provided inadequate responses and presented ageist features. Victims' encounter with the police legal system, in some cases, included a probe as to their cognitive state, which was also felt as a preconceived idea because of how old they were. Here is how an 80-year-old man, victim of psychological, physical and financial abuse from his son describes the police interaction after a neighbour had called them:

> "*The police went over there* [victim's house] *and they took about 15-20 minutes talking to him* [son] *and with me, it was like what's your name? What is your age? They only ask me these questions and with him they spent 30 minutes talking!! 30 minutes!! So, is it the way it is?!? This is the police mentality…"*

Another illustrative extract comes from a 63-year-old woman, who was a victim of psychological and financial abuse from her husband and stepdaughter. When asked about the reluctance she said the police had in accepting her complaint, she mentioned: "*They refused it a bit. I do not know why... Maybe it's because I am an old woman and not a young girl…*"

In the case of abuse perpetrated by offspring the solution indicated by the victims was often to keep themselves in the abusive relationship in order to answer to the children' problems (e.g., unemployment, alcohol or substance misuse, mental health problems).

Discussion

Four thematic categories were constructed based on victims' narratives of the abuse and the ageing process: (i) abuse grown old, (ii) abuse after entering later life, (iii) vulnerability to abuse, (iv) responses to abuse: time to accept it or end it. In all these, ageing came across as a key dimension that shapes the perception of the abuse, whereas the recognition of being older frames how participants view their own vulnerability to abuse and cope with it.

For the abuse that started at earlier stages of life (abuse grown old) or abuse that initiated in older ages (abuse after entering later life), the experience was conjointly shaped by the experience of time and ageing. For participants describing abuse that started early on and continued into old age, time without and with abuse was perceived as being "indistinctive" though the cumulative effects of abuse were reported clearly. On the other hand, in the cases where abuse started later in life, despite the existence of punctual previous conflicts, the beginning of the abuse was clearly identified in time.

Regardless of the perpetrator, for older adults who reported a continuous escalade of abuse throughout time, the experience of time resulted in regret over a life mostly lived with violence. The suffering resulting from the longstanding abuse became a central focus of one's life and it was difficult to distinguish between a time prior to and after abuse. This may be linked to the impact of a lifetime of violence in old age (Band-Winterstein, 2015; Buchbinder & Winterstein, 2003). If the retrospective analysis of life is contextualised within a lifetime abusive relationship, and suffering and violence are perceived to be continuous (Band-Winterstein, 2015; Buchbinder & Winterstein, 2003), abuse was always present.

As for abuse that began at older stages of life, the experience was found to be described with a clearer detail as to its beginning and process. This may be because abuse is more recent and the events that lead to abuse (namely physical abuse) are relived with greater detail (e.g., dates) or because the perceived impact is seen as more specifically identified in time. For IPV cases, individuals were surprised to find themselves in an abusive relationship, especially when comparing to previous non-abusive marriage experiences. In the case of abuse perpetrated by offspring, there was a longstanding difficult and conflictual relationship, often with psychological abuse (though not always perceived as such), that resulted, later in life, in physical and financial abuse.

Some studies have already showed the presence of problematic relationships within cases of elder abuse, even though age was not seen as a contributing factor (Lafferty *et al.*, 2012; Mowlam *et al.*, 2007). Chronological age does not directly result on elder abuse (Goergen & Beaulieu, 2013), but the ageing process can be associated with changes in the relationship that increase vulnerability to abuse in older age. While some studies focusing on IPV have already highlighted the importance of changes on the relationship dynamics with issues associated with ageing (Band-Winterstein, 2015; Band-Winterstein & Eisikovits, 2009; Montminy & Straka, 2006; Pritchard, 2000; Walsh *et al.*, 2007), parents-adult child relationships also change throughout time and changes and transitions associated with the ageing process have an impact in the dynamics. A suggested

scenario for abuse regards “an adult child who has never become completely independent from the parent” and a relationship that becomes abusive or violent when the older adult decline or refuses to provide support (Roberto, 2017, p. 319).

While difficult family relationships are certainly something that can happen at any age, abuse between the adult child and his/her parent is often the result of an interactive long-term experience (Band-Winterstein, 2015). Hence, the dynamics of the intergenerational relationships are crucial to understanding when and how family conflict results in abuse since family conflicts often include complex unresolved issues. In fact, it is possible that the ageing process may provide an “opportunity” for elder abuse occurrence: some studies indicate that in IPV the relationship power and control tended to change, as the couple grew older (Band-Winterstein & Eisikovits, 2009), and that there may also be changes in the relationship power between the adult and adult-child, as the parent gets older. Our results suggest that despite previous difficult relationships between the parent and adult-child, getting older was perceived by older adults as being linked to the abuse occurrence. Namely, because being older and the recognition of personal and contextual age-related vulnerabilities was associated with abuse.

The third category that emerged in our study regards to “vulnerability”; ageing is perceived to be associated with abuse because of the vulnerability that it encloses. Having less strength and a worse health status were presented as factors that lead to (or increased) the severity of abuse. Despite this being true for both genders, in the case of women, this was also associated with the loss of the father figure in the case of abuse at the hands of children. Women felt particularly vulnerable to abuse from the male son, which suggests the importance of a gendered analysis of the abusive relationship. In overall, older adults recognize the changes in their capacity to defend themselves (or to be defended) as they grow older. In the case of male victims, the loss of physical strength is perceived as a seized opportunity for the abuser and results in the feeling of fear. The decline in the health of one partner was considered a factor that could lead to or exacerbate spousal abuse (Hightower *et al.*, 2006; Podnieks, 1993; Pritchard, 2000), while poor physical health and/or needing help with basic care, rendered older men as easy targets for the abuse by family members (Pritchard, 2007).

Age related social and contextual factors were also evidenced as potential vulnerabilities to abuse, namely, social isolation and retirement. Victims reported geographical and social isolation and limited income because of retirement. Loneliness, inadequate social and emotional support, isolation and lack of community resources were also identified as possible factors that could lead to or intensify elder abuse (Podnieks, 1993; Pritchard,

2000), whereas retirement has also been linked to abuse due to increased living time (Hightower *et al.*, 2006; Montminy & Straka, 2006). These results indicate that older adults not only recognise these contextual factors but that they also recognised them as the result of the ageing process. Being old was a self-category explicitly affirmed by the victims.

The recognition of one's age, of the vulnerabilities or difficulties intrinsically associated with becoming older, and the limited time left to live were aspects highlighted by victims to explain how they tried to cope with abuse and its consequences. The fourth and last category, focused on how the ageing (and its awareness) influenced the decision of ending (or not) the abuse and the victims' repertoire of responses.

As highlighted by previous studies (Pritchard, 2000), some older adults decide to end an abusive situation as their poorer health makes them afraid of the consequences. In addition, awareness of time and of the ageing process is also important for deciding to seek help as it may be associated with the participants' perception of a limited time to live.

Nevertheless, the decision to not seek help may also be constraint by the recognition of financial and social hardships. Our results show that the prospect of enduring difficulties and hardships related to financial problems in old age can be reason enough not to consider ending the abuse. This indicates the need to consider vulnerabilities to cope with abuse and its consequences. To cope with the situation implies also to have adequate responses and the means to activate them and the help-seeking behaviour will, therefore, be framed within these features and the knowledge of limited time.

Conclusion

For elder abuse conceptualization, age can constitute an arbitrary criterion since there is a lack of an association between chronological age and the victimisation experienced (Goergen & Beaulieu, 2013; Walsh *et al.*, 2007). However, our results show that the ageing (process), being older (product) and their interaction with abuse and violence results in common features among different victims' narratives. Time constitutes a lens from which victims frame their experience. Either by focusing on the cumulative effects of abuse throughout time or by focusing on this experience taking place at this stage of their life's, older adults perceived time to be limited and precious. Older adults not only recognised they were older, as they perceived that they had increased vulnerabilities associated with the ageing process. It is also by coming to term with their own ageing that the decision (or not) to seek help takes place. Although being important to recognise that older adults are particularly vulnerable to some types of family violence and to its

consequences, caution is also required not to enhance ageistic social features by framing elder abuse within a restricted set of vulnerability (either perceived and/or real).

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Chapter VIII

Maus Tratos e Negligência da Pessoa Idosa: Modelos Teóricos e Intervenção [Mistreatment and neglect against older adults: theoretical models and intervention]

Maus Tratos e Negligência da Pessoa Idosa: Modelos Teóricos e Intervenção [Mistreatment and neglect against older adults: theoretical models and intervention]

Introdução

Ao longo dos últimos anos o fenómeno dos maus-tratos e negligência sobre as pessoas idosas tem vindo a ganhar espaço na opinião pública, junto das autoridades e no campo científico, sendo genericamente representado como uma violação grave dos direitos humanos (Lachs & Pillmer, 2004). A primeira referência teórica aos maus-tratos a pessoas idosas surge em 1975 sob a nomenclatura "granny battering" (O´Connor & Rowe, 2005) e apesar de este constituir um importante marco cronológico, e de se assistir, desde então, a uma crescente atenção da investigação nessa área, só a partir da década de 90 é que se verifica um interesse mais generalizado sobre as múltiplas formas e contextos que o fenómeno pode assumir (Biggs & Haapala, 2010).

Os estudos desta temática foram inicialmente dirigidos ao número de pessoas idosas tidas como vítimas de maus-tratos e de negligência numa determinada população, e das várias revisões sistemáticas da literatura que identificam estimativas de prevalência, verifica-se uma disparidade de valores entre países e estudos. Em alguns países ocidentais, e considerando amostras representativas nacionais, tem-se estimado valores entre os 1% e os 5% (Swagerty, Takahashi & Evans, 1999); no entanto, estes valores poderão sempre ser consideravelmente mais elevados, como revelou a revisão sistemática de estudos de prevalência de Cooper, Selwood e Livingston (2008) segundo a qual os valores se situaram entre os 3,2% e os 27,5%. Conquanto esta variabilidade se possa dever aos contextos culturais onde os diversos estudos decorreram, a dificuldade de concordância na definição concetual, e mesmos nos tipos de maus-tratos a incluir, terão também contribuído para este desfasamento numérico (Santos, Nicolau, Fernandes, & Gil, 2013). Concretamente em Portugal, um estudo populacional recente sobre a violência contra as pessoas com 60 e mais anos a residir na comunidade obteve uma prevalência de 12.3%, sendo os tipos de maus tratos mais relevantes os de índole financeira (6.3%) e psicológica (6.3%), aos quais se seguiram os de índole física (2.3%), a negligência (0.4%) e os maus tratos sexuais (0.2%) (Gil, Santos, Kislaya,& Nicolau, 2014).

Presentemente, a definição de maus tratos e negligência sobre os mais velhos que tem agregado mais consenso, sobretudo na Europa, foi avançada em 1995 pelo "Action on Elder Abuse"[1] do Reino Unido, a qual tem vindo desde então a ser adotada por vários organismos internacionais, nomeadamente a Organização Mundial de Saúde (World Health Orgnanization [WHO], 2002). Neste âmbito, os maus-tratos e a negligência contra as pessoas idosas são definidos como "*um acto único ou repetido, ou a falta de uma acção apropriada, que ocorre no âmbito de qualquer relacionamento onde haja uma expectativa de confiança, que cause mal ou aflição a uma pessoa mais velha*" (WHO, 2002:148). Esta definição tem alcançado grande popularidade no que diz respeito aos movimentos políticos e às Organizações Não Governamentais (ONGs) pois permite englobar as várias dimensões do problema (Biggs & Haapala, 2010), como serão as diferentes tipologias em que se podem desagregar os maus-tratos e a negligência, os diferentes contextos em que podem ocorrer e as diferentes relações em que se desenvolvem. Relativamente aos tipos de maus-tratos, o relatório mundial sobre a violência da OMS (2002, pp.148) define cinco tipos fundamentais:

(i) os *maus tratos físicos*, que incluem ações que causam dor física ou ferimentos à pessoa idosa, que impliquem coerção física e sub ou sobre medicar;

(ii) os *maus-tratos psicológicos*, que se referem às ações que infligem sofrimento, angústia ou aflição à pessoa idosa;

(iii) os *maus-tratos sexuais*, que implicam qualquer tipo de contacto sexual, não consentido, com a pessoa idosa;

(iv) os *maus-tratos económicos ou financeiros*, que incluem o uso ilegal ou inapropriado de bens, fundos ou propriedades da pessoa idosa;

(v) a *negligência*, que constitui outra dimensão do problema e que se refere à recusa, omissão ou ineficácia na prestação de cuidados, obrigações ou deveres à pessoa idosa.

Alguns autores, considerando a intencionalidade das condutas, dividem ainda a negligência em dois subtipos: por um lado, a *negligência ativa,* através da negação ou fracasso intencional no cumprimento das ações necessárias ao bem-estar da pessoa

[1]Action on Elder Abuse (AEA) é uma organização especializada apenas no tópico dos maus-tratos de pessoas idosas que visa a prevenção, intervenção e divulgação do fenómeno. Estabelecida em 1993 por um grupo de profissionais de saúde e serviço social, académicos e representantes de trabalho voluntário, a AEA opera no Reino Unido e também Irlanda. http://www.elderabuse.org.uk/Index.htm

idosa e, por outro, a *negligência passiva* que difere da primeira pelo facto de não ser consciente ou intencional (Wolf & Pillemer, 1989). No entanto, é de notar que para além da tipologia da OMS que pode ser apelidada de "clássica", outras tipificações podem ser encontradas na literatura. O comité nacional de abuso de pessoas idosas nos EUA (National Center on Elder Abuse, 1998), por exemplo, a partir da revisão das definições já existentes propõe a inclusão de mais dois tipos de abuso: o *abandono* e a *autonegligência*. O primeiro sucede quando a pessoa que tinha a custódia física ou a responsabilidade de cuidar da pessoa idosa, a deixa "entregue a si mesma", desaparece, ou a abandona numa instituição, hospital, ou mesmo na rua; a autonegligência, por sua vez, explicita atos cometidos pela própria pessoa idosa que atentam contra a sua saúde ou segurança, como serão exemplos, isolar-se dos outros, vestir-se inadequadamente face às condições ambientais ou ter uma alimentação inapropriada, entre outros. Por último, importa também referir que há autores que incluem no amplo leque de ações relativas aos maus tratos e negligência sobre as pessoas idosas a *violação de direitos pessoais*, tipificação desenvolvida inicialmente no âmbito de pessoas idosas institucionalizadas e que se refere, em grande escala, à violação do direito à privacidade, à confidencialidade, às escolhas livres, à liberdade religiosa e ao próprio consentimento para ser institucionalizado (Cohen, Levin, Gagin & Friedman, 2007).

Dado o desenvolvimento de diferentes definições de maus-tratos, ou mesmo da introdução de "novas" tipologias, compreende-se a atual dificuldade em obter um enquadramento conceptual uniforme para o fenómeno dos maus tratos e negligência sobre as pessoas idosas. Contudo, é comummente aceite que estes englobam condutas por comissão ou omissão por parte de alguém que mantém uma relação de confiança com a pessoa idosa, a quem causam, ou potenciam, algum tipo de dano, tornando-a vitima. Considera-se, assim, como maus-tratos qualquer comportamento que, pela ação ou não tomada de ação, provoque sofrimento físico, psicológico e/ou emocional, podendo-se tipificar em, pelo menos, cinco formas distintas – físico, psicológico, financeiro/material, sexual e negligência (Lachs & Pillemer, 2004; O`Connor & Rowe, 2005; WHO, 2002; Tortosa, 2004).

No que se refere aos contextos em que podem ocorrer os maus tratos e a negligência sobre a pessoa idosa, convém explicitar que estes podem suceder em domicílios particulares, hospitais, residências de terceira idade e em qualquer outro equipamento gerontológico e/ou no âmbito de serviços destinados às pessoas idosas (e.g., serviço de apoio domiciliário), sendo, por isso, passíveis de ser agrupados em duas grandes categorias: os maus-tratos ocorridos na comunidade (no domicilio) e os maus-tratos

institucionais. Esta diferenciação tem, por sua vez, implicações na conceptualização dos perpetradores, os quais se podem agrupar em duas grandes categorias, os cuidadores informais e os cuidadores formais. Os primeiros, habitualmente familiares, dizem respeito a todos aqueles que, sem serem pagos, efetuam tarefas de apoio emocional, instrumental ou financeiro à pessoa idosa, enquanto os segundos remontam habitualmente a profissionais pagos para a prestação específica de serviços de apoio.

Modelos teóricos explicativos e de intervenção

O aumento do reconhecimento dos maus-tratos e negligência na população mais velha como fenómeno social, surge acompanhado pela maior intervenção de diversas disciplinas, instituições e atores que tendem a desenvolver formas de intervir nesta problemática. Os primeiros autores a debruçarem-se sobre o tema, procurando obter um referencial teórico para explicar os maus-tratos e a negligência sobre pessoas idosas, adotaram o paradigma do modelo da violência sobre as crianças, o que produziu uma representação simplista e incompleta do problema: a vítima surge tipificada como uma mulher muito idosa e dependente e o agressor como um cuidador bem-intencionado, mas sobrecarregado (Wolf, 1992). A investigação mais recente viria a mostrar, todavia, que tal díade não corresponde necessariamente à realidade, i.e., que a vítima nem sempre é especialmente frágil ou vulnerável, nem o agressor é sempre um cuidador experienciando níveis mais elevados de stress, em comparação com cuidadores não abusivos (Pillemer, 2005). Na esteira da potencial aplicabilidade de um modelo ajustado ao universo infanto-juvenil à realidade da população mais velha, outros autores (Vinton, Harris, citados por Bergeron, 1991 e Brandl, citada por Burnight & Mosqueda, 2011) sugeriram uma portabilidade similar do modelo da violência conjugal. Este modelo, que enfatiza a intencionalidade e responsabilidade dos cuidadores, levantou críticas acerca da sua adequação para as pessoas idosas como, por exemplo, para explicar situações de negligência passiva (Wolf, 1992). Na verdade, ainda que o fenómeno apresentasse semelhanças tanto com a violência exercida sobre as crianças como com a violência conjugal, trata-se de uma situação distinta pois engloba tanto os aspetos da violência interpessoal como aspetos do próprio envelhecimento, nomeadamente, o aumento da vulnerabilidade física, as mudanças estruturais de vida (e.g., perda de pessoas significativas, reforma) e o potencial para o isolamento social ou a diminuição no acesso à informação e aos recursos.

Tentativas ulteriores para explicar a emergência dos maus tratos sobre as pessoas idosas, e sobretudo a complexidade que lhe está associada, recorreram a um vasto leque

de fatores psicológicos, sociais e gerontológicos. De um modo geral, a literatura existente parece suportar a exploração das seguintes teorias: o modelo do stress situacional; a teoria da troca social; a teoria da díade da discórdia; a teoria da aprendizagem social ou modelo da violência transgeracional; a teoria da psicopatologia do cuidador; a teoria do poder e do controlo; a teoria da modernização e o modelo socio ecológico. Burnight e Mosqueda (2011) agrupam várias destas teorias em quatro grandes abordagens de acordo com o foco de cada um deles: *abordagem intrapessoal*, *abordagem interpessoal*, *abordagem multissistémica* e *abordagem sociocultural*. Assim, nas teorias que salientam apenas as características individuais (*abordagem intrapessoal*), enquadram-se o modelo da violência transgeracional e a teoria da psicopatologia do cuidador. O primeiro, oriundo da teoria da aprendizagem social (Bandura, citado por Burnight & Mosqueda, 2011), postula que quando os indivíduos experienciam maus-tratos ou observam comportamentos violentos por parte dos seus pais ou outros modelos de referência durante a infância, têm mais probabilidade de se comportarem de forma violenta quando na idade adulta; a teoria da psicopatologia do cuidador, por seu lado, examina o papel do cuidador e as suas características, relacionando os seus problemas mentais com o risco de maus-tratos e de negligência (Burnight & Mosqueda, 2011; Ferreira-Alves, 2005; Fulmer, Guadano, Dyer, & Connolly, 2004).

A *abordagem interpessoal* engloba as teorias que examinam a dinâmica relacional entre vítima e agressor, nomeadamente o modelo do stress do cuidador, a teoria da troca social e a teoria da díade de discórdia. O modelo do stress situacional ou stress do cuidador defende que os maus-tratos emergem da sobrecarga cuidador, o qual não é capaz de responder às necessidades da pessoa idosa de quem cuida (Fulmer et al., 2004). Correspondendo a um fenómeno situacional, este originar-se-ia pela incapacidade, física ou mental, da vítima, bem como por condições socioeconómicas desfavoráveis e por baixas competências de *coping* do cuidador (Ferreira-Alves, 2005). O modelo da troca social aborda a relação entre a pessoa idosa e um cuidador agressor e as táticas e respostas implícitas que foram sendo estabelecidas na vida familiar daquela relação (Luescher & Pillemer, 1998, citados por Burnight & Mosqueda, 2011). Com o envelhecimento dar-se-ia uma diferença de poder que altera a reciprocidade, fazendo com que o cuidador sinta mais poder, mas simultaneamente menor recompensa na relação, originando a violência. Já a teoria da díade da discórdia posiciona a violência enquanto um fenómeno bidirecional e resultante da interação entre pessoa idosa e cuidador (Archer, 2000 citado por Burnight & Mosqueda, 2011).

Na *abordagem sociocultural* destaca-se a teoria da modernização e a teoria do poder e do controlo. A teoria da modernização associa os desafios enfrentados pela população idosa – perda do seu papel de membro ativo da sociedade e o facto de terem de depender de outros para o seu bem-estar – ao aparecimento dos maus-tratos. As transformações decorrentes do elevado grau de modernização nas sociedades contemporâneas levariam a uma perda do estatuto das pessoas idosas e à descriminação com base na idade (idadismo), fatores que, por sua vez, antecederiam a ocorrência da violência (Fulmer et al., 2004; Litwin & Zoabi, 2004). É também o idadismo que está na base da teoria do poder e do controlo. Esta teoria, proveniente da perspetiva feminista e desenvolvida na investigação sobre a violência contra as mulheres, defende que a violência decorre de uma desigualdade de poder sustentada social e culturalmente (Walker, 1990, citado por Burnight & Mosqueda, 2011) a qual, no caso das pessoas idosas, decorre precisamente do fenómeno de discriminação e preconceitos que sobre elas recai. Por último, o *modelo socio-ecológico* enquadra-se numa abordagem multissistémica e postula que os maus-tratos surgem de fatores não só individuais e relacionais, como também sociais que, por seu lado, podem ser mais ou menos potenciados pelas normas sociais e culturais vigentes em determinado período histórico e espaço geográfico (Sev'er, 2009).

Se o modo como o fenómeno dos maus tratos e negligência sobre os mais velhos é passível de múltiplas interpretações que dão conta da complexidade do fenómeno em causa, as várias teorias explicativas têm implicação nos modelos de intervenção que têm vindo a ser equacionados por académicos e profissionais de terreno ao longo dos tempos. De acordo com Bergeron (2001) as teorias sobre a etiologia do fenómeno, servindo para a sua compreensão, servem precisamente para moldar também a prática profissional. Assim, e a título de exemplo, se considerarmos que a sobrecarga do cuidador é a principal explicação para a ocorrência de maus tratos e negligência, a intervenção passará inevitavelmente por diminuir esta sobrecarga, seja através de respostas de descanso do cuidador (e.g., respite care), apoio psicoeducativo sobre a gestão dos cuidados e suas consequências, ou grupos de autoajuda para cuidadores.

No quadro que se segue (quadro 1) apresentam-se os principais modelos de intervenção nos maus-tratos e negligência. Estas abordagens correspondem a grandes linhas orientadoras de estratégias e técnicas de intervenção, que envolvem a utilização de serviços, leis e procedimentos clínicos para tratar as consequências dos maus-tratos, bem como para prevenir a sua ocorrência (Anetzberger, 2004). Convém referir que tem sido proposto um leque diversificado de estratégias que podem ser oferecidas pelos

serviços de saúde, sociais ou através de procedimentos jurídico-legais, sendo habitualmente de uma visão e ação concertada dos mesmos que emanam intervenções com potencial de eficácia mais elevado. São, no entanto, estratégias que ainda se encontram numa fase inicial do seu desenvolvimento, apresentando, por isso, pouca evidência de suporte a esse nível (Penhale 2006; Ploeg, Fear, Hutchison, Macmillan & Bolan, 2009), sendo também estimável que o advir de modelos que pressupõem concetualizações diferenciadas sobre o fenómeno, privilegiando mais ou menos determinada estratégia, poderá dificultar o diálogo entre os vários profissionais envolvidos na gestão das situações.

Quadro 1. Síntese dos modelos de intervenção nos maus-tratos e negligência sobre as pessoas idosas

Modelos	**Conceptualização** ***Grupo-alvo***	**Contextos / Áreas estratégias** ***Exemplos***	**Observações**
Programas de Proteção de Adultos	Maus-tratos como resultantes dos cuidados *Vítimas e agressores*	Legislação; Autoridades de Segurança Pública; Serviço Social ▪ Leis de denúncia obrigatórias ▪ Comissões de proteção de adultos ▪ Aconselhamento ▪ Apoio social ▪ Intervenção em crise ▪ Grupos de autoajuda para cuidadores	Abordagem paternalista; obrigatoriedade de reportar ao sistema jurídico-legal; falta de integração de outros serviços na comunidade (e.g. sistemas de saúde primários).
Modelo de Risco	Maus-tratos como resultantes dos cuidados *Potenciais vítimas e respetivas famílias*	Serviço Social; Serviços Comunitários Não Especializados ▪ Apoio e acompanhamento de famílias ▪ Apoio psicoeducativo a cuidadores ▪ Educação social	Variedade de critérios para identificar as pessoas idosas em risco; falta de atenção à prevenção e à resposta imediata em casos de maus-tratos e de negligência.
Modelo *Advocacy*	População idosa como grupo particularmente vulnerável *Vítimas*	Sociedade Civil; Serviços Comunitários Não Especializados. Foco no *empowerment.* ▪ Aconselhamento jurídico-legal ▪ Apoio social ▪ Grupos de autoajuda ▪ Intervenção psicoterapêutica	A limitação e enfase da participação das pessoas idosas será irrealista em muitos casos de maus-tratos e negligência.

Modelos	**Conceptualização** ***Grupo-alvo***	**Contextos / Áreas estratégias** ***Exemplos***	**Observações**
Modelo da Violência Doméstica	Clientes são perspetivados como vítimas de crime *Vítimas*	Legislação e Forças de Segurança Pública; Organizações Estatais em articulação com Serviços de Apoio à vítima. Foco no *empowerment*. ▪ Casas-abrigo ▪ Linhas telefónicas de apoio ▪ Advocacy juridico-legal ▪ Intervenção psicoterapêutica	A perspetiva feminista baseada na teoria do poder e controlo poderá ser adequada para casos de violência conjugal, mas não se adequará, por exemplo, à negligência.
Modelo de Gestão de Casos	Maus-tratos e negligência como fenómeno heterogéneo *Vítimas e agressores*	Forças de segurança pública, sistemas estatais de saúde, sociais e serviços comunitários especializados ▪ Aconselhamento jurídico-legal ▪ Serviços de apoio social ▪ Serviços de apoio domiciliário ▪ Cuidados de saúde ▪ Intervenção psicoterapêutica	Podem ser de muita longa duração Implica a coordenação interagências e serviços A valorização da decisão da pessoa idosa em todo o processo pode por em causa a sua segurança.

Nota: Adaptação de Anetzberger (2004), Loughlin & Duggan (1998) e de Neremberg (2006).

Intervenção psicológica

As revisões de literatura sobre programas de resposta ao fenómeno apontam para um vasto leque de estratégias de natureza legislativa, política ou modelos de provisão de serviços que variam consideravelmente na literatura e de acordo com os contextos nacionais em causa (Loughlin & Duggan, 1998; Penhale 2006; Ploeg et al. 2009; WHO, 2011). Estas abordagens, muitas vezes multidisciplinares, incluem a intervenção psicológica. Concretamente, tem-se observado duas tendências: uma primeira situa-se no recurso a modelos de intervenção não exclusivos dos maus-tratos, mas antes dirigidos aos sintomas clínicos apresentados pelas vítimas. Neste âmbito, vários estudos têm revelado que os mais velhos vítimas de violência apresentam frequentemente sintomatologia depressiva e ansiosa, medo, sentimentos de desesperança, vergonha ou culpa (e.g., Dong, Chen, Chang & Simon, 2013) e, neste sentido, vários autores sugerem que os serviços de intervenção psicológica deverão inicialmente dar resposta os sintomas apresentados pelas vítimas, ao mesmo tempo que utilizam estratégias de *empowerment* (Wolf, 1998; citada por Thompson & Priest, 2005). De um modo geral, estima-se que as pessoas idosas vítimas de violência beneficiarão dos mesmos tipos de psicoterapia utilizadas com este grupo etário, sejam elas de abordagem cognitivo-comportamental,

interpessoal, narrativa de vida, reminiscência, terapia familiar ou outras (Pinquart & Soerensen, 2001).

Partindo de um posicionamento mais comprometido com as especificidades do fenómeno dos maus tratos e negligência desde um ponto de vista clínico, outra linha de intervenções psicológicas refere-se à sua adaptação aos vários grupos-alvo da violência doméstica. Essas intervenções são principalmente desenvolvidas no âmbito dos modelos de intervenção de risco ou de violência conjugal e centram-se na vítima, na redução do risco experienciado, e focam-se na autonomização e remoção da situação abusiva (Anetzberger, 2005). Neste posicionamento, uma das abordagens mais comuns é a terapia cognitivo-comportamental que visa fornecer ferramentas que auxiliarão as vítimas de violência doméstica a identificar as situações abusivas, a avaliar a realidade das suas cognições e a modificar crenças disfuncionais (Desmarais & Reeves, 2007). Focando-nos no *empowerment*, um dos elementos que tem sido mais enfatizado é a psicoeducação, a qual pode ser dirigida aos cuidadores (Reay & Browne, 2002), às famílias (Davis & Medina-Ariza, 2001) ou a grupos de vítimas (Brownell &Heiser, 2006, citados por Ploeg et al. 2009).

Ultrapassando esta abordagem dicotomizada em relação ao foco interventivo (sintomas clínicos *vs* problemática em causa), vários autores têm vindo a sugerir a junção de diferentes intervenções psicoterapêuticas. Papadopolous e LaFontaine (2000, citados por Thompson & Priest, 2005), por exemplo, propõem a combinação de terapia individual, familiar e interpessoal focando o treino comportamental, a reestruturação cognitiva e o controlo emocional, no seio de uma abordagem que privilegia o trabalho da relação interpessoal entre pessoa idosa e cuidador; outros exemplos são também apontados pelo relatório europeu sobre a prevenção dos maus tratos à pessoa idosa, enfatizando a importância de combinar programas psicológicos e educativos, desta feita sobretudo para os cuidadores com o objetivo de reduzir os seus níveis de ansiedade e stress, bem como aumentar competências na gestão de raiva (WHO, 2011).

Sobre a intervenção psicológica no âmbito dos maus tratos e negligência sobre os mais velhos, importa referir ainda dois aspetos centrais. Por um lado, que a investigação realizada sobre a sua eficácia é ainda emergente (WHO, 2011), apesar de alguns estudos apontarem para uma avaliação positiva do seu impacto, como é o caso do *National Center on Elder Abuse* (2005) que revelou melhorias significativas num grupo de vítimas que participou num programa psicoterapêutico breve com base na terapia cognitivo-comportamental. Por outro lado, que a intervenção psicológica é indissociável de barreiras estruturais, culturais e sociais que determinam a procura de apoio por parte

da vítima, as quais incluem, entre outras, a fragilidade física e emocional da pessoa idosa e a sua frequente dependência em relação aos perpetradores do maltrato e negligência. Estes constrangimentos associar-se-ão a outros, que se sintetizam, de acordo com Penhale (1994, citada por Biggs, Phillipson & Kingston, 2000), no direito dos mais velhos à autodeterminação (e que se poderá traduzir na recusa de apoio oferecido pelos profissionais), na escassa disponibilidade de respostas especializadas a este nível, no niilismo terapêutico por parte dos profissionais envolvidos, e ao fracasso no processo de sinalização/identificação dos casos. Estas barreiras, não sendo explicitamente exclusivas da intervenção psicológica, enfermam uma grande diversidade de intervenções sobre esta problemática no campo gerontológico.

O modelo de gestão de casos

O modelo de gestão de casos é considerado aquele que providencia uma resposta mais global e adaptada às necessidades específicas das várias partes envolvidas nos casos de maus-tratos e negligência de pessoas idosas (Anetzberger, 2005; Straka & Montminy, 2006; Vladescu, Eveleigh, Ploeg, & Patterson, 2000). De acordo com este modelo, a intervenção refere-se à utilização de serviços estatais ou de ONGs, aplicação de medidas legais e procedimentos clínicos (cuidados de saúde, intervenção psicológica) com o objetivo de tratar as consequências dos maus-tratos e negligência e de prevenir a sua ocorrência ou reincidência. A intervenção deve ser sempre planeada de acordo com dois grandes objetivos: a preservação da autonomia e a promoção da segurança da pessoa idosa. Embora estes dois objetivos possam, por vezes, entrar em conflito um com o outro, já que nem sempre as respostas mais adequadas na preservação da autonomia são as mais eficazes na promoção da segurança, estes são essenciais para a gestão da violência (Lachs & Pillemer, 1995). O primeiro diz respeito à capacidade e vontade da pessoa idosa e do cuidador em receber ajuda, enquanto o segundo fator diz respeito à adequação e eficácia de determinados tratamentos e serviços. Desde um ponto de vista prático, o planeamento da intervenção em relação ao primeiro fator será diferente consoante se trate de (i) uma pessoa idosa não competente; (ii) uma pessoa idosa competente que não consente a intervenção; (iii) uma pessoa idosa competente que consente a intervenção; (iv) um cuidador que deseje ou não ajuda e apoio. No que concerne ao segundo fator, o planeamento deverá, em princípio, ser efetuado tendo em conta o modo como as intervenções afetam a autonomia e a segurança da pessoa idosa e garantem uma melhor qualidade de vida, sendo que em caso algum se deverá desvalorizar os efeitos iatrogénicos que a própria intervenção pode trazer, i.e., deve-se

sempre ter em conta a possibilidade de os tratamentos, serviços ou ações desenvolvidas para dar resposta a um determinado caso de maus-tratos poderem ser sentidos pela pessoa idosa (e, assim, serem-no) como mais prejudiciais do que benéficos.

Caso prático

Assumindo-se a perspetiva da gestão de caso para se apontar alguns aspetos importantes no atendimento e na intervenção a pessoas idosas vítimas de maus-tratos em contexto comunitário, o caso que a seguir se expõe decorre da experiência clínica e de investigação dos autores, nomeadamente da pesquisa de acontecimentos verídicos.

> *Arminda[2] é uma professora primária reformada de 84 anos, viúva, com um filho. A sobrinha, de 64 anos, encaminha-a para um atendimento numa organização de apoio a vítimas de violência doméstica. A sobrinha expõe que recebeu uma denúncia, de um casal vizinho de Arminda. Essa denúncia refere que desde que o filho e a namorada foram viver para casa dela "tem sido alvo de agressões psicológicas. É constantemente ameaçada de morte pela namorada do filho, a qual lhe atira objetos e danifica bens existentes na casa. Refere também que Arminda é constantemente humilhada e difamada por ela, que lhe chama nomes e que está constantemente aos berros, os quais são ouvidos por todo o prédio. Arminda chegou a ter que pedir também dinheiro a esse casal para poder ir ao café, apesar de a sua reforma ser mais que suficiente e aquele casal, que fez a denúncia, acha que aquela já não tem qualquer tipo de acesso ao seu dinheiro da reforma." A sobrinha acrescenta que quando a vai visitar (cerca de 1 vez por mês), Arminda se apresentou frequentemente com marcas. No primeiro atendimento, Arminda mostra estar reticente, referindo não achar necessário a intervenção. Apesar disso não manifesta qualquer angústia e parece confortável e cooperante. Após uma primeira avaliação é possível observar que Arminda está atenta e orientada no tempo e no espaço, não mostrando aparentemente dificuldades cognitivas. Mostra algumas dificuldades na marcha e apresenta-se bem vestida e cuidada. Arminda inicia o seu relato afirmando que as preocupações da sobrinha que a trouxeram ali são exageradas e que o filho, desde que está desempregado, anda muito "abatido e nervoso" e que ela nem sempre é uma "pessoa fácil". Além disso, desde que caiu e se magoou que precisa cada vez mais de apoio*

[2] Nome fictício.

> *para as suas rotinas do dia-a-dia. Manifesta preocupação pelo peso que exerce sobre o filho, face ao aumento da sua dependência, e sentimentos de angústia por aquele se encontrar desempregado já há algum tempo e por considerar que a sua reforma não é suficiente.*

No modelo de gestão de casos, e dada a sua vertente clínica, as diferentes fases num processo de intervenção incluem a deteção, a avaliação, o planeamento, a intervenção propriamente dita (intervenção em crise, intervenção psicológica, grupos de autoajuda, *empowerment* e acionar serviços ou respostas sociais de apoio) e o *follow-up* (Anetzberger, 2004, 2005).

O caso apresentado indicia a suspeita de maus-tratos à utente, detetados tanto pela sobrinha, como pelo casal vizinho. No entanto, apesar das suspeitas que qualquer profissional pode desenvolver na sua prática com uma pessoa idosa, é importante diferenciar entre os casos de suspeita de maus-tratos e os casos em que os maus-tratos são "conhecidos", ou seja, se a sua ocorrência foi presenciada ou reportada pela vítima ou alguém com possibilidade de ter esse conhecimento. Suspeita-se de maus-tratos e de negligência através da identificação de sinais ou indicadores que usualmente representam consequências do ato perpetrado, sugerindo assim a possibilidade de que o fenómeno esteja a ocorrer. Os sinais ou indicadores são constatações físicas, psicológicas e sociais que surgem após a ocorrência de maus-tratos e de negligência (Lachs & Pillemer, 2004). Podem representar consequência de um tipo de maus-tratos ou podem estar presentes em diferentes tipos, como, por exemplo, será o caso de queimaduras ou nódoas negras nos maus-tratos físicos, ou alterações significativas em bens e propriedades no caso dos maus-tratos financeiros (Lachs & Pillemer, 2004).

O relato da sobrinha e do casal de vizinhos aponta para maus-tratos psicológicos ("*ameaçada de morte*"; "*chama nomes*"; "*está constantemente aos berros*") e para a suspeita de maus-tratos físicos ("*apresenta frequentemente com marcas*") e financeiros ("*danifica bens existentes*"; "*[ela] chegou a pedir também dinheiro*"). As afirmações da utente apontam também para a existência de maus-tratos financeiros (filho está desempregado e "*a sua reforma não é suficiente*") e até de negligência ("*preocupação pelo peso que exerce sobre o filho face ao aumento da sua dependência*"). A presença destes indicadores de maus-tratos apontam a necessidade de se efetuar uma avaliação mais aprofundada (Gray-Vickrey, 2000; citado por Anetzberger, 2004).

Avaliação ou diagnóstico

A avaliação ou o diagnóstico representa uma abordagem organizada para recolher informação acerca das pessoas e das suas circunstâncias, permitindo melhorar a exatidão da identificação e, assim, consubstanciar ou não os maus-tratos, bem como providenciar informação para o planeamento da intervenção. Só a partir de uma avaliação será possível determinar (i) a necessidade de assistência à vítima e em que medida esta deve ser mais ou menos imediata; (ii) os recursos disponíveis para apoiar a pessoa idosa e (iii) a prioridade que deve ser dada a esses apoios e recursos.

A avaliação inicia-se na primeira sessão de atendimento e inclui não só a observação, como a entrevista estruturada ou a aplicação de instrumentos de avaliação. No mínimo, a avaliação deve englobar a recolha de informação sobre: problemas de saúde física; estado cognitivo e mental; limitações funcionais (nas atividades básicas e instrumentais da vida diária); informação sobre finanças e contextos de vida, crises pessoais ou familiares recentes e recursos sociais (e.g. rede social de apoio real e percebido, presença de serviços de apoio domiciliário). A natureza dos maus-tratos deve ser também avaliada incluindo: (a) tipos presentes; (b) frequência (e.g. todos os dias, uma vez por semana, todos os meses, etc.); (c) intencionalidade por parte do perpetrador; (d) severidade, que pode ser avaliada combinando a densidade (o número de tipos ou número de atos presentes) e a frequência com que os comportamentos foram sendo perpetrados e (e) a duração (desde quando é que o ocorre) (Anetzberger, 2004).

No presente caso, e dado que Arminda não se deslocou voluntariamente para denunciar a situação de violência de que é alvo - que aparentemente nem sequer reconhece como tal - é importante que a exploração da situação e a necessidade de averiguação de perigo imediato seja sempre balanceada com o estabelecimento de uma relação de confiança (Quinn & Tomita, 1997). Assim, é importante que o profissional procure, nesta primeira sessão, *considerar a resistência e não confrontar a vítima,* mostrando compreensão e não insistindo para que esta assuma a vitimação. Clarificando com a Arminda que o espaço onde se encontram é de total privacidade[3] e que ela pode aproveitá-lo da forma que melhor entender, possibilita que esta o reconheça como um espaço seguro onde, então, a questão da vitimição poderá ser de facto trabalhada. Pode

[3] A confidencialidade no trabalho do psicólogo, estipulada no próprio código deontológico, reveste-se de dificuldades acrescidas pelo enquadramento legal do crime de violência doméstica enquanto crime público, que obriga a qualquer profissional a efetuar a denúncia do crime. A conjugação, nem sempre fácil ou consensual entre a natureza do trabalho e o código penal, obriga ao equilíbrio contínuo entre o dever do profissional de apoiar a vítima e as suas decisões e a tomada de decisão do profissional em apresentar queixa-crime contra a vontade da vítima. O trabalho do profissional junto das vítimas deve incentivar sempre a revelação por parte da vítima, ainda que a decisão unilateral deva ser considerada em último recurso e suportada pela avaliação do risco em que a vítima se encontra.

também utilizar-se a preocupação da sobrinha que marcou o atendimento e *explorar o tema dos maus-tratos como algo que acontece em todas as classes, idades, sexos e em todo o tipo de famílias* (generalizar e não individualizar). É importante referir que os conflitos, muitas vezes presentes nas famílias, podem levar a situações de maus-tratos e de negligência. Após a introdução do tema, questiona-se diretamente Arminda e pode-se iniciar a *exploração da vitimação*, inquirindo sobre o seu dia-a-dia e sobre a sua relação com o filho e companheira deste. Deve-se *evitar o uso de tom acusatório ou culpabilizante do agressor*, mas antes utilizar questões gerais ("*Agora que o seu filho está desempregado, costuma estar mais com ele, durante o dia?*"; "*Como costuma ocupar o seu dia?*"; "*Disse-me que vive também com a companheira do seu filho. Como é a sua relação com ela?*"). Deve-se finalizar a primeira sessão sumarizando aspetos associados aos maus-tratos e negligência, não só em termos de dinâmicas e caracterização, como dos recursos existentes que podem ou não ser acionados. Ou seja, *educar a pessoa acerca do fenómeno* e possíveis respostas, *providenciar informação* sobre recursos e serviços existentes e, se possível, desenvolver um plano de acompanhamento. De notar que, no modelo de gestão de casos, o gestor do caso - neste caso o psicólogo que fez o primeiro atendimento - não disponibiliza apenas a informação sobre os recursos existentes, mas disponibiliza-se para apoiar a vítima a fim de obter mais informação e a acionar os recursos necessários e disponíveis.

A avaliação poderá ter de prosseguir para uma segunda sessão e deverá incluir outras fontes de informação. Dado que Arminda se mostrou reticente com a própria intervenção, a avaliação poderá, neste primeiro momento, apenas permitir eliminar a possibilidade de perigo imediato. A exploração do dia-a-dia de Arminda indica que os maus-tratos psicológicos são os mais frequentes e continuados ("*desde que o pai faleceu e ele se meteu outra vez dentro de casa, há dois anos*") e surgem, muitas vezes, por discussões sobre a casa e a apropriação e gestão do espaço por parte do filho e da companheira ("*é que querem tudo à maneira deles, mas são as minhas coisinhas. São as minhas coisinhas, que eu sempre tive muito orgulho na minha casa. Sempre arranjadinha*"). Os maus-tratos intensificam-se, há 9 meses atrás, quando a companheira do filho se muda para a casa de Arminda. Aquela é percecionada por Arminda como a responsável pelo comportamento do filho ("*porque ela a que lhe fez a cabeça, que coitado ele deixa-se sempre levar por elas*"). Os maus-tratos físicos ocorreram, segundo o relato de Arminda, três vezes após discussões ("*Ele é que estava todo desvairado e mandou-me um encontrão que eu, pronto, caí.*"). Não foi possível, porém, verificar a existência de maus-tratos financeiros, pois ainda que Arminda refira que o filho trata das contas e que tem acesso à sua conta, Arminda soube especificar, exatamente, o que gasta em média com

água, luz e outras despesas domésticas. No entanto, e referindo-se ao desemprego do filho, relata que "*o dinheiro não chega. Não chega pra todos nós e ele, ainda por cima, quer para tabaco, para ir ao café, mas eu não posso. Não posso porque não tenho, que não é que eu não queira*". Quanto à negligência também não foi possível avaliar de forma aprofundada, ainda que se tenha percebido que o filho costuma dar algum apoio nas idas ao médico e outras deslocações.

Em suma, a avaliação levada a cabo na primeira sessão sugere que se trata de uma vitimação prolongada no tempo, perpetrada pelo filho e pela companheira deste. Apesar de aparentemente não existir perigo iminente, foram identificados alguns fatores de risco: a coabitação; a dependência financeira e alguma limitação na locomoção. Em termos globais, Arminda não apresenta problemas de saúde física incapacitantes, apesar de ter algumas limitações funcionais na marcha. Manifesta um humor depressivo ("*que é que eu estou aqui a fazer? Diga-me o que é que eu ainda estou aqui a fazer*") e ansiedade pela possibilidade de ficar dependente ("*é que se eu ficar acamada, quem me basta? Ninguém!*").

No presente caso, o profissional considera ser necessária uma avaliação mais aprofundada da vitimação, bem como do estado de saúde e da rede social de Arminda. Nesse sentido, além da manutenção do acompanhamento psicológico individual, numa perspetiva de aconselhamento, o profissional, após consentimento de Arminda, entra em contacto com a sobrinha que contactou o serviço e com a diretora do centro de dia que providencia apoio domiciliário (só ao nível das refeições) para esclarecimento e pedidos de informação. Da auscultação destes informantes, conclui-se que Arminda apresenta algum suporte social, nomeadamente por parte dos vizinhos e da sobrinha. Tem também contacto diário com as auxiliares do apoio domiciliário que, apesar de referirem que a casa está mais desorganizada e menos limpa desde que o filho foi para lá viver, consideram as condições de habitabilidade razoáveis. Dão indicação de já terem referido a Arminda e ao filho a necessidade de apoios físicos para a casa de banho, uma vez que Arminda se queixa da banheira ser muito alta. A relação com a companheira do filho é bastante conflituosa, e ela não se inibe de insultar Arminda, mesmo na presença dos técnicos. Em termos de saúde, não foi possível obter informação junto do médico de família, mas de acordo com a informação da primeira sessão com Arminda, da sobrinha e dos técnicos do apoio domiciliário, as dificuldades da marcha resultaram de uma queda, agravada por um quadro clinico prévio de osteoporose. Além disso Arminda foi diagnosticada com Diabetes tipo II há mais de 30 anos, doença crónica que tem sido acompanhada pelo médico de família. Relativamente à vitimação, esta parece ter-se

intensificado com o tempo, aumentado na frequência e severidade - os maus-tratos físicos são, segundo a sobrinha e o pessoal do apoio domiciliário, mais frequentes que os admitidos por Arminda.

Planeamento

O planeamento, ainda que possa concetualmente ser entendido como uma etapa separada da avaliação e da intervenção, surge, na maior parte dos casos, durante a avaliação e estende-se para a própria intervenção (Anetzberger, 2004, 2005). Considerando os dois grandes objetivos da intervenção - preservação da autonomia e da segurança - a avaliação efetuada (até ao momento) indica que, ao nível do planeamento: (a) se reconhece a *necessidade de assistência à vítima*, a qual não passará por providências de emergência ou mais imediatas como retirar a vítima de casa, dado que a situação não constitui perigo eminente. Além disso, e dada a resistência de Arminda, inicialmente dever-se-á trabalhar com esta o reconhecimento da situação e o *empowerment*; (b) podem ser *disponibilizados recursos* para minimizar as consequências da vitimação e diminuir a probabilidade da sua ocorrência. Inicialmente o *aconselhamento psicológico individual* poderá permitir a consciencialização da situação por parte da vítima e desenvolver, com esta, formas de proteção; (c) se impõe determinar a *prioridade a ser dada aos apoios e recursos* que, em complementaridade ao apoio psicológico individual, deverão considerar as possíveis consequências da vitimação ao nível do bem-estar emocional e psicológico, podendo incluir-se como possibilidades:

(i) o reforço do apoio domiciliário, integração num centro de dia ou até contratualização de uma empregada doméstica que pudesse dar apoio na rotina do dia-a-dia;

(ii) o estabelecimento de contacto com a polícia de proximidade da zona de residência, procurando um interlocutor privilegiado e considerando-se a possibilidade de apresentação de queixa-crime e remoção do filho e companheira da habitação;

(iii) a marcação de atendimento jurídico para esclarecer questões legais e orientar em termos de proteção financeira, através de um plano de apoio de gestão financeira com o gestor de caso e com um elemento de confiança da rede social;

(iv) a criação de um plano de segurança que pode ter, como suporte, os vizinhos e a sobrinha;

(v) a promoção de um aumento dos contactos sociais, nomeadamente através de organizações de voluntariado que providenciam acompanhamento e visitas domiciliárias;

(vi) o desenvolvimento de um plano de intervenção com o filho e com a companheira deste.

O aconselhamento psicológico individual deverá ser continuado e o psicólogo, enquanto gestor de caso, deverá trabalhar com a pessoa idosa o planeamento da sua intervenção. Num primeiro momento, e dado o incremento da violência física, deve ser elaborado com Arminda um plano de segurança, utilizando a rede de suporte social de que ela dispõe. A intervenção jurídico-legal, nomeadamente com a apresentação de uma queixa-crime, poderia "solucionar" a vitimação, mas será de difícil aceitação por parte de Arminda. Contudo, o estabelecimento de um contacto privilegiado poderia facilitar a comunicação futura com as autoridades competentes. No imediato, o reforço de contactos sociais, seria outra forma de diminuir a vulnerabilidade de Arminda. O desenvolvimento de um apoio de gestão financeira poderá também ser efetuado, recorrendo a apoio especializado.

Intervenção

A intervenção deve, em primeiro lugar, responder às necessidades de saúde física e mental da pessoa idosa (Anetzberger, 2004, 2005). Em segundo lugar, deve garantir a segurança da vítima, procedimento que requer trabalhar com a própria vítima para identificar formas de esta permanecer em segurança nas particulares circunstâncias do seu contexto de vida (Silverman & Hudson, 2000, Hirsch, Stratton, & Loewyn, 1999; citados por Anetzberger, 2004). Nem sempre as vítimas optarão por tomar as medidas que, do ponto de vista do profissional, serão as mais adequadas. Respeitar os desejos de uma vítima (a não ser que aquela não tenha competência, por incapacidade física ou cognitiva), é parte do terceiro grande objetivo: *empowerment*. A intervenção deve ajudar as vítimas a recuperar um sentimento de autoeficácia e de controlo que possam ter sido diminuídos pela experiência de maus-tratos (Brandl, 2000). Trata-se de facilitar o *empowerment* das vítimas, o que implica também a renúncia, por parte dos profissionais, a tomarem decisões pelas vítimas e respeitarem as suas escolhas (Quinn & Tomita, 1997), o que no caso da população idosa deve ser particularmente combatido dadas as representações sociais tidas em relação aos mais velhos sobre a sua capacidade de decisão, secundarizando-se, com frequência, a sua efetiva competência enquanto adultos. Em quarto lugar, a intervenção deve servir para aliviar as causas subjacentes

aos maus-tratos, o que implica também uma intervenção global considerando a vítima, o agressor e a sua relação (Aravanis et al., 1993).

O modelo de gestão de casos assume que as diferentes etapas que o constituem não são sequenciais. Assim, o segundo atendimento com Arminda equivale, não só à continuação do desenvolvimento do planeamento da intervenção, como à intervenção propriamente dita (Anetzberger, 2004, 2005). Avançando-se com esta linha de raciocínio, no segundo atendimento, o profissional continua a explorar a situação de vitimação e a trabalhar as estratégias cognitivas utilizadas por Arminda para lidar com a sua situação, nomeadamente a minimização dos maus-tratos físicos e a racionalização de que a violência se deve à companheira ou ao facto do filho "*andar abatido e estar desempregado*". Apesar de Arminda reconhecer, em parte, a situação de vitimação, continua a mostrar-se resistente a uma intervenção que implique o filho ou a companheira deste e que passe por qualquer estratégia jurídico-legal. O reconhecimento da ambivalência de Arminda e a validação de sentimentos contraditórios é essencial por parte do profissional ("*Não gosta desta situação, de ter o seu filho ou a companheira a tratarem-na desta forma, mas também não quer que este tenha problemas com a polícia*"). A expressão e gestão dos sentimentos de Arminda pode, por si só, permitir a diminuição da tensão e constituir um dos objetivos da intervenção, mas pode ainda promover a confiança na relação entre gestor de caso e utente e, deste modo, criar abertura para a intervenção. O profissional decide então trabalhar com Arminda o plano de intervenção delineado, acautelando promessas ou referências excessivas de otimismo ("*Se concordar, podemos então pensar os dois em formas de procurar melhorar a sua situação em casa*"; "*Mesmo que não consigamos melhorar as coisas de imediato, podemos tentar e ir decidindo com o tempo*"). Se as afirmações pessimistas podem aumentar a resistência da pessoa idosa, as afirmações otimistas podem contribuir para a manutenção de um pensamento "mágico" de que os maus-tratos irão desaparecer por si mesmos (Quinn & Tomita, 1997). O equilíbrio é essencial para que a pessoa não se sinta pressionada, nem crie expectativas irrealistas sobre a solução da sua situação.

Do planeamento elaborado pelo profissional, Arminda aceita que, para além da continuação do acompanhamento psicológico, se desenvolva um plano de segurança pessoal com suporte no casal de vizinhos e na sobrinha. Concretamente é também pedida autorização a Arminda para se efetuar um atendimento com a sobrinha, dado a proximidade e confiança que Arminda deposita nela. Esse contacto permite perceber que a sobrinha constitui uma outra possibilidade para a intervenção, já que explicita o desejo de receber a tia em sua casa. A sobrinha vive sozinha (nunca foi casada) e foi criada por

Arminda, dado o falecimento da mãe com 8 anos - Arminda é tida pela sobrinha como uma segunda mãe. Contudo, e por se encontrar bastante longe da zona de residência de Arminda, esta opção não é bem aceite, mantendo-se apenas a possibilidade dessa mudança de residência, se tal for necessário. Após esse contacto, o profissional acompanha Arminda ao atendimento jurídico, para que esta se possa informar dos mecanismos legais, nomeadamente em termos do controlo e gestão financeira. Arminda recusa qualquer tipo de intervenção que possa ter consequências legais para o filho e a companheira deste, ou que leve ao reconhecimento social da sua situação ("*Mas já viu a vergonha que é, as pessoas a verem o meu filho ser chamado à atenção, que toda a gente lá me conhece, não é*").

A intervenção é desenvolvida ao longo de 3 meses e ao longo do acompanhamento psicológico (10 sessões) o profissional vai trabalhando com Arminda o reconhecimento da vitimação (e o facto de ser inaceitável a situação) e os sentimentos de culpa ("*Eles não têm direito de a insultar dessa forma, ninguém merece ser vítima de maus-tratos*"), permitindo que ela verbalize isso mesmo já não justificando a vitimação pela situação pessoal e profissional do filho: "*Ele não tem direito de me culpar de coisas em que eu não posso fazer nada* [referindo-se ao desemprego]". São também trabalhados os incidentes precipitantes dos maus-tratos (sobretudo no caso dos maus-tratos físicos) e discutidos novos comportamentos e um plano no caso de incidentes semelhantes ocorrerem. Os vizinhos foram incluídos neste plano, estabelecendo-se como um local seguro no caso de Arminda sentir necessidade de sair de casa.

Inicialmente, Arminda reconhece a necessidade de se proteger a nível financeiro e, após o atendimento jurídico, decide que irá retirar o nome do filho da sua conta e elaborar um plano de gestão que lhe permita contratar uma empregada para dar apoio no seu dia-a-dia. Porém, na sessão seguinte, refere já não ter intenção por considerar que tal comportamento seria uma afronta para o seu filho. Dadas as restrições financeiras impostas por este, o profissional entra em contacto com o centro de apoio domiciliário, que passará também a dar apoio a Arminda ao nível de higiene. Posteriormente contacta-se também uma organização que tem como voluntariado contactos sociais com pessoas idosas.

À medida que se vão desenvolvendo as sessões de apoio psicológico, Arminda refere sentir-se mais apoiada, protegida e capaz de gerir os conflitos, tanto com o filho como com a sua companheira. Ainda que não se tenham registado novos incidentes de maus-tratos físicos, os maus-tratos psicológicos permanecem ainda com menor frequência e severidade. O acompanhamento é cessado por opção de Arminda. O profissional

demonstra disponibilidade para futuros contactos e relembra a possibilidade de ter de pensar noutra solução se a vitimação se mantiver, o que Arminda parece reconhecer ("*Também não quero ficar aonde não me querem*"; "*que eu amo o meu filho, amo mais que tudo, mas também não consigo aguentar com ele todo desvairado*"). Num contato de acompanhamento cerca de três meses mais tarde, Arminda relata um ambiente menos conflituoso. Refere, no entanto, um episódio de agressão física, a partir do qual passou a deslocar-se ao fim-de-semana para casa da sobrinha (de sexta a segunda-feira), dado que é nesses dias que passa mais tempo sozinha e com o filho e a companheira.

O quadro 2 provê uma sistematização das etapas de intervenção no modelo de gestão de casos, evidenciando os objetivos, áreas de intervenção e métodos a considerar para cada uma delas.

Follow-up

O objetivo primordial do follow-up é a avaliação da eficácia da intervenção, re-avaliação das necessidades e monitorização para a prevenção da reincidência dos maus-tratos. Os maus-tratos a pessoas idosas e os seus efeitos, tipicamente, não cessam rápida ou facilmente, obrigando a um compromisso para a mudança por parte da vítima ou perpetrador. Ainda que o ritmo e o grau de mudança possam não coincidir com as expectativas do profissional, este deve sempre ter em conta e respeitar o ritmo de desenvolvimento do cliente que acompanha. Anetzberger e Miller (1999; citados por Anetzberger, 2004) sugerem alguns princípios que devem orientar todos profissionais que intervêm nos maus-tratos a pessoas idosas: primado da liberdade sob a segurança; autodeterminação; participação no processo de tomada de decisões; apresentação de alternativas menos restritivas; primazia da confidencialidade; benefício da dúvida; não efetuar dano; evitar a culpabilização e manutenção da família.

Quadro 2. Síntese das etapas de intervenção no modelo de gestão de casos

	Objetivo	Áreas	Métodos
Avaliação	Recolher informação	▪ Problemas de saúde física (estado cognitivo e mental e incapacidade) ▪ Finanças e contextos de vida ▪ Crises recentes pessoais ou familiares ▪ Recursos sociais ▪ Natureza pré e pós maus-tratos	▪ Observação ▪ Entrevistas ▪ Grelhas de observação ▪ Inventários ▪ Escalas
Planeamento	Desenvolver um curso de ação	▪ Necessidade de assistência à vítima ▪ Listagem dos recursos e apoios ▪ Definição da prioridade desses apoios e recursos	▪ Estabelecimento de protocolos e comunicação com elementos da rede social informal e formal ▪ Contacto com especialistas de áreas específicas
Intervenção	Tratar consequências e prevenir a ocorrência	▪ Sáude física e mental ▪ Segurança ▪ *Empowerment* ▪ Aliviar as causas subjacentes	▪ Aconselhamento/ intervenção psicológica ▪ Integração em grupos de autoajuda ▪ Cuidado médico ▪ Legal e financeiro (por exemplo, designação de um procurador) ▪ Habitação (por exemplo, acolhimento familiar temporário e apoio na reparação da habitação) Apoio social (por exemplo, centro de dia e apoio domiciliário) ▪ Emergência (por exemplo, suporte financeiro temporário e casas de abrigo) ▪ …

Fontes: Anetzberger, 2004, 2005; Quinn & Tomita, 1997

Conclusão

O modelo de gestão de casos permite uma abordagem holística a um problema complexo e multidimensional, considerando as necessidades da pessoa idosa e o seu papel ativo em todo o processo (Straka & Montminy, 2006; Vladescu et al., 2008). Constitui uma abordagem que providencia um alargado leque de estratégias de intervenção, muitas retiradas e utilizadas noutros modelos (Straka & Montminy, 2006; Vladescu et al., 2008), e que exige profissionais altamente especializados e sensíveis às especificidades da

população idosa. Adicionalmente, assenta numa abordagem centrada no cliente, o que pode ser mais ajustado e mais eficaz em pessoas idosas mais autónomas e sem incapacidade, apesar de não ser necessariamente desadequado noutras situações conquanto o primado da segurança se possa sobrepor ao primado da autonomia (Straka & Montminy, 2006; Vladescu et al., 2008). Tratando-se de uma abordagem integrativa quanto aos objetivos, áreas de intervenção e metodologias que incorpora, e que pode ser considerada em diferentes contextos e desenvolvida por profissionais de diferentes disciplinas, reunindo, por isso, algum virtuosismo interventivo, é no entanto, de ressalvar que continuam a faltar estudos sobre a sua eficácia, designadamente da intervenção psicoterapêutica. É essencial, assim, que se desenvolva investigação sobre boas práticas, avaliando os resultados das diferentes estratégias e técnicas que o modelo utiliza.

O caso prático apresentado focando-se numa pessoa idosa autónoma e com capacidade de decisão representa apenas uma das várias situações possíveis que se podem apresentar quando nos referimos aos maus-tratos e negligência com pessoas idosas. Pretendeu-se representar a dificuldade de intervir num tipo de situação em que a relação entre vítima e agressor assenta num laço afetivo muito importante, o qual, por sua vez, está enquadrado em crenças e normas de papéis sociais, como será a obrigatoriedade parental de cuidar dos filhos. O reconhecimento das dinâmicas dos maus-tratos e negligência de pessoas idosas, mas também do contexto onde esta ocorre, poderá aumentar a dificuldade de desenvolvimento de uma intervenção, mas certamente permitirá a criação de intervenções mais compreensivas e, desejavelmente, mais eficazes.

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Part 3 – General discussion and conclusion

General discussion

We began this thesis by describing the current difficulties within the elder abuse research field and how conceptual developments have been constrained by the problems of the compound nature of the phenomenon. Elder abuse is a multidimensional construct and several dimensions can and should be used to describe, characterise and explain the wide range of victimisation experiences. When combined the different dimensions (e.g., relationship with the perpetrator; type of abuse; setting; victims characteristics) may allow for a more complex picture of the problem, whereas their relevance may be distinct depending on the specific elder abuse configurations.

The overarching goal of the thesis presented herein was to investigate elder abuse multidimensionality. We set out to examine how to capture the interaction of different dimensions and to describe it within community-dwelling elder abuse. To that end, we conducted six studies using data from two elder abuse surveys of the "Ageing and Violence" project (Gil, Kislaya, et al., 2015; Gil, Santos, & Kislaya, 2015).

The first study focused on family conflictual relationships and psychological abuse as a possible continuum rather than as a dichotomous variable (Chapter IV – *Psychological elder abuse: measuring severity levels or potential family conflicts?*). We tried to assess how two different psychological elder abuse threshold measures affected the prevalence, appointed perpetrators, and correlates.

The following two studies focused on depressive symptoms (Chapter V). One regarded the psychometric analysis of short versions of the Geriatric Depression Scale, which was used to evaluate the presence of depressive symptoms (*Estudo de validação em Portugal de duas versões reduzidas da Escala de Depressão Geriátrica* [Portuguese validation study of two short versions of the Geriatric Depression Scale]). The other study analysed whether the type of relationship with the perpetrator, the types of abuse, the number of abuse occurrences in addition to the victims' characteristics were related to the depressive symptoms (*Exploring the Correlates to Depression in Elder Abuse Victims: Abusive Experience or Individual Characteristics?*). By focusing on both victims' characteristics and other elder abuse dimensions (e.g., perpetrators, abuse type and number of abuse occurrences) it was possible to explore depressive symptoms as both risk factor and consequence.

The fourth study examined the emotional reactions, as an outcome of elder abuse, and the association to some of the elder abuse dimensions (Chapter VI – *Older adults' emotional reactions to elder abuse: individual and victimisation determinants*). The type of relationship with the perpetrator, the types of abuse, the abuse severity and the victims' characteristics were assessed in the evoked emotions elicited by victims of elder abuse.

To depict elder abuse multidimensionality, we further conducted two studies (Chapter VII). One sought to explore configurations of victimisation experiences by analysing both abusive behaviours and the relationship with the appointed perpetrators (*From appointed perpetrators and abusive behaviours to victimisation patterns: new approaches to elder abuse typologies using two cross-sectional surveys*). In this fifth study we evaluated whether the combination of these two dimensions could represent and distinguish different victimisation configurations. The sixth and last empirical study with a qualitative approach, focused on the victims' narratives considering abuse perpetrated by spouses or partners, by children and grandchildren, and by elements outside the nuclear family (*Personal stories within elder abuse: betrayed trust in a vulnerable age and abusive bonds that just grown old*). Victims' narratives of three victim-perpetrator dyads were analysed to understand patterns, differences and similarities in the history of abuse and the respective process of ageing.

We reflect on the interventions that have been developed to respond to elder abuse victims in the last published text (Chapter VIII - *Maus Tratos e Negligência da Pessoa Idosa: Modelos Teóricos e Intervenção* [Mistreatment and neglect against older adults: theoretical models and intervention]). It highlights the approaches that can better embrace elder abuse's complex nature.

In the upcoming pages we will discuss how research can incorporate elder abuse multidimensionality by considering the main dimensions evidenced by this thesis findings; we will also focus how they relate to distinct elder abuse configurations. Finally, we will present some potential venues for intervention.

The relevance of multidimensionality for elder abuse configurations

The issue of elder abuse has not yet emerged as a major theme in research and lacks appropriate theoretical and conceptual clarity (de Donder et al., 2011). Despite the increasing number of research and published studies since 2000 showing interdisciplinary efforts to identify the victims, causes of abuse, and interventions (Daly, Merchant, & Jogerst, 2011), findings are still sometimes complex and contradictory (Goergen & Beaulieu, 2013; Lachs & Pillemer, 2004; Pillemer, Burnes, Riffin, & Lachs, 2016). In addition to studies being conducted in different settings, with varying types and definitions, as well as methodologies (Cooper, Selwood, & Livingston, 2008; de Donder et al., 2011; Gil, Kislaya, et al., 2015), the multi-facets of the problem hinder evidence-based development.

The need to undertake an evidence-informed approach in tackling the problem has been expressed by the World Health Organization (2011), and it implies acknowledging elder abuse as a result of the interplay of different dimensions. Two main approaches can be employed to account for multidimensionality in elder abuse research. On the one hand, rather than focusing on the overall construct, research efforts can aim at analysing specific victimisation experiences and assess prevalence, associated factors and the dyad victim-perpetrator for those specific configurations. For instance, notable differences between neglect or financial abuse and other interpersonal forms of abuse (e.g., psychological, physical and sexual) have stemmed the development of specific studies for those types of abuse (Gassoumis, Navarro, & Wilber, 2015; Jackson, 2016a; Lowenstein, 2010; Macassa et al., 2013; Speck et al., 2014). Research can also attempt to evaluate the impact of different dimensions on elder abuse experiences. This can be accomplished, for instance, by analysing and comparing dynamics of different victim-perpetrator dyads for each abuse type. Regarding this matter several studies have shown differences in victims' individual risk factors, case characteristics, interpersonal dynamics, and outcomes across distinct types of elder abuse (Jackson, 2016b; Pillemer et al., 2016).

In this thesis, we sought to capture elder abuse multidimensionality by assessing the impact of distinct dimensions on elder abuse, while also focusing on specific abuse types. The empirical studies conducted show that cross-sectional studies can capture the interplay of several dimensions either by describing outcomes considering distinct levels of the same dimension (e.g., impact of two frequency measures of psychological abuse for prevalence, perpetrators or correlates), or by identifying differences and similarities in elder abuse outcomes (e.g., depressive symptoms as risk factor or consequence and the evoked emotional reactions).

The use of binary measures and univariate outcomes (abuse yes/abuse no) is understandable to develop effective prevention and intervention strategies, considering the need to establish incidence/prevalence rates, define risk, define protective factors and consequences. Binary measures, however, reduce the variation range and depth of elder abuse configurations into over-simplified terms (Burnes, Pillemer, & Lachs, 2017). Given that elder abuse results from the complex interaction of individual, relationship, social, cultural and environmental factors (World Health Organization, 2011), outcome measures that do not accurately reflect the true nature of the latent phenomenon might generate invalid indicators.

Elder abuse can assume distinct presentations and be categorised within different dimensions. For instance, we can distinguish settings, impaired and non-impaired victims,

abuse types, victim-perpetrator bonds, or severity of abuse occurrences. The combination of all the dimensions results in specific elder abuse configurations. According to the conducted studies, three dimensions were found to be particularly relevant: severity, the victim-perpetrator dyad, and the abuse types and behaviours.

Severity

The first study described the effect of applying two different psychological elder abuse measures to prevalence rates, appointed perpetrators and correlates (Chapter IV – *Psychological elder abuse: measuring severity levels or potential family conflicts?*). The frequency criterion that differentiated the two measures revealed variation, particularly for one of the three abusive behaviours. Findings suggest that including frequency in a psychological abuse measure separates mild from more frequent and severe forms of abuse. Results also point to differences between abusive behaviours considered within the broader category of psychological abuse.

In the study addressing depressive symptoms, of all the abuse characteristics evaluated only the number of occurrences correlated to screening positive (Chapter V - *Exploring the Correlates to Depression in Elder Abuse Victims: Abusive Experience or Individual Characteristics?*). These results suggest that depressive symptoms are possibly better accounted as a risk factor. Despite the number of occurrences increasing the likelihood of presenting depressive symptoms, the association with individual characteristic links it to non-abuse individual and contextual aspects that overall increase vulnerability of specific subgroups within older adults' population not only to abuse, but to psychological well-being.

Both these studies highlighted indicators of abuse severity, namely, intensity (frequency) and density (number of occurrences). Bennett and Kingston (1993, p. 13) suggested taking into account the combination of density and intensity, resulting in a "severity" level that could represent the potential degree of danger for the older adult. The authors indicate that not only is the type of abusive act important but also the severity of its occurrence. Severity is acknowledged as a relevant clinical dimension, with practical applicability for professionals working with older adult victims (Burnes, Pillemer, et al., 2017). Deciding the priority of services to provide and the urgency needed requires also assessing how severe the victimisation at hand is. Some authors have in addition take on severity as a dimension that may more accurately represent the phenomenon (Burnes, Pillemer, et al., 2017; Conrad et al., 2011). Bonnie and Wallace (National Research Council, 2003) suggest most abusive behaviours be analysed as dimensional variables, since they fall along a continuum in terms of frequency, intensity and severity.

Some studies focusing on severity have identified risk factors and prevalence from samples of population-based studies (Burnes, Pillemer, et al., 2017; Conrad et al., 2011; Donder et al., 2016). Burnes and colleagues found variation of severity across abuse types, with psychological abuse and neglect presenting the higher severity levels, in comparison to physical abuse (Burnes, Pillemer, et al., 2017). The authors add that experts generally weight physical abuse with greater clinical significance. Based on the study of psychological abuse measures (Chapter IV – *Psychological elder abuse: measuring severity levels or potential family conflicts?*), we would further argue that some abusive behaviours within the same type can be more serious than others. Despite severity being one of the dimensions that might help to conceptualise elder abuse and to understand differences and similarities between distinct elder abuse configurations, it must be considered along other dimensions.

The dyad victim-perpetrator

The type of bond between victim-perpetrator was one of the most significant dimensions to emerge in the empirical studies mentioned. The examination of emotional reactions, considering both individual and abuse characteristics (e.g., abuse type, polyvictimisation, severity and perpetrator), revealed that within all the assessed dimensions, the relationship with the perpetrator was one of the most meaningful aspects to differentiate them (Chapter VI – *Older adults' emotional reactions to elder abuse: individual and victimisation determinants*). The proportion of older victims reporting fear, sadness and shame (the main evoked emotions) was more similar for older adults victimised by spouses or partners and individuals outside the nuclear family, than for individuals who reported abuse perpetrated by children or grandchildren. The type of relationship between victim-perpetrator was also one of the two dimensions considered in the analysis of the victimisation configurations of two elder abuse surveys using Latent Class Analysis (Chapter VII - *From appointed perpetrators and abusive behaviours to victimisation patterns: new approaches to elder abuse typologies using two cross-sectional surveys*). The study results show that specific abusive behaviours and the relationship with the perpetrator may distinguish victimisation experiences associated with different victims' characteristics. A clear distinction is made between abusive behaviours perpetrated by spouses/partners, children/grandchildren or individuals outside the nuclear family. Furthermore, the two samples suggest that elder abuse victims seeking help and individuals included in population-based studies of elder abuse prevalence may represent quite distinct groups.

The final empirical study looked into victims' abuse history narratives grouped in three categories: victims of spousal abuse; victims of abuse perpetrated by offspring, and victims of individuals outside the nuclear family (Chapter VII - *Personal stories within elder abuse: betrayed trust in a vulnerable age and abusive bonds that just grown old*). Narratives shared parallels and differences. For the most part victims felt the relationship with the perpetrator was difficulty with appointed conflicts prior to the beginning of abuse. Dependency emerged as an important theme in abuse within the family. However, victims abused by their offspring and intimate partner revealed two opposite perspectives. The former revealed perpetrators to be highly dependent on them for financial and instrumental support, whereas in the latter group, victims were mostly dependent of perpetrators. Elder abuse perpetrated by individuals outside the nuclear family was heterogeneous; it presented features like elder abuse within the family (especially when perpetrated by other relatives), but for the most part, the pattern was not so severe.

These results shed insight on the relevance and nature of distinct types of relationship between the older adult and abusive individuals for elder abuse configuration. Elder abuse has tended to focus on either victims or perpetrators, failing to take into consideration that both, throughout their relationship (prior to, and within elder abuse), play a role in elder abuse occurrence (Jackson & Hafemeister, 2013; Schiamberg & Gans, 2000). Given that differences in the relationship`s nature presuppose different dynamics, "it is reasonable to assume that the factors precipitating marital violence among the elderly will differ, at least in part, from those precipitating adult children's abuse their elderly parents" (Pillemer & Suitor, 1988, p. 261).

Abuse types and behaviours

Abuse types are a classical typology in elder abuse research as it usually acknowledges five distinct categories: psychological, physical, financial and sexual abuse and neglect (Pillemer et al., 2016). However, there may be significant differences in what concerns the specificities of abusive behaviours encompassed in each type. Furthermore, part of the victimisations' experiences within elder abuse includes the co-occurrence of different abuse types.

Results from the study focusing on psychological elder abuse suggest that "threats" might be more serious, even though less frequent, than "ignore or refuse to talk" or "verbal aggression" (Chapter IV). The impact and effect of the abusive behaviour on the victim has taken some authors to apply the frequency criterion only to some items of psychological abusive behaviours, excluding threats (Conrad, Iris, & Ridings, 2009; Lachs et al., 2011).

Data from the application of the Latent Class Analysis to elder abuse configurations showed differences by perpetrator, but also by abusive behaviours (Chapter VII). Differences were found regarding the relevance of abusive behaviours to the classes' distinction, pointing out that some abusive behaviours committed by specific perpetrators might better distinguish elder abuse configurations. In the population-based survey, the two abusive behaviours perpetrated by individuals outside the nuclear family were the most distinctive items, grouped in two classes: "overlooked by others" (*ignoring or refusing to talk*) and "stolen by others" (*stealing*). *Threatening* was the next behaviour to distinguish Intimate Partner Violence (IPV) groups. The abusive behaviours that resulted in the least distinctive items were *hindering of speaking or meeting someone* and *undue household appropriation*. In the victims' survey, *verbal aggression* by spouses or partners (in the class "physical and psychological IPV"), by offspring (in the class "physical and psychological by children") or by individuals outside the nuclear family (in the class "polyvictimisation by others") was the most distinctive item from all the abusive behaviour items. It was followed by *physical aggression* committed by spouses or partners (in the class "physical IPV"), by offspring (in the class "physical by children") or by individuals outside the nuclear family (in the class "physical abuse by others"). The abusive behaviours that came across as the least distinctive were *hindering of speaking or meeting someone*, *ignoring or refusing to talk* and *undue household appropriation.* These results suggest that some abusive behaviours and victims-perpetrators dyads may be more common. While interpersonal abuse (such as physical and verbal aggression) is a common abuse behaviour within victimisations experienced either by spouses/partners or offspring, stealing is probably better accounted by perpetrators outside the nuclear family.

Overall, the findings stress elder abuse multidimensionality and variability across severity levels, victim-perpetrator dyads, and abusive behaviours. Available evidence suggests that prevalence, risk and protective factors, and the type of relationship between victim and perpetrators vary across abuse types and behaviours (Jackson & Hafemeister, 2014) and severity levels (Burnes, Pillemer, et al., 2017). Furthermore, differences have also been found in victims' appraisals of abuse seriousness according to their own characteristics, as well as according to that of the perpetrator and context (Burnes, Lachs, Burnette, & Pillemer, 2017). It is, therefore, unlikely that one single theoretical perspective will suffice in accounting for every configuration of elder abuse. This implies that "a variety of different conceptual frameworks and explanations will be necessary to develop a theoretical model that accounts for specific but different phenomena that constitute the continuum as a whole." (Penhale, 2010, p. 241).

Multidimensionality and responses to elder abuse in community settings

Results from the empirical studies point out to elder abuse configurations that are distinguishable according to perpetrators, abuse behaviours and severity patterns. We assume elder abuse as a continuum rather than as a restricted or separated phenomenon, where cases are not represented as mutually exclusive categories. However, some of these configurations may be more commonly found and deserve notice. In addition, according to our results, some elder abuse dimensions outweigh others. This is the case of the relationship established between the victim and the perpetrator, which seems to be the most relevant dimension to the description and characterization of the problem. Severity may well be a distinctive feature of these configurations, in addition to specific abusive behaviours.

Even though some dimensions of elder abuse are more relevant than others in distinguishing elder abuse experiences, some victimisation configurations may share more similarities than differences between them. Elder abuse of community-dwelling older adults can be first classified as within or outside the nuclear family, and both spouses/partners and offspring can perpetrate family violence against older adults. Abuse that occurs in these relationships is usually characterised by interpersonal abuse, such as psychological and/or physical. However, even within such configurations there might be markedly different patterns and dynamics. For instance, financial abuse appears to be more commonly perpetrated within adult and adult child abusive relationships. Also, a very wide range of severity patterns can describe different victimisation experiences. As for abuse perpetrated by individuals outside the nuclear family, despite the heterogeneous configurations it may render, it is within financial abuse that a most distinctive configuration seems to appear. In the following pages we present four possible elder abuse configurations, based on the empirical work of this thesis and supported by other research findings: (i) *Intimate Partner Violence (IPV) grown old vs. with late onset*; (ii) *Longstanding interpersonal abuse by offspring*; (iii) *Psychological abuse by the nuclear family* and (iv) *Financial abuse by individuals outside the nuclear family*. Possible implications of these elder abuse configurations for intervention are discussed after their brief synthesis exposition.

Intimate Partner Violence (IPV) grown old vs. with late onset

Because this configuration resembles domestic violence in younger ages, it hasn't been yet established an agreement as to consider it as a subset of elder abuse or a specific form of domestic violence (Brandl & Raymond, 1997; Penhale, 2003). IPV grown old describes older victims in an on-going relationship with an abusive spouse or partner, and in this sense, abuse has started earlier in life and persists into old age (Phillips, 1983). Victims experience physical and psychological abusive behaviours, such as being hit, grabbed, pushed, threatened, intimidated, or isolated, among others.

Research of IPV in younger age groups shows that most often than not various abusive behaviours and abuse types coexist, including controlling behaviour (Band-Winterstein, 2013; Bonomi et al., 2007; Hellemans, Loeys, Buysse, & De Smet, 2015; Lee, Yang, Wang, Huang, & Chang, 2015). Our results suggest that threatening may be particularly frequent among this type of relationship, compared to elder abuse perpetrated by offspring. Sexual coercion and rape are also commonly found in IPV at younger ages (Hellemans et al., 2015; Lee et al., 2015; Walsh et al., 2007). Financial abuse (such as theft and undue household appropriation) does not seem to be commonly reported within this subset of elder abuse, even though controlling household financial resources is a commonly perpetrated behaviour.

As expected, abuse duration seems to be longer in older age groups when compared to younger ones with distinct patterns of severity through the years (Wilke & Vinton, 2005). Some studies report a decrease of the likelihood of spousal or partner victimisation with increased age (Brozowski & Hall, 2004; Rennison & Rand, 2003; Zink, Fisher, Regan, & Pabst, 2005). Differences however seem to be related with types of abuse: while psychological abuse tends to grow over time, physical and sexual abuse may decline within older age groups (Poole & Rietschlin, 2012; Rennison & Rand, 2003).

This subset of elder abuse is likely to affect younger old adults. The victims in these cases are more likely to be women in the youngest old age groups, because of the differential mortality rate, which make widowers more prevalent (Penhale, 2003). Research, however, indicates that the victims' gender depends on the type of abuse (Joosten, Vrantsidis, & Dow, 2017; Lowenstein, 2009; Pillemer et al., 2016). Abuse often takes place within the couple's house making cohabitation an important risk factor. The victims may present poor emotional health but be relatively independent in activities of daily living.

IPV with late onset describes abuse that begins in old age. This may occur within a longstanding relationship where an already strained relationship resulted in abuse or be

representing older people who have entered into abusive relationships late in life (e.g. the perpetrators being new spouses or intimate partners).

Abuse that occurs within a new relationship that started after old age possibly presents similar features to IPV grown old. Some studies have found second marriages in older age to be associated with conflicts and victimisation (Zink, Jacobson, Pabst, Regan, & Fisher, 2006). However, the results of one empirical study (Chapter VII - *Personal stories within elder abuse: betrayed trust in a vulnerable age and abusive bonds that just grown old*) presented also a possible distinct feature, where an older widowed woman contracted marriage and was later victim of a financial fraud from the current husband and stepdaughter. This case alerts to the possibility of undue influence, a particular aspect that also relates to vulnerability in older age (Brandl, Heisler, & Stiegel, 2005). Undue influence is often used to commit financial abuse and occurs when people use their role and power to exploit the trust, dependency, and fear of others, and gain control over the decision-making of their victim (Brandl et al., 2005).

Another type of cases encompasses the beginning of abuse in old age in a non-abusive long-time relationship. Among the situational factors that can lead to abuse between spouses, some studies suggest retirement, changing roles of family members (Hightower, Smith, & Hightower, 2006; Montminy & Straka, 2006), worsening of physical health and needing help with basic care (Hightower et al., 2006; Podnieks, 1993; Pritchard, 2000; Wolf & Pillemer, 1989). These may be heightened by loneliness, inadequate social and emotional support, isolation and lack of community resources (Podnieks, 1993; Pritchard, 2000). Another possibility is the reverse of an abusive situation, and a woman who experienced abuse from a man at an earlier point in their family's history may become the perpetrator (Kinnear & Graycar, 1999). These cases may include psychological and physical abuse from a perpetrator with some sort of cognitive impairment or neglect by a caregiver with lack of knowledge or unable to provide care (Spangler & Brandl, 2007). The dynamics would be quite dissimilar to those present within IPV grown old.

Possible venues for intervention. In overall, IPV dynamics might not present, for the most part, a unique feature within older age adults and probably have consistent similarities to IPV in younger age groups. In fact, researchers and practitioners have recognised that the dynamics of abuse in later life are often very similar, in many cases, to those experienced by younger battered women (Pillemer & Finkelhor, 1988; Podnieks, 1993; Wolf, 1998). For IPV grown old, part of the cases can be conceptualized within the lens of the feminist and domestic violence perspective, where family violence is described as being associated with circumstances of power imbalance (Penhale, 2003). The "Power and control

dynamics" refers to a pattern of tactics employed by the abuser to gain and maintain compliance of the victim (Spangler & Brandl, 2007). Abusers' thinking patterns lead them to believe their needs and wants are more important than others in their lives are, and that they can use any method necessary to obtain what is necessary to fulfil them (Spangler & Brandl, 2007).

Efficient domestic violence resources already in place would therefore be adequate to approach this subset of elder abuse cases. These interventions include twenty-four-hour crisis lines, emergency shelters, legal advocacy programs, support groups and counselling services (Brandl, 2000). Usually the interventions developed within the domestic violence framework consist of providing safety support and empowerment to the victims and holding the perpetrators accountable (Brandl & Raymond, 1997).

However, abused older women - and men - are different from the younger group on several aspects, which has important implications for their ability to be helped by existing domestic violence resources (Montminy & Straka, 2006). The services usually target younger age victims and may not properly translate to older adults, and to older women in particular, given that these victims have most probably been socialized with traditional attitudes and values, particularly relating to gender roles, marriage, and family (Montminy & Straka, 2006). Women were taught to be submissive, to respect the privacy on family matters, and to sustain religious traditional values (Rennison & Rand, 2003; Wilke & Vinton, 2005; Zink et al., 2005). It is important that the services provided consider these specificities.

In addition, information and support is key within the empowerment model, since abusers often give victims inaccurate information about what will happen if they decided to end the relationship (Brandl, 2000). This is particularly relevant within the older age groups. On one hand, older women tend to have less knowledge about services for abuse victims and greater difficulties in acceding them (Pritchard, 2000; Wilke & Vinton, 2005). On the other hand, some older abused women have no formal education and are more economically vulnerable and more likely to be financially dependent on their abusers than younger women (Band-Winterstein, 2015; Hightower, Smith, Ward-Hall, & Hightower, 2000). Legal and financial advocacy programs may help victims to reach a decision (Brandl, 2000; Brandl & Raymond, 1997) and are very important for older women who have been financially dependent on the husband or partner for most, if not all, of their lives.

Economic problems often observed in older women who are victims of abuse can be exacerbated during old age and have further impact by the lack of employment opportunities and a decreased physical ability to work (Band-Winterstein, 2015). This

aspect should also be acknowledged within shelters or safe houses. Most women's shelters offer a range of services, programming, and community outreach, but these tend not to be specifically adapted to older women, nor are most shelters physically accessible for women with disabilities (Montminy & Straka, 2006). Compared to their younger counterparts, older women may have more health problems and a smaller informal network (Wilke & Vinton, 2005). All this, in addition to being much more invested in their marriages (e.g., informal network and community for the past 40 years) may lead these victims not to view leaving their home of a lifetime as a possibility (Montminy & Straka, 2006). Responses to such situations may include providing social and health home services and increasing older people's activities outside the house (Brandl, 2000).

Situations where an aged husband is abusive toward his wife are one aspect of the large and diverse concept of IPV between older adults (Montminy & Straka, 2006). Some elder abuse between spouses and partners can encompass distinct dynamics and patterns for which the use of the domestic violence framework might be limited. Illness, disability or other related trauma may have a toll on relationships and, particularly in an already problematic relationship, these changes may deteriorate into abuse if unwanted and unexpected limitations and pressures are suddenly thrust upon a couple (Penhale, 2003). A lack of understanding and knowledge about these events may also be of relevance. In such cases, providing services (e.g., carer support, respite care), training to the family members and counselling can help to reduce family conflict and improve communication (Spangler & Brandl, 2007). The caregivers stress and new difficulties that strain the family daily livings are known to increase vulnerability to abuse but are not an explanation (Spangler & Brandl, 2007).

When employing domestic violence approaches to elder abuse it is important to consider the differences between the targeted subgroups. The cohort and generational features should be considered when developing intervention, and these include value system and beliefs, economic and financial resources, and physical and cognitive dependency and disability. But professionals continue to hold stereotypes and assumptions about domestic abuse as a phenomenon only encountered by younger adults (McGarry, Simpson, & Hinchliff-Smith, 2011). Education regarding older adults, and older women in particular, should be embedded within general domestic abuse training programmes to ensure that professionals are able to recognise and take appropriate action (McGarry et al., 2011). Domestic violence services and resources should be intertwined with ageing resources and services to properly address elder abuse cases that also can be represented as IPV (Vinton, 1999).

Longstanding interpersonal abuse by offspring

Elder abuse within the family also includes interpersonal abuse by offspring. Longstanding abuse by offspring describes recurring victimisation experiences of psychological and physical nature and, in some cases, financial abuse behaviours. Even when abuse has not been occurring for long time, the conflicted relationships may probably characterise the family interactions (Fitzpatrick & Hamill, 2010). Hence, abuse is likely to have its underpinnings in longstanding pathological family dynamics and interpersonal processes.

Some studies have indicated that conficting past relationships with the parents constitutes a risk factor for both psychological (Downes et al., 2013) and physical abuse (von Heydrich, Schiamberg, & Chee, 2012). The perpetrator is likely to live with the older adult and to be dependent on the victim for financial and instrumental support (e.g., housing, daily living, etc.). In addition, the adult child is more likely to have a history of substance or alcohol abuse, and there may be some cases of perpetrators with the history of psychopathology. On this matter, commonly identified risk factors include mental/psychiatric illness, substance abuse, a history of violence or aggression, and dependence on the older abused adult (Anetzberger, Kornin, & Austin, 1994; Fulmer, Guadagno, & Bolton, 2004; Reis & Nahmiash, 1998). Financial abuse may occur when the children feel entitled to be supported by parents who no longer can or want to provide such support. Research findings indicate that people who financially abuse the elderly are often family members, particularly adult children and grandchildren (National Center on Elder Abuse, 1998; Quinn, 2000). This type of abuse may be difficult to detect and, consequently to intervene. There may be cases where the older adult does not even recognise the abuse (Jackson & Hafemeister, 2012).

Financial abuse can include subtle behaviours such as undue household appropriation or misuse of someone's money and assets. Older adults may feel under undue influence to financially support their adult child and even feel obliged to continue to support him or her (Hightower et al., 2006; O'Donnell et al., 2012). Key characteristics and behaviours, namely substance abuse and financial dependency seem also to be strongly associated (National Research Council, 2003). Other type of cases describes offspring with mental illness, with abuse being linked to acute episodes of the illness.

Research has indicated that for some abuse types the risk factors associated with the perpetrator are more predictive of abuse than those associated with the older adult (Anetzberger, 2000). More specifically, the characteristics of the perpetrators and the quality of relationship between perpetrators and victims are more related to physical and psychological abuse than the characteristics of victims (Walsh & Yon, 2012).

Both women and men are likely to be victims in these cases, including couples that experience victimisation committed by their offspring. Data is not clear about the impact of gender in elder abuse between adult and adult child (Pillemer et al., 2016). A systematic review of risk factors related to elder abuse in community settings found no clear trend in what regards the victim's gender (Johannesen & Logiudice, 2013). It seems that while women are more likely to be victims of IPV, men are more likely to be victims of elder abuse than other forms of family violence (Pritchard, 2007).

Even though victims do not necessarily display any physical or cognitive dependency; vulnerability may be an important aspect to consider within elder abuse. Goergen and Beaulieu defined vulnerability as "an older person's exposure to situations and conditions where abuse and mistreatment can occur" (2013, p. 5). Because it pertains not only to the capacity to defend oneself, but also to one's capacity to cope with abuse, vulnerability is a very broad construct. It can be easily identifiable (e.g., by observed financial dependence and mobility impairment), but other factors, not directly accessible, can also be linked to vulnerability (Goergen & Beaulieu, 2013; National Research Council, 2003). For instance, the negative self-perception of ageing can contribute to the individuals' vulnerability. Individuals may experience difficulties in protecting their own interests due to the interaction of deficits in individual attributes (e.g., power, physical strength, emotional well-being, coping abilities) with sociocultural processes and with the cumulative effects of poor education, income and health conditions throughout life (Barbosa et al., 2017).

In the case of longstanding abusive relations between adult and adult-child it is important to recognise that even though chronological age does not equal increased vulnerability, as one gets older increasing vulnerabilities are more likely to occur. This may contribute to a shift in the patterns of the abuse or even be linked to the occurrence of abuse in already conflictive relationships (Goergen & Beaulieu, 2013). Roberto (2017) describes a frequently occurring scenario that:

> "involves an adult child who has never become completely independent from the parent because of personal (e.g., mental illness, drug dependence), relational (e.g., unable to sustain intimate relations), or financial issues (e.g., unable to maintain employment). These relationships may become abusive or violent when the older adult decline or refuses to provide money or other types of support, particularly when the dependent adult child becomes desperate" (p. 319).

Possible venues for intervention. One significant and distinct aspect featured in abusive situations perpetrated by offspring when compared to other forms of family violence is the

type of emotional bond. The ambivalent feelings of commitment, love, and anger, along with affection and pain have been recorded (Lüscher & Pillemer, 1998). The emotional and coping strategies employed by victims to deal with abuse and its consequences can be distinct and therefore require distinct responses.

Some studies have indicated that one of the reasons older adults do not report abuse by offspring is so they can protect the abuser (Jackson & Hafemeister, 2014; Luo & Waite, 2011; Nahmiash, 2004). The bond between adult and adult child also hinders the recognition of the situation and development of self-protective measures (Begle et al., 2009; Luo & Waite, 2011; Nahmiash, 2004; Spangler & Brandl, 2007). Moreover, older adults may also fear to be taken away from the house they live, be placed in an institution and loose the relationship with the perpetrator (Wolf & Pillemer, 2000); some of these situations may be characterised by an interdependency between the older person and the perpetrator (Band-Winterstein, 2015; Pickering & Rempusheski, 2014; Roberto, 2016), being that both parts know and share memories, experiences and feelings that include but are not limited to abuse (Band-Winterstein, 2015).

Separating the victim and perpetrator (e.g., long-term care placement), though an often-successful strategy within IPV might not be acceptable to most victims of abuse by offspring, even though it appears to immediately stop the abuse situation (Wolf & Pillemer, 2000). To decrease the interdependency between the two, one can address the needs of the abusive individual along with intervention to promote the victims' safety (Hwalek, Neale, Goodrich, & Quinn, 1996; Jackson & Hafemeister, 2011b; Vinton, 1991). Abuser- or dyad-centred interventions may improve outcomes by specifically addressing the abusers' problem behaviours that contribute to harmful actions, recognising that successful interventions address both parties involved (DeLiema, Yonashiro-Cho, Gassoumis, Yon, & Conrad, 2017). Attention must be given to the degree of impairment of the perpetrator, and distinct interventions should be addressed taking into account the adult-child competency and capacity.

Considering that impaired abusers often have problems such as physical and mental illness and development disabilities that have unmet needs from community support services (Ramsey-Klawsnik, 2000), treatment referral might be appropriate and help to stop abuse. Wolf and Pillemer (2000) examined the factors that led to case resolution where the case was closed because the abuse stopped and found that such cases were frequently resolved because the perpetrator was hospitalised for mental health problems. Despite some authors arguing the importance of the legal intervention and perpetrators accountability, namely within the IPV services approach (Brandl & Raymond, 1997;

Rennison & Rand, 2003; Spangler & Brandl, 2007), it is important to acknowledge that the case of an adult with schizophrenia who is abusing his or her parent will need different treatment strategies than that of an adult child that financially abuses the parents in order be able to gamble.

Various issues that increase vulnerability to abuse occurrence cannot or should not be used as explanations or excuses for the abuse (Spangler & Brandl, 2007). Hence, treatments towards substance or alcohol dependency, anger management or stress cannot alone address the situation. Nahmiash and Reis (2001) assessed the effectiveness of interventions of elder abuse and found that while for perpetrators that are caregiving dependent older adults, individual supportive counselling to reduce anxiety, stress and depression and education and training were successful strategies; interventions on substance abuse treatment programs were not so effective. Even though psychological interventions and services referral for perpetrators have been suggested to reduce stress and conflict, abuse usually ends with the removal of the perpetrator from the older adult cohabitation (Alon & Berg-Warman, 2014).

The best approach in the cases of interpersonal abuse by offspring might be combining interventions towards the perpetrators needs (employment, substance or alcohol abuse, stress, etc.), while simultaneously working with the victim to increase his/her safety. Positive outcomes could be achieved by providing alternative housing, financial support, job training, or other life skills training that could increase the abuser's independence (DeLiema et al., 2017). For older victims abused by adult children, ending the relationship may never be a real option (Spangler & Brandl, 2007). In addition, even though relocation may remove the abused person from harm's way, it does so at the cost of placement in unfamiliar surroundings and probable reduction in autonomy and disruption of social relationships (Ploeg, Fear, Hutchison, MacMillan, & Bolan, 2009). Responses that break social isolation (e.g., health and social home visits; increase of social activities and support groups), that provide referral to local agencies and promote safety planning (e.g., crisis responses) can help decrease abuse likelihood. Ongoing monitoring or support may be beneficial, even if does not end abuse altogether.

In addition to other types of intervention strategies and services already mentioned above, other set of interventions that have recently been considered to respond to elder abuse include an approach to the family system. Despite family mediation and family group conferences being relatively new in the elder abuse field, they have been successfully used with adults in other areas (Hobbs & Alonzi, 2013) and may prove to be able to properly adapt to elder abuse. Family mediation uses an impartial third-party to help

people in conflicted relationships to communicate within a supportive environment (Hobbs & Alonzi, 2013). Research suggests mediation is more successful when used earlier in a conflict, and can be better suited as a preventive measure (Bagshaw, Adams, Zannettino, & Wendt, 2015; Hobbs & Alonzi, 2013). For elder abuse in particular, more evaluation needs to be done and it needs to be recognised that family mediation may not be appropriate in situations where severe abuse is present (Bagshaw et al., 2015; Hobbs & Alonzi, 2013). Family care conferences are similar to family mediation but with a focus on supporting family collaboration rather than resolving the conflict (Hobbs & Alonzi, 2013), and similar problems might be posed to integrating the abuser in the process. Furthermore, the restorative justice model (similar to family conferences) suggests that intervention approaches help the abuser avoid future incidence of abuse as it aims to restore relationships rather than just punish the offender (Hobbs & Alonzi, 2013).

Psychological abuse by the nuclear family.

Psychological abuse of an older adult may occur isolated from other forms of abuse. In such cases, the dynamic of the relationship between victim and perpetrator is likely to be characterised by longstanding conflictive family interactions (Fitzpatrick & Hamill, 2010). Abusers include spouses, partners and offspring and abuse encompasses making the older adult afraid, blame him/her, confuse and belittle the older adult, ignore his/her pain, discount his/her feelings and minimise his/her needs (Conrad et al., 2009). Multiple behaviours may be occurring at the same time, and the severity hierarchy may vary depending on the case (Conrad et al., 2009). The threatening behaviour may correspond to higher levels of severity, where the perpetrator uses threats of violence, abandonment or nursing home placement. Psychological abuse is harder to identify than other types. The impact can be severe and unless victimised older adults also experience other types of abuse that leave observable evidence, the infliction of psychological abuse may be difficult to prove (Liu, Conrad, Beach, Iris & Schiamberg, 2017). The conceptualisation of psychological abuse within the family implies taking into account family dynamics, and since it manifests in several ways, different family members may interact differently and perceive the same behavioural act to be more or less appropriate. Likewise, the type of relationship can impact the perception on either a specific behaviour is perceived as abusive or not (Mowlam, Tennant, Dixon, & Mccreadie, 2007).

Possible venues for intervention. These cases might benefit from intervention towards the family, such as the above-mentioned family mediation and family group conferences. In addition, psychological or counselling approaches that include the family are a promising

area of prevention and intervention and should be further researched (Khanlary, Maarefvand, Biglarian, & Heravi-Karimooi, 2016). These interventions can inform and educate families about elder abuse, triggers, and techniques of conflict resolution.

Psychological interventions for older adults may also be effective, particularly if the abuse involves a child, but research evaluation results are mixed (Mariam, McClure, Robinson, & Yang, 2015). Motivational interviewing has proved to be an effective component of an elder abuse intervention, particularly allowing older people to overcome or address their ambivalence and become empowered to make decisions about their situation (Mariam et al., 2015; Tetterton & Farnsworth, 2011). In line with this approach, counselling can also help to cope with the consequences of abuse. Several studies have highlighted that older people value counselling and group support as the process of listening and relating their experiences in a group setting is found itself to be helpful (Beaulaurier, Seff, Newman, & Dunlop, 2007; Hightower et al., 2006; Pritchard, 2000). Older women particularly value support groups as an important source of peer support, validation, and self-help (Montminy & Straka, 2006). The willingness and openness of older men to speak about their experiences of abuse has also been reported (Pritchard, 2007).

Financial abuse by individuals outside the nuclear family

Additional contexts for the occurrence of abuse include the perpetrator being left alone with readily accessible assets or desiring money. In these cases, rather than interpersonal pathology or victim dependency, the abusive individual may simply have failed to resist an unexpected opportunity (Jackson & Hafemeister, 2011a, 2012). Financial abuse by individuals outside the nuclear family include misuse of powers of attorney, coerced changes to wills, unethical trading in title to property, the coercion of people into signing documents or theft. The onset is often gradual and insidious, with subtle deception that may mimic legitimate transactions and escalate over time (Conrad et al., 2009). The perpetrator may use his or her position of trust through psychological manipulation or misrepresentation (Conrad et al., 2009).

Victims' gender does not increase the risk, as similar rates of financial abuse were found across genders (Biggs, Manthorpe, Tinker, Doyle, & Erens, 2009). People experiencing financial abuse may be more likely to live alone and have low social support (Jackson & Hafemeister, 2011b; Podnieks, 1993; Quinn, 2000). Victims most likely present some level of dependency, such as mild cognitive impairment or lack of financial sophistication (Conrad et al., 2009). Vulnerability of the older adult is also an important aspect within such type of cases. These risks may increase for those older adults with paid or unpaid

caregivers who have access to the elders' financial assets, such as bank accounts, and money market funds, among others (Anetzberger, 2000).

Possible venues for intervention. In these cases, legal interventions may be appropriate and effective in ending the abuse (for example, use of appropriate legal systems to prosecute for theft). Some studies suggest that for financial abuse cases, legal programs directed at crime victims' can be effective (Brownell & Wolden 2008). Lithwick (1999) found that the provision of supportive services (medical and homecare), and placement in institutional settings did not promoted any change in a large proportion of financial abuse. Legal intervention may include the issuing of intervention orders, caveats on property, debt recovery procedures, advice regarding wills and power of attorney, and letters to perpetrators and other services. Many studies that detail legal interventions have a focus on guardianship and powers of attorney as a way of addressing neglect or abuse in situations where the older person has reduced capacity or dementia (Gassoumis et al., 2015; Hwang, 1996; Rabiner, O'Keeffe, & Brown, 2006). Nevertheless, such legal interventions should be paired with financial assistance, supportive services and advocacy. Finally, in cases in which an elderly person is relatively isolated, it may be useful to facilitate a relationship with a trustworthy person to provide oversight of the elderly victim's financial situation (Gassoumis et al., 2015).

Other configurations

There are others possible configurations and subsets of elder abuse that we have not explored here. The empirical studies considered perpetrators within three possible categories: spouses and partners, offspring and others. The others category because of the diverse types of relationships encompassed may be too heterogeneous to correctly identify patterns and commonalities. For instance, *polyvictimisation by others* was identified in the study using Latent Class Analysis (Chapter VII), and this class describes more than one type of abusive behaviour perpetrated by acquaintances, neighbours or professionals' caregivers or relatives other than nuclear family. Moreover, the studies did not include cognitive impaired older adults, which can represent one or more different victimisation experiences that require specific intervention strategies. Also, the few number of neglect cases hindered further analysis. It is likely that neglect, because it involves some sort of impairment and dependency, would require a different research approach. Distinct patterns may be found for neglect committed within a family relationship or by a professional caregiver (National Research Council, 2003).

Conclusions

All these approaches must consider the victims' safety and the legal framework. Whether the applicable authorities find a case to constitute abuse may also influence the intervention development (Pillemer, Mueller-Johnson, Mock, Suitor & Lachs, 2006). The efficiency of the legal approach also depends on the purpose of the intervention in a particular case and other aspects of the social context. The question being asked should be whether an intervention or treatment to be implemented might or not help the elder. These determinations are all rooted in a specific context and societal values and legal framework of a specific country (Pillemer et al., 2006). These judgments should be subject to empirical study and in such investigations, what must be defined and measured are the variety of possible clinical, social, and legal responses that might be made to particular cases and their impact for case outcomes.

Concluding remarks

It is important to understand the dynamics involved in abusive situations for the development of appropriate interventions. Even though the goal of all interventions is to halt the abuse, whatever form it takes, the conceptualisation of the relationship and the way abuse takes place might help tailor intervention efforts. For example, if we understand that older adults are willing to tolerate a considerable amount of abuse because they perceive that their only alternative is placement in a nursing home, making them aware of alternatives (e.g., providing in-home services), may encourage them to identify the abuse and to take action. If older adults fear the repercussions for their abusive offspring, developing interventions that allow the relationship to continue may help older adults to seek help.

The focus on the different dimensions and the variability that characterises elder abuse can help to find patterns and point to hypotheses about the dynamics that further on stem the conceptual development of the field. The studies conducted throughout the work presented in this thesis focused on the different dimensions that usually characterise elder abuse and allowed to describe their impact for elder abuse configurations. We contributed to the validation of a Portuguese short version of the Geriatric Depression Scale (GDS5), useful to analyse depressive symptoms in studies targeting older adults. The study of community elder abuse culminated in the following findings, (i) elder abuse is a construct that encompasses distinct phenomena sharing common features; (ii) elder abuse is best characterised by considering different dimensions; (iii) the dyad victim-perpetrator is one of the most important dimensions, (iv) severity, type of abusive behaviours and victim and perpetrator characteristics are other relevant dimensions, (v) the interplay of these different dimensions helps apprehend the nature and dynamics of different elder abuse configurations.

The overarching conception of elder abuse as possible distinct phenomena with intertwined features highlights the critical need for longitudinal and qualitative studies to gain a better understanding of the underlying dynamics. A process-oriented perspective designed to apprehend meanings of different elder abuse configurations would lead to investigation of the reversibility of the process and provide a better understanding of the aetiology of specific configurations of elder abuse (National Research Council, 2003). Such a perspective would benefit knowledge on the preventive and remedial measures that could be undertaken (National Research Council, 2003).

In addition, research on the multidimensionality of elder abuse can also be incorporated within quantitative cross-sectional research, by including evaluation of the quality of the

relationship between victim and abusive individual and evaluation of the process of elder abuse rather than only the univariate outcome.

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