NATURE OF ABUSE

N1. Neglect

Definition

This factor reflects the failure of the perpetrator (P) to meet the needs of a vulnerable older adult, the victim (V). Neglect can be an act of commission or omission and may be either intentional or unintentional.

Exemplars

- P fails to provide V with the necessities of life (e.g., food, clothing, hygienic living environment, adequate living conditions, adequate care)
- P does not attend to V's medical needs (e.g., P over or under medicates V; P unduly delays bringing V to doctor after V is injured; P takes V to different doctors to conceal poor care; P has withdrawn V from professional care without a suitable alternative)
- P fails to protect V from potential and preventable harm (e.g., P locks V outside in cold weather without proper winter attire; P allows a cognitively impaired V to wander off alone in public places; P leaves V in an unsafe environment for extended periods of time)
- P does not provide proper care (e.g., P fails to provide adequate care but refuses to place V in a care home; P locks V in a room for most of the day)

Discussion

Related terms and concepts include lack of care, inadequate care, negligence, and withholding the necessities of life. The legal terminology is "failure to provide the necessities of life". This factor is important when considering the quality of the care provided by the perpetrator and the diversity and severity of the abuse.

Rating this item requires a degree of judgment, particularly with respect to the level of care that should be provided and the capabilities of the victim. The level of care should be based on a standard of reasonableness. Excellent care and poor care are more easily identified but there is a large grey area between those extremes that can be difficult to rate. Evaluators should gather all possible information and provide an informed decision based on the level of care they believe a reasonable person would provide. Gathering the opinions of other professionals with different expertise and insight into appropriate care can be helpful in making this distinction and is recommended where regulations related to confidentiality permit. Judgments must also consider the pres-

ence of chronic illness that can mimic signs of abuse (Lachs & Pillemer, 1995). For instance, dehydration can be caused by mediations or diabetes, fractures can be caused by Osteoporosis, weight lost can be the results of cancer or other illness, and bruising can be caused by a bleeding disorder (coagulopathy) or accidents that result from the older adult's functional limitations. When making these considerations, consultation with medical experts is advised.

Other judgments made when coding this item will depend on the capabilities of the victim. For instance, the capabilities of an older person will dictate whether they have been placed in a dangerous situation. The situations in which an individual with Alzheimer's would be at risk would differ from those that would place an individual in a wheelchair at risk. Again, these judgments should be made to the best of the evaluator's ability and their knowledge of the case, and in consultation with other knowledgeable professionals.

Neglect can be a precursor to other forms of abuse including emotional, financial and physical abuse (Patterson, 1994). Neglect is also a lethality risk factor; victims of all forms of older adult abuse have three times the mortality rate of non-abused older adults (Lachs et al., 1998). Further, a recent study found caregiver neglect to be one of two forms of older adult abuse with the lowest 5-year survival rate (Burnett et al., 2016).

Studies have found upwards of 125 indicators of neglect and several tools have been developed strictly to identify older adult neglect and other forms of older adult abuse (Sengstock & Hwalek, 1987; Spencer, 2009; Tatara, 1993). Some indicators of older adult neglect include poor nutritional status, dehydration, untreated injuries, a lack of care support, skin disorders, untreated bedsores, a lack of clean clothing or bedding, absence of prescribed medication or assisting devices (e.g., dentures), deficiencies in personal hygiene, cognition, health or environment (e.g., the type, smell and condition of the older person's home or yard), and frequent visits to emergency rooms with vague complaints (Dyer et al., 2005; Gray-Vickrey, 2001; Lachs & Pillemer, 1995; Meeks-Sjostrom, 2004; Nadien, 2006; Tatara, 1993). Cases in which a dependent older person has adequate resources but presents with these or other empirically identified indicators should raise suspicion that older adult neglect is present (Lachs & Pillemer, 1995).

NATURE OF ABUSE

N2. Emotional Abuse

Definition

This factor reflects attempts by the perpetrator to cause the victim emotional pain. These objectives can be reached through utterances or behaviors that cause psychological harm or distress. The nature of the behavior can be direct or indirect; however, the clear intent is to cause harm or distress to the victim.

Exemplars

- P is verbally abusive to V (e.g., P degrades, humiliates, or ridicules V; P yells at and insults V; P habitually blames V for things or uses V as a scapegoat)
- P is very controlling of V (e.g., P does not allow V to go anywhere alone, although V is capable of doing so; P regulates what V is allowed to do on a daily basis)
- P isolates V from others (e.g., P does not let V see or speak with others either personally or professionally without P present; P makes others feel very uncomfortable when they visit V; P does not allow V to join social clubs)

Discussion

Related terms and concepts include bullying, belittling, demeaning, dehumanizing, denying freedom, psychological abuse, and psychological terrorism. This is a factor can be detected by examining the victim's relationships with others. For instance, it should raise one's concern if the perpetrator does not allow professionals (e.g., health care, social service) to speak with the victim alone, or if the perpetrator has stopped friends and family from seeing the victim. This risk factor is important when considering the diversity and severity of the abusive behavior.

Indicators of emotional abuse include confusion, paranoia, depression, anger, fear of strangers, fear in one's own environment, ambivalence toward one's caregiver, becoming quiet around one's caregiver, low self-esteem, craving attention, trembling, clinging, lack of eye contact, cowering and expressions of hopelessness or helplessness (Braun, 2009; Gray-Vickrey, 2001; Quinn & Tomita, 1997). Yan (2014) found that the best predictor of psychological abuse over the course of their 6-month follow-up study was the presence of psychological abuse at the start of the study. Wolf and Pillemer (2000) found that psychological abuse rated as more serious at intake to an intervention program was less likely to be resolved at follow-up than cases rated as less severe.

NATURE OF ABUSE

N3. Financial Abuse

Definition

This factor reflects attempts by the perpetrator to obtain some good or benefit from the victim. Actions may be taken to convince or force the victim to give up tangible items or control, against their best interests, or the perpetrator may simply take things without permission.

Exemplars

- P convinces V to sign over property or legal rights (e.g., P convinced V to give him power of attorney; P has V put assets in P's name; P convinces V to sign over his pension checks)
- P steals from V (e.g., under guise of managing V's finances, P withdraws money for himself; P begins prematurely taking things from V that V has willed to P)
- P demands goods from V (e.g., P demands money or goods, in addition to salary, in order to assist V with basic needs such as taking V to the bathroom; P demands V pay for his living expenses)

Discussion

Related terms and concepts include economic abuse, coercion, stealing, fraud, theft, theft by power of attorney, misuse of authority, use of funds without full knowledge or consent, use of undue influence to gain control of money or property, and duress. This factor is important when considering whether financial (e.g., bank employees) or legal experts (e.g., estate lawyers) should be involved in or consulted about the case. This factor is also important when considering the diversity and severity of the abusive behavior as well as motivations for continued contact or abuse. For instance, a dependent adult child may be more likely to make contact with a victim when their rent is due or after losing their job.

Victim-related indicators of financial abuse include the signing of legal documents by a cognitively impaired older person, missing financial records, unexplained loss of pension checks, lack of payment for utilities, lack of knowledge about financial status, anxiety about personal finances, and evidence of undue influence (Gray-Vickrey, 2001; Hwang, 1996; Tueth, 2000; Weiler, 1989).

Perpetrators often feel entitled to take material goods or property from older family members, assuming that they will eventually inherit those goods when that family

member passes away. Nevertheless, taking goods prematurely should be considered under this factor since doing so is a risk factor for continued abuse (Dessin, 2000).

Although financial abuse that does not cause physical or serious psychological harm is not sufficient grounds for conducting a risk assessment with the HOPE it is an important factor to consider in a risk assessment for older adult abuse. When financial abuse is present, other forms of abuse are often also being perpetrated, such as emotional abuse, intimidation, threats, and physical abuse (Baron & Welty, 1996; Braun, 2009). Financial abuse can also be the cause of other abuse and a risk factor for more serious forms of older adult abuse (Hwalek et al., 1996).

NATURE OF ABUSE

N4. Intimidation/Threats

Definition

This factor reflects attempts by the perpetrator to induce fear in the victim via utterances or behavior that threaten physical, psychological, or social harm in some manner, be it ambiguous, vague, and indirect, or unambiguous, explicit, and direct. The perpetrator deliberately or recklessly causes fear to the victim, that is, the perpetrator's conduct gives rise to a reasonable perception that the victim or secondary victims may, or did, suffer considerable physical or some other type of harm.

Exemplars

- P intimidates V with his language or behavior (e.g., P damages V's property; P physically blocks V from leaving the room; P tells V that she will suffer for having denied P what he is owed)

- P makes threatening statements to V (e.g., P makes threatening statements or gestures to V; P writes threatening statements about V; P threatens to put V in a care home or not to let him see his grandchild if he does not comply with P's demands)

- P engages in behavior that is clearly threatening (e.g., P brandishes a weapon while yelling at V; P takes V's medication; P argues with and tries to destabilize V as he is walking down the stairs; P points a gun at V)

Discussion

Related terms and concepts include direct or veiled threats, threatening communication, and homicidal threats. This factor is important when considering the diversity and severity of the abusive behavior.

The presence of intimidation and threats have been identified as risk factors in cases of intimate partner violence and stalking (Kropp & Hart, 2015; Kropp et al., 2008). Further, such behaviors have been identified as risk factors for life-threatening intimate partner violence. In general, any behavior that generates significant fear in the victim should be considered since mounting evidence in the areas of intimate partner violence and stalking suggests that such fear is associated with subsequent violence (Kropp & Hart, 2015; Kropp et al., 2008).

NATURE OF ABUSE

N5. Physical Abuse

Definition

This factor reflects attempts by the perpetrator to cause physical harm to the victim or secondary victims. The perpetrator either deliberately intends to cause physical harm or is reckless concerning the possibility of causing physical harm.

Exemplars

- P physically assaults V (e.g., P punches and kicks V; P holds V down)
- P sexually assaults V (e.g., P has non-consensual sexual contact with V, where V either does not give consent or lacks the capacity to give consent)
- P uses a weapon against V (e.g., P uses restraints on V; P hits V with belt)

Discussion

Related terms and concepts include physical or sexual aggression, non-consensual sexual activity, assault, forcible restraint or confinement, rough handling, deliberate or reckless poisoning or overmedication, and violence. This factor is important when evaluating the diversity and severity of the abusive behavior. Consideration should be given to the consequences that violent acts can have for the victim. For instance, a push can have greater consequences for an older adult with osteoporosis than it would for a healthy 20-year-old. It is appropriate to consider these facts since a reasonable person in the perpetrator's position would have some awareness of the victim's frailty and therefore an understanding of the potential consequences of their actions.

Identifying physical abuse is complicated by the frailty of older victims and the commonalities in the appearances of injuries sustained from health issues and those sustained from abuse (Lachs & Pillemer, 1995). Indicators of physical older adult abuse include unexplained injuries, injuries incompatible with the described event, multiple injuries, injuries in various stages of healing, evidence of previous untreated injuries, signs of confinement, history of repeated injury or illness, symmetrical bruising and/or grip marks, delay in seeking treatment, sexually transmitted diseases, agitation, hesitancy in speaking openly, eating disturbances, sleeping disorders, discomfort when being touched physically, and avoidance of a significant individual in their life (e.g., a family member) (Braun, 2009; Gray-Vickrey, 2001; Hoban & Kearney, 2000; Meeks-Sjostrom, 2004).

Yan (2014) found that the best predictor of physical abuse over the course of their 6-

month follow-up study was the presence of physical abuse at the start of the study, suggesting that physical abuse is likely to continue without intervention. Wolf and Pillemer (2000) found that physical abuse rated as more serious at intake to an intervention program was less likely to be resolved at follow-up than cases where abuse was rated as less severe. Physical older adult abuse is also a lethality risk factor; victims of older adult abuse have three times the mortality rate of non-abused older adults (Lachs et al., 1998).

NATURE OF ABUSE

N6. Abuse is Persistent

Definition

This factor reflects a pattern of abuse that is chronic, enduring, intense, or continuous.

Exemplars

- P's abuse of V is chronic (e.g., P has been abusive toward V for many months or many years)
- P's abuse of V is intense (e.g., episodes of physical abuse last for extended periods of time; V will be left locked in a room for hours or even days at a time)
- P's abuse of V is continuous (e.g., P's abuse of V occurs often with few or short interruptions)

Discussion

Related terms and concepts include chronicity, duration, and frequency of older adult abuse.

Wolf and Pillemer (2000) found that frequent abuse was a risk factor for continued older adult abuse. Specifically, their results indicated that all forms of older adult abuse that were more frequent at intake to an intervention program were less likely to be resolved at follow-up compared to those that were less frequent (Wolf & Pillemer, 2000). Older adult abuse will often occur on more than one occasion. For instance, O'Malley and colleagues (1984) found that repeated abuse had occurred in 70% of the cases in their sample. Similarly, Block and Sinnot (1979) found that 58% of the abused older adults surveyed had previously experienced abuse.

This item should be coded as present when abuse is chronic, intense, or continuous, not simply because it has occurred on more than one occasion. Persistent abuse may be, in part, a consequence of perpetrators' receiving intermittent positive reinforcement (e.g., money, assets, control) as a result of their abusive behavior and abuse will often continue unless there is a major change in the environment (Canadian Task Force on the Periodic Health Examination, 1994).

NATURE OF ABUSE

N7. Abuse is Escalating

Definition

This factor reflects a pattern of abuse that is clearly worsening over time in frequency (intensity), diversity (scope), or severity.

Exemplars

- P's abusive behavior toward V is becoming more frequent (e.g., P is assaulting V more often; P escalates his harassing and threatening behavior when he wants money from V; P is demanding money increasingly often)

- P's abusive behavior toward V is becoming more diverse (e.g., in addition to abusing V, P is now also verbally abusive toward those trying to protect V; in addition to neglecting V, P now also threatens V with harm if he does not give P money)

- P's abusive behavior toward V is becoming more severe (e.g., P's abusive behavior toward V has escalated from intimidation to direct threats, or from threats to violence; P is becoming increasingly controlling of V, allowing him to see others less and less; P is taking larger and larger sums of money from V; P's acts of abuse have remained consistent, however, due to V's failing health the injuries sustained by V have increased in severity)

Discussion

Related terms and concepts include acceleration, worsening, and exacerbation of older adult abuse. It should be noted that this item reflects changes in behavior over time. Escalation can only be identified from a pattern of two or more events; therefore, the first occurrence of a violent act, threat, or thought is not considered an escalation.

Older adult abuse rarely ceases without intervention and instead tends to escalate in the same manner as spousal abuse (Canadian Task Force on the Periodic Health Examination, 1994). Sudden increases in abusive behavior may coincide with the perpetrator's need for money or other goods from the victim. These needs can increase when outside parties become involved and the perpetrator is cut-off from the victim or the victim's resources. This pattern of escalation may be particularly evident among perpetrators who feel desperate or who have succeeded in obtaining a desired outcome through abusive behavior in the past.

Escalating abuse can sometimes also be the result of changes in the victim, such as declining physical or mental health. The impact of the abuse on the victim should be

considered when rating this item because similar abusive acts perpetrated toward an increasingly frail victim over time may constitute an escalation in the consequences of abuse.

NATURE OF ABUSE

N8. Abuse Involves Supervision Violations

Definition

This factor reflects a pattern of older adult abuse that occurs or continues despite formal warnings to desist from such conduct. The warnings (e.g., not to contact the victim, to provide appropriate care) are issued by people in positions of authority (e.g., hospital or care home authorities, police, corrections, review boards, tribunals, courts, employers) and caution the perpetrator that serious consequences may result from a failure to comply (e.g., police involvement, arrest, civil action, dismissal, seclusion, suspension).

Exemplars

- P ignores official cautions (e.g., P disregards instructions from police to vacate V's residence; P pays no heed to formal directions from staff at V's care home that he is not permitted on the premises)

- P violates conditions (e.g., P does not comply with probation conditions to seek treatment; P refuses to abide by directions from parole staff to cease all communication with V)

- P breaches court orders (e.g., P defies an order to stop drinking alcohol or ingesting illicit substances)

Discussion

Related terms and concepts include escape, as well as violations of institutional rules and regulations, bail, probation, parole, restraining or protective orders, and peace bonds.

Within the risk assessment literature, it is well known that when attempting to forecast someone's reaction to authoritative directions, such as those given by the police or the court, it is best to examine the individual's compliance with such directions in the past. Evidence indicates that perpetrators who have violated orders or terms of release in the past are more likely to re-offend than those who have not (Andrews & Bonta, 2003; Hart et al., 1988; Nuffield, 1982, Quinsey, Harris et al., 1998).

The presence of this risk factor is likely an indicator of other risk factors for older adult abuse such as antisocial attitudes, problems with stress and coping, dependency and substance use problems. Although empirical research has not yet examined this risk

factor in cases of older adult abuse, research on intimate partner violence has shown that perpetrators who have a lower stake in conformity are more likely to re-offend (Carlson et al., 1999; Sherman et al., 1992). The presence of supervision violations has also found support as a risk factor for stalking and is included in violence risk assessment tools for stalking and intimate partner violence (Harmon et al., 1998, Hilton et al., 2004; Kropp et al. 1999; Kropp et al., 2005, 2010; Kropp et al., 2008).

PERPETRATOR RISK FACTORS

P1. Problem with Physical Health

Definition

This risk factor reflects physical health problems that include illness and functional impairment. Functional impairment refers to difficulties performing Activities of Daily Living (ADLs) such as grooming, dressing and feeding oneself, walking, and making functional transfers (e.g., getting out of bed), and Instrumental Activities of Daily Living (IADLs) such as housework, meal preparation, taking medication, managing money, shopping, and using the telephone or applicable technology.

Exemplars

- P has a physical health problem (e.g., P has a chronic illness; P has a physical disability; P is in poor health; P has had a recent decline in physical health)

- P is functionally impaired (e.g., P is unable to fully take care of his own hygiene; P is unable to prepare meals; P's health problems cause him to be dependent on others; P's ability to work is impaired)

Discussion

Related terms and concepts include disease, and disability.

Coding this risk factor does not require the evaluator to conduct a formal evaluation of the perpetrator's capabilities. It can be coded based on diagnoses made by a physician or other professional. Alternatively, it can be coded based on the individual's self-reports or the observations of the evaluator or collateral informants. See "Diagnosis Ratings" on page 29 of this manual for instructions on how to indicate whether this item is *Diagnosed* or *Undiagnosed*.

Many empirical studies conducted over several decades have identified physical health problems as a risk factor for older adult abuse perpetration (Anme et al., 2005; Beach et al., 2005; Eisikovits et al., 2004; Lachs & Pillemer, 2015; Pillemer & Finkelhor, 1989; Pillemer & Wolf, 1986). Perpetrators of older adult abuse have been found to be more likely to have, and be limited by, physical health problems than caregivers who do not engage in abuse (Anme et al., 2005; Pillemer & Finkelhor, 1989). Fulmer and colleagues (2005) found that caregivers who engaged in older adult neglect were more likely to report unmet needs for assistance with ADLs and IADLs, indicating a group in poorer health than the caregivers who did not engage in neglect. Similarly, Beach and colleagues (2005) found that self-rated health status was predictive of older adult abuse among spousal caregivers. In addition, studies have shown that increased medical

problems, more chronic health problems, and more physical symptoms (e.g., vision problems, difficulty breathing) increase the risk of older adult abuse perpetration (Beach et al., 2005; Eisikovits et al., 2004; Pillemer & Wolf, 1986). Nevertheless, Johansson's (2018) meta-analysis suggests that ADLs and physical impairments may be less relevant for caregivers.

PERPETRATOR RISK FACTORS

P2. Problems with Mental Health

Definition

This risk factor reflects problems with mental and personality functioning, which in turn, can result in substantial problems with cognition, mood, and behavior.

Exemplars

- P has a major mental disorder (e.g., P has been diagnosed with dementia; P is depressed; P has grossly distorted or unrealistic beliefs due to psychosis; P has extreme shifts in mood)

- P has a personality disorder (e.g., P has been diagnosed with antisocial, borderline or narcissistic personality disorder; P is quick to anger, emotionally volatile or has poor emotional regulation; P is grandiose and unable to take on the perspectives of others)

- P is cognitively impaired (e.g., P often becomes confused; P engages in disruptive or combative behavior; P has suffered brain damage)

- P is experiencing homicidal or suicidal ideation or intent (e.g., P is having suicidal thoughts; P plans to take V's life and then his own)

Discussion

Related terms and concepts include psychosis, mental disorder, major mental illness, intellectual deficits, cognitive deficits, Alzheimer's disease, and emotional problems.

Coding this risk factor does not require the evaluator to make a diagnosis. This item can be coded based on diagnoses made in the course of psychiatric or psychological evaluations conducted by others. Alternatively, it can be coded based of the person's self-reports or the observations of the evaluator or collateral informants. See "Diagnosis Ratings" on page 29 of this manual for instructions on how to indicate whether this item is *Diagnosed* or *Undiagnosed*.

Major mental disorder has been identified in dozens of empirical studies and literature reviews as a risk factor for older adult abuse perpetration (Dunlop et al., 2001; Henderson et al., 2002; Johannesen & LoGiudie, 2013; Labrum et al., 2015; Lachs & Pillemer 2004, 2015; Pillemer et al., 2007; Roberto, 2016; Schiamberg & Gans, 1999; Wolf, 2000). In particular, depression has been identified as one of the most common, if not the most common, mental health problem associated with older adult abuse perpetration

(Campbell Reay & Browne, 2001; Homer & Gilleard, 1990; Johansson, 2018; Miller et al., 2006; Paveza et al., 1992; Pérez-Rojo et al., 2009; Williamson & Shaffer, 2001; Wolf & Pillemer, 1989). Cognitive impairment and dementia have also commonly been identified as risk factors for older adult abuse perpetration (Beach et al. 2005; Bristowe & Collins, 1989; Eisikovits et al., 2004; Miller et al., 2006; Ryden, 1988). Cognitive decline may also be linked to older adult abuse because it can cause declines in health, social well-being, and the ability to provide care and may influence depression (Backman & Hill, 1996; Ferrucci et al., 1993; Kosberg, 1988). Suicidal ideation was recently identified as a risk factor among caregivers in a meta-analysis by Johansson (2018).

Indirect associations between mental health problems and older adult abuse perpetration have also been identified. For instance, provocative behavior (often caused by mental health problems like dementia) by the perpetrator was found to be a risk factor for psychological older adult abuse (Wolf et al., 1984). Mental health problems can also increase the dependency of the perpetrator on the victim, another risk factor for older adult abuse (Griffin & Williams, 1992; Pillemer, 1985) (see P4). Henderson and colleagues (2002) suggest that mental health problems may result in unrealistic expectations of the older person's capabilities, which is a risk factor for older adult abuse (see P6). Henderson and colleagues (2002) also suggest that mental health problems can limit one's control over emotions such as anger or frustration and cause someone to take out those emotions on an older victim. Mental health problems may also be a risk factor for homicide. Statistics Canada (2007) reported that half of all individuals accused of killing an older family member were suspected of having a psychological or developmental disorder.

PERPETRATOR RISK FACTORS

P3. Problems with Substance Use

Definition

This risk factor reflects serious problems with health, occupational, financial, social, or legal functioning resulting from the use of illegal substances or the misuse of legal substances (e.g., alcohol, prescribed medications).

Exemplars

- P has physical health problems due to substance use (e.g., P has liver problems due to alcohol use; P has been hospitalized due to abuse of prescription drugs)

- P has psychological problems due to substance use (e.g., P has experienced tolerance or withdrawal symptoms due to the use of cocaine; P's alcohol use is exacerbating his schizophrenia; P has memory loss due to alcohol use; P cannot make appropriate care decisions for V due to intoxication)

- P's substance use is affecting his social adjustment (e.g., P has financial problems due to his use of illicit drugs; P's alcohol use has caused problems in his relationships and at work; P has been arrested for impaired driving; P spends an inordinate amount of time obtaining or using substances; P becomes more violent when using substances)

Discussion

Related terms and concepts include drug and alcohol use problems, abuse, and dependence.

Substance abuse has been described as a dominant risk factor—the single best predictor of older adult abuse perpetration—and has been found to be associated with the risk of older adult abuse perpetration in many empirical studies and literature reviews (Conrad et al., 2019; Dunlop et al., 2001; Henderson et al., 2000; Jayawarneda & Liao, 2006; Jones et al., 1997; Lachs & Pillemer, 2004, 2015; Podneicks, 2008; Roberto, 2016; Schiamberg & Gans, 1999; von Heydrich et al., 2012; Wolf, 2000). Wolf (1997) describes substance abuse, along with mental health problems and dependence, as one of the most likely explanations for older adult abuse perpetration. Furthermore, multiple studies suggest that older adults are at the highest risk of abuse when their caregivers have substance abuse problems (Anetzberger et al., 1994; Bristowe & Collins 1989; Homer & Gilleard 1990; Pillemer, 2005; Reay & Browne 2001; Wolf & Pillemer 1989). Rates of substance abuse among older adult abuse perpetrators range from 20% to

50% (Jackson, 2016).

Several hypotheses have been posited to account for the association between substance abuse and older adult abuse (see Henderson et al., 2002; Kravitz, 2006). First, older adult abuse may be committed in order purchase substances. Second, substance abuse may cause dependency, where an addiction may prevent an individual from sustaining employment thereby causing them to be reliant on the older person for support or necessities (see P4). Third, supporting an addiction can be a major stressor, and stress is a risk factor for older adult abuse (see P5). Fourth, substance abusers are more likely to act out due to decreased inhibitions. Fifth, due to intoxication or the desire to obtain substances, substance abusers are more likely to make inappropriate care decisions or fail to place a priority on care.

PERPETRATOR RISK FACTORS

P4. Dependency

Definition

This risk factor reflects a perpetrator's dependency on the victim or other individuals. Dependency is most often related to housing and finances but can also be emotional and functional in nature.

Exemplars

- P has difficulty obtaining or maintaining work (e.g., P has had long periods of unemployment; P refuses to attend education or vocational training; P is frequently fired from jobs; P often quits jobs, education or vocational training with no other work lined up; P is frequently late or absent from work; P's work performance is poor)

- P is not self-sufficient (e.g., P does not have enough money to pay for his living or food costs; P spends all of his money on drugs or gambling and relies on V for necessities)

- P has impairments that cause emotional dependence on V (e.g., P has few social contacts and depends on V for social support; P is quick to anger and has impulse control issues, and V is the only person who will deal with him)

Discussion

Related terms and concepts include financial dependency, social dependency, housing dependency, and emotional dependency.

Financial dependency can result from problems maintaining economic self-sufficiency, stemming from difficulty with or the lack of a desire to establish or maintain stable employment. Alternatively, despite employment, perpetrators may fail to make enough money to support habits such as gambling or substance abuse. Disabilities and disorders such as cognitive impairment, major mental disorder, physical impairment, and substance abuse can also create dependency. Such dependencies can be financial, emotional and/or functional in nature. Functional and mental health impairments and their causes are considered under P1, P2, and P3, here we are evaluating only the presence of dependencies caused by such impairments.

Although it was initially theorized that most older adult abuse stemmed from the victim's dependence on the perpetrator and the resulting caregiver stress, empirical evidence has not borne out this hypothesis and instead has shown the reverse to be true

(Greenberg et al., 1990; Henderson et al., 2002; Lachs & Pillemer, 2004, 2015; Jayawardena & Liao, 2006; Pillemer, 1985, 1986, 2005; Pillemer & Finkelhor, 1989; Wolf, 2000; Wolf & Pillemer, 1989; Wolf et al., 1982). Perpetrator dependence on the victim is now recognized as a dominant risk factor for older adult abuse that can dramatically increase risk and is one of the most likely explanations for older adult abuse (Dunlop et al., 2001; Jones et al., 1997; Roberto, 2016; Wolf, 1997). Researchers note that dependence may be a particularly relevant risk factor when the perpetrator is an adult child (biological or in-law) of the victim (Jayawardena & Liao, 2006; Lachs & Pillemer, 1995; Wolf, 1990). In accord, Johansson's (2018) meta-analysis suggests that financial dependency may not be relevant for caregivers.

Financial and housing dependence are the types of dependence most commonly associated with older adult abuse (Pillemer, 1985). Wolf and colleagues (1982) found financial dependency of the perpetrator on the victim to be present in two-thirds of the cases examined. Similarly, Pillemer (1985) found financial and housing dependency to be present among 64% and 55% of perpetrators, respectively. In line with these findings, unemployment, financial problems, and poverty have been identified as risk factors for the perpetration of older adult abuse (Eisikovits et al., 2004; Lachs & Pillemer, 2015; Lachs et al., 1997; Roberto, 2016; von Heydrich et al., 2012).

Different hypotheses have been forwarded to account for the association between perpetrator dependence and older adult abuse. First, abuse may be the result of a perpetrator attempting to obtain resources (e.g., housing, money) from the victim upon whom they depend. Second, caregivers who rely on care recipients for financial or emotional support have been found to hold more feelings of anger, impotence, and frustration—feelings that may cause resentment and result in abuse (Curry & Stone, 1995). Third, a difficult family situation may escalate to abuse because a financially dependent adult child refuses to leave home (Pillemer & Finkelhor, 1989).

PERPETRATOR RISK FACTORS

P5. Problems with Stress and Coping

Definition

This risk factor reflects serious problems with stress related to an inability to cope with life problems. The problems may be a reaction to unusually stressful life events, inadequate coping with normal or day-to-day life stresses, or inadequate coping with caregiving responsibilities.

Exemplars

- P has recently experienced a sudden increase in stress (e.g., P recently separated from his wife; P recently lost a loved one; P was recently fired)
- P lacks the ability to cope (e.g., P is inexperienced or unable to provide care for V; P feels unable to cope; P feels unable to make important decisions about the future; P is quick to feel frustrated and lashes out at V)
- P feels highly stressed (e.g., P perceives that she is overburdened by her caregiving responsibilities; P feels unable to cope with day-to-day stressors)

Discussion

Related terms and concepts include strain, stress management, caregiver stress, despair, hopelessness, and burnout.

The feeling of being burnt-out, commonly referred to as caregiver stress has been identified as a risk factor for older adult abuse (Johannesen & LoGiudie, 2013; Johansson, 2018; Lachs & Pillemer, 2015; Roberto, 2016; Serra et al., 2018; Stall et al., 2019; Yan et al., 2015). When coding this item, the sense of stress should be judged subjectively (i.e., based on the perpetrator's feelings) and not objectively (i.e., based on the amount of time or effort they expel in their caregiving role). Several studies have found that the perception of stress and burden are associated with abuse; sometimes more so than objectively measured levels of burden (e.g., the needs of the older person being cared for) (Anme et al., 2006; Cohen et al., 2007; Cooper et al., 2008; Johansson, 2018; Serra et al., 2018). Abusive caregivers are also more likely to feel that they are not receiving adequate support from social networks or agencies (Anetzberger, 1987; Compton et al., 1997).

A substantial amount of evidence exists to suggest that stress is a risk factor for abuse (Henderson et al., 2002; Jones et al., 1997; Lachs & Pillemer, 1995; von Heydrich et al., 2012; Wolf et al., 1984). For instance, Wolf and Pillemer (2000) found that cases in

which the perpetrator saw the victim as a source of a great deal of stress were less likely to be resolved at follow-up than cases where the victim was not seen as a source of stress. In addition, cases where there was a reduction in the stress caused by the victim were more likely to be resolved at follow-up. The influence of stress may be mediated by other factors including the perpetrator's coping abilities, the perpetrator's perception of the caregiver burden, and the quality to the relationship held between the perpetrator and the older person (see V8) (Nerenberg, 2002; Serra et al., 2018). For instance, financial pressure can decrease the quality of the relationship between the perpetrator and victim, which is a risk factor for abuse (see V8), and increase the likelihood of abuse (von Heydrich et al., 2012).

Individuals experiencing any type of stress are at greater risk of perpetrating older adult abuse compared to individuals who can successfully cope with and manage their stress (Bendik, 1992; Henderson et al., 2002; Quayhagen et al., 1997; Schiamberg & Gans, 1999). Henderson and colleagues (2002) explain that inexperienced caregivers may become angry or frustrated with an older person's disruptive behavior, and if they lack the knowledge of how to cope with that stress they may resort to aggression to gain control of the individual. In support of this, Serra and colleagues (2018) found that resilience acted as a protective factor against abuse. Jayawarneda and Liao (2006) identify investigating and increasing coping skills as important components in the detection and prevention of older adult abuse.

External stress (i.e., stress unrelated to the older person) is also a risk factor for abuse (Johansson, 2018). Some researchers have hypothesized that the reason for this association is that perpetrators displace external stress onto the older person, treating them as a scapegoat (O'Malley et al., 1983; Palincsar & Cobb, 1982). Forms of external stress that have been linked to older adult abuse include separation or divorce, financial problems, job loss, recent medical complaints, illness, and a recent change in living arrangements (Brozowski, & Hall, 2005; Eisikovits et al., 2004; Jones et al., 1997; Wolf & Pillemer, 1989). Lachs and Pillemer (1995) maintain that it is important to determine the factors that cause stress and provoke abuse as they can illustrate the pattern and frequency of abuse and identify targets for intervention.

The recency and seriousness of the stress may relate to the imminence and severity of the risk of harm to the older person. Sudden increases in stress or recent stressful events including unusual family events and recent crises have been identified as risk factors for abuse (Anetzberger, 1987; Fulmer & O'Malley, 1987).

PERPETRATOR RISK FACTORS

P6. Problems with Attitudes

Definition

This risk factor reflects serious problems with attitudes related to caregiving, older persons, and the rights of others.

Exemplars

- P is unhappy with their role as caregiver (e.g., P is resentful of her caregiving role and feels obliged to carry it out)
- P has unrealistic expectations about what V can do (e.g., P refuses to assist V with necessary activities; P does not properly supervise V, who has dementia, when V is engaging in potentially dangerous activities such as cooking; P thinks V is purposefully being difficult when V is actually functionally or cognitively impaired)
- P holds antisocial attitudes (e.g., P does not take responsibility for his behavior; P does not feel bad about his behavior or the harm it causes to V; P has a history of violent or criminal behavior)

Discussion

Related terms and concepts include reluctance to provide care, unrealistic expectations, ageism, lack of empathy or remorse, attitudes supporting or condoning use of violence, antisocial personality disorder, and psychopathy.

Problematic attitudes for caregivers to hold include not wanting to provide care and feeling resentful or angry about having to provide care. Problematic attitudes for any perpetrator to hold toward older adults include unrealistic expectations about what an older person is capable of doing or what they are doing intentionally, and ageist (sometimes culturally promoted) beliefs about the worth of older adults. Problematic attitudes related to the rights of others include unrepentant and antisocial attitudes. Unrepentant attitudes include minimizing or denying abusive behaviors or their effects on a victim; a lack of remorse or empathy for abusive behavior; and blaming others for the abusive behavior or its consequences. Antisocial attitudes are sociopolitical, religious, cultural or sub-cultural, and personal beliefs and values that directly or indirectly encourage or excuse antisocial behavior. Antisocial attitudes are often accompanied by antisocial behavior that includes violence and other acts that constitute a violation of criminal and related laws and association with antisocial peers.

Anger or reluctance regarding having to fulfill a caregiving role is a risk factor for older

person abuse (Erlingsson et al., 2003; Fulmer & O'Malley, 1987; Johannesen & LoGiudie, 2013; Kosberg & Nahmiash, 1996; Reis & Nahmiash, 1998; Saveman & Sandvide, 2001). Misunderstanding an older person's problems or condition or holding unrealistic expectations about their capabilities have also been found to be risk factors for older adult abuse (Anme et al., 2006; Campbell Reay & Browne, 2001; Erlingsson et al., 2003; Kosberg 1988; Pillemer & Wolf, 1986; Reis & Nahmiash, 1998; Wolf et al., 1984). Henderson and colleagues (2002) hypothesized that some unrealistic expectations may be linked to the mental health problems of a perpetrator. Alternatively, they suggest that a lack of caregiving skills may result in a misinterpretation of the older person's behavior as retaliatory or stubborn and result in the caregiver becoming angry or frustrated and responding aggressively (Henderson et al., 2002). Intolerance of an older person's behavior has also been identified as a risk factor for older adult abuse, and a lack of empathy can exacerbate such intolerance (Erlingsson et al., 2003; Johnson, 1991; Quinn & Tomita, 1997). A lack of sympathy or understanding of the older person has also been found to be a risk factor (Anme et al., 2005; Kosberg, 1988).

Attitudes toward older adults generally, such as ageism, have been found to be associated with older adult abuse (Fulmer, 1989; Nerenberg, 2002). Several hypotheses have been suggested to account for why such attitudes may lead to violence. For instance, some individuals may place less value on the treatment of older persons because they are perceived as contributing less to society. It has also been suggested that caring for older persons is viewed with resentment in modern society. Such attitudes can then lead some to believe that abuse is deserved (Fulmer, 1989; Henderson et al., 2002).

Diagnoses of Antisocial Personality Disorder or Psychopathy should be considered under P2; here the outcomes of, or attitudes and beliefs associated with such diagnoses are considered. Antisocial attitudes and personality traits including the tendency to blame others, be hypercritical, hostile, impatient, have a bad temper, and poor impulse control, have been identified as risk factors for older adult abuse (Anetzberger, 1987; Campbell Reay & Browne, 2001; Erlingsson et al., 2003; Johannesen & LoGiudie, 2013; Kosberg 1988; Reis & Nahmiash, 1998). Antisocial behavior (which can be indicative of attitudes), including a history of arrests, property destruction, aggression, threats, and violence (although Johansson (2018) found that violence may be less relevant for caregivers), is associated with older adult abuse perpetration (Campbell Reay & Browne, 2001; Fulmer & O'Malley, 1987; Lachs & Pillemer, 1995, 2015; Pillemer, 2005; Pillemer & Finkelhor, 1989). Pillemer and Finkelhor (1989) held that such findings demonstrate that older adult abuse is not caused by victims' increasing needs but instead by the deviance and dependence of the perpetrators who are often "severely troubled individuals with histories of antisocial behavior or instability" (p. 186).

PERPETRATOR RISK FACTORS

P7. Victimization

Definition

This risk factor reflects previous abuse experienced or witnessed by the perpetrator during their childhood or adolescence. The abuse could have been at the hands of any individual, including the victim.

Exemplars

- P was the victim of abuse as a child or adolescent (e.g., P was neglected as a child; P was physically or sexually abused as a child)
- P witnessed abuse as a child or adolescent (e.g., P witnessed his father abusing his mother; there is a history of violence in P's family that P witnessed)

Discussion

Related terms and concepts include childhood victimization, physical abuse, and neglect.

The association between childhood victimization and older adult abuse perpetration can be direct in the case of a perpetrator acting out revenge or retribution motives against a previous abuser. Alternatively, older adult abuse may be the result of generalized problems (e.g., problems with psychosocial adjustment) caused by abuse experienced in childhood or adolescence. Evidence for the former revenge motivated or direct cycle of abuse is limited and much debate exists about this mode of transmission (Biggs et al., 1995; Schiamberg & Gans, 1999; Wolf, 1992; Wolf & Pillemer, 1989). In fact, Pillemer (1986) and Anetzberger (1987) did not find a relationship between child abuse and later abuse by the adult child toward the formerly abusive, and now older, parent. Some research suggests that this type of violence transmission applies more to child abuse than it does to older adult abuse (Korbin et al., 1995).

Past victimization more generally is supported as a risk factor for older adult abuse by empirical research. Being the victim of abuse as a child has been found to be associated with later perpetration of older adult abuse in several studies (Athens, 1992; Campbell Reay & Browne, 2001; Reis & Nahmiash, 1998). Being raised in a home with domestic violence, be it spousal, child abuse, or a pattern of violent interactions within the family, has also been linked to later perpetration of older adult abuse (Athens, 1992; Campbell Reay & Browne, 2001; Erlingsson et al., 2003; Griffin & Williams, 1992; Heide, 1995; Kethineni, 2004; Kosberg & Nahmiash, 1996; Schiamberg & Gans, 1999). It has been suggested that adult children or grandchildren who witnessed or were the vic-

tims of family violence are more likely to use violent tactics learned in childhood to resolve problems in later life. Erlingsson and colleagues (2003) found that a history of family violence, where violence was a normal response to stress, was a risk factor for older adult abuse, indicating that violence may be a learned coping mechanism. Similarly, Fulmer and colleagues (2005) found that caregivers who had experienced childhood neglect were more likely to perpetrate neglect compared to caregivers with no such history. The authors suggest this association might be the result of learned norms of caregiving.

PERPETRATOR RISK FACTORS

P8. Problems with Relationships

Definition

This risk factor reflects serious problems establishing or maintaining positive, prosocial intimate and non-intimate relationships. Intimate relationships are relationships with age-appropriate partners that are romantic and sexual in nature, and that involve an expectation of joint residence, monogamy, or long-term commitment. It does not matter whether the relationships are heterosexual or homosexual in nature. The legal status of the relationship (i.e., marital versus common-law versus dating) also does not matter. Non-intimate relationships are relationships with family, friends, and acquaintances that are not expected to be romantic or sexual in nature. This factor can include the perpetrator's relationships with the victim, if applicable.

Exemplars

- P has conflictual relationships with or mistreats others (e.g., P has a history of violence toward an intimate partner; P is constantly arguing with friends, co-workers or neighbors; P has a history of violence or threats toward family members; P has stolen from or relied excessively on family members)

- P is—or feels—socially isolated (e.g., P is a mature adult and has never had a significant intimate relationship; P is a young adult and has never dated; P rarely leaves his residence; P has alienated most of his co-workers and has no friends; P socializes only with V or family)

- P has—or feels he has—little or no social support (e.g., P says he has no support in caring for V; P feels she has no family support to help her get back on her feet)

Discussion

Related terms and concepts include impaired or conflicted relationships, failed relationships, loss of relationships, social incompetence, poor social networks, lack of social or family ties, loneliness, social maladjustment, and attachment problems.

Typical childhood fights and family disagreements are not considered under this item. Problems considered here are more extreme and will often involve the perpetrator and more than one family member.

Conflict with others, including social dysfunction and perpetration of intimate partner violence, has been found to be a risk factor for older adult abuse (Lachs & Pillemer, 1995; Homer & Gilleard, 1990; Williamson & Shaffer, 2001). In addition, a lack of social

interaction and social support in both formal and information settings are also associated with the perpetration of older adult abuse (Schiamberg & Gans, 1999). Many studies have found social isolation, a sense of loneliness, and a lack of social contacts to be associated with perpetrating older adult abuse (Anetzberger, 1987; Breckman & Adelman, 1988; Eisikovits et al., 2004; Kosberg, 1988; Lachs & Pillemer, 2015; Pillemer & Finkelhor, 1988; Reis & Nahmiash, 1998; Schiamberg & Gans, 2000; Wolf et al., 1984, 1986). Both Anetzberger (1987) and Cooney and Mortimer (1995) found that perpetrators of older adult abuse rated themselves as more isolated than did non-abusive controls, although they were in fact no more isolated based on objective measures. Thus, when coding this item, the perpetrator's perception of their level of isolation should be considered. Specifically, a perpetrator who appears to have social connections and contact but describes feeling isolated and alone, should receive a rating of present or possibly or partially present.

A lack of social support is widely cited as a risk factor for older adult abuse (Compton et al., 1997; Fulmer & O'Malley, 1987; Kosberg, & Nahmiash, 1996; Lee, 2008; Lee & Kolomer, 2005; Phillips, 1983, 1986; Phillips et al., 2000; Pillemer & Finkelhor, 1988; Reis & Nahmiash, 1998; Wolf & Pillemer, 1989; Yan & Kwok, 2011), but may be less relevant for caregivers (Johansson, 2018). Similar to social isolation, some researchers have found that it is the perception of not receiving adequate support that is associated with abuse, not objective measures of the support obtained (Compton et al., 1997; Kravitz, 2006; Serra et al., 2018).

Several theories have been forwarded to explain the association between isolation, a lack of support and the perpetration of older adult abuse. First, Gottlieb (1991) proposed that when caregivers have no one to turn to they tend to engage in fewer pleasant activities, have less control over their time, less privacy, increased stress, depression, and anger symptoms. Many of these factors are in turn risk factors for older adult abuse. Second, several researchers have suggested that isolation increases risk because it decreases the likelihood of older adult abuse being detected (Henderson et al., 2002; Kosberg & Nahmiash, 1996; Lachs & Pillemer, 2004). Third, isolation and a lack of support can make perpetrators feel that no one knows or cares about their abusive behavior thus making it more likely for them to continue (Jayawarneda & Liao, 2006).

VICTIM VULNERABILITY FACTORS

V1. Problems with Physical Health

Definition

This risk factor reflects physical health problems that include illness and functional impairment. Functional impairment refers to difficulties performing Activities of Daily Living (ADLs) such as grooming, dressing and feeding oneself, walking and making functional transfers (e.g., getting out of bed) and Instrumental Activities of Daily Living (IADLs) such as housework, meal preparation, taking medication, shopping, and using the telephone or applicable technology.

Exemplars

- V has a physical health problem (e.g., V has a chronic illness; V has a physical disability; V is in poor health; V has had a recent decline in physical health)

- V is functionally impaired (e.g., V is confined to a wheelchair; V is very physically frail; V is not physically capable of getting away from P; V is physically unable to protect himself from P; V is not physically capable of calling police; V is unable to fully take care of his own hygiene; V is incontinent)

Discussion

Related terms and concepts include illness, disease, and disability.

Coding this vulnerability factor does not require the evaluator to conduct a formal evaluation of the victim's capabilities. It can be coded based on diagnoses made by a physician or other professional. Alternatively, it can be coded based on the older person's self-reports or the observations of the evaluator or collateral informants. See "Diagnosis Ratings" on page 29 of this manual for instructions on how to indicate whether this item is *Diagnosed* or *Undiagnosed*.

A large number of studies have found an association between physical health problems, functional impartment (sometimes measured by the presence of ADLs and IADLs, pre-existing medical conditions, level of physical function, and frequency of health care use, or described as frailty or lower health status) and various types of older adult abuse victimization (Anme et al., 2005; Brozowski & Hall 2005, 2010; Burnes et al., 2016; Cohen et al., 2007; Dong, 2015; Dong & Simon, 2015; Eisikovits et al., 2004; Erlingsson et al., 2003; Friedman et al., 2011; Fulmer et al., 2005; Garre-Olmo et al., 2009; Johannesen & LoGiudie, 2013; Lachs & Pillemer, 2015; Laumann et al., 2008; Lee, 2008; Macassa et al., 2013; Schiamberg & Gans, 1999; Schiamberg et al., 2012; Post et al., 2010; von Heydrich et al., 2012; Yan et al., 2015). Further, Dong and colleagues (2012),

using a prospective design, found that physical function as measured through either objective assessment or self-report was associated with increased risk of older adult abuse and increased risk of multiple (3 or more) forms of older adult abuse. In addition, De Donder and colleagues (2016) found that poor physical health was associated with more severe older adult abuse.

Potential reasons for the association between health problems and victimization include the fact that physical impairment can lead to isolation, which is a vulnerability factor (see V8) and can decrease the likelihood that abuse will be detected (Roberto, 2016). Another pathway to victimization identified by Kong and Jeon (2018) is that ADL and IADL limitations are associated with reduced victim self-esteem and increased family assistance which are associated with increased risk. Researchers generally agree that the physical health of the victim is an important vulnerability factor that should be considered in assessment (Lachs & Pillemer, 2004; Pillemer et al., 2007; Wolf, 1997). The primary reason for this is that physical health has been identified as an indicator of a victim's ability to escape harm, protect him or herself, and obtain assistance (Burnes et al., 2015; Kosberg & Nahmiash, 1996; Tatara & Blumerman, 1996). For instance, Naughton and colleagues (2014) found that older adults with impaired physical health are less aware of the term elder abuse, raising the possibility that they will be less likely to identify and report their own victimization.

VICTIM VULNERABILITY FACTORS

V2. Problems with Mental Health

Definition

This risk factor reflects problems with mental and personality functioning, which in turn, can result in substantial problems with cognition, mood, and behavior.

Exemplars

- V has a mental health disorder (e.g., V has been diagnosed with a major mental disorder; V is depressed; V has dementia; V has grossly distorted or unrealistic beliefs due to psychosis; V has a personality disorder that causes extreme shifts in mood or violence; V is experiencing suicidal ideation or intent)

- V is cognitively impaired (e.g., V is experiencing memory loss; V often becomes confused; V's memory and concentration problems could hamper his ability to ask for help or know how to get help; V has shown a recent decline in cognitive ability)

- V engages in difficult behavior due to mental disorder (e.g., V is violent or verbally abusive; V is combative; V engages in disruptive or socially inappropriate behavior such as threatening or disrobing in public; V's behavior is very difficult to manage)

Discussion

Related terms and concepts include major mental illness, intellectual deficit, cognitive deficit, Alzheimer's disease, emotional problems and provocative behavior.

Coding this factor does not require the evaluator to make a diagnosis. This item can be coded based on diagnoses made in the course of psychiatric or psychological evaluations conducted by others. Alternatively, coding can be based on the victim's self-report or the observations of the evaluator or collateral informants. See "Diagnosis Ratings" on page 29 for instructions on how to indicate if this item is Diagnosed or *Undiagnosed*.

Mental health problems, particularly depression, are vulnerability factors for older adult abuse (Chokkanathan, 2018; Dong, 2015; Dong & Simon, 2012; Fulmer et al., 2005; Johannesen & LoGiudie, 2013; Naughton et al., 2012; Roepke-Buehler et al., 2015; Yan et al., 2015). Mental health problems are also associated with increased abuse severity, and depression is a vulnerability factor for mortality (De Donder et al., 2016; Dong et al., 2011a). Mental health problems may be associated with older adult abuse since they are related to denial, isolation, self-blame, and a failure to seek help (see V6, V8) and because they are associated with self-neglect (see V5), all of which are vulnerability

factors for older adult abuse (Bartley et al., 2007; Henderson et al., 2002).

Reduced cognitive status (i.e., dementia, confusion, reduced memory, reduced perceptual speed, Alzheimer's disease) has been described as one of the most likely explanations for older adult abuse, and is one of the vulnerability factors with the strongest empirical support (Cohen et al., 2010; Cooper et al., 2006; Dong et al., 2011b, 2014; Dyer et al., 2003; Fulmer et al., 2005; Friedman et al., 2017; Johannesen & LoGiudie, 2013; Lachs et al., 1997; Roberto, 2016; Serra et al., 2018; Shugarman et al., 2003; Yan et al., 2015). There is also evidence that reduced cognition may indirectly increase the risk for older adult abuse by increasing the presence of other vulnerability factors. For instance, problems with cognition, particularly dementia, can lead older adults to engage in self-neglect (see V5). Cognitive issues may also have an indirect impact because they are related to reduced physical health (see V1), high dependence (see V4), and difficult behavior (see below), (Kravitz, 2006; Tatara & Blumerman, 1996; Coyne et al., 1993). In fact, many researchers suggest that cognitive problems are not the triggering behavior for older adult abuse, but instead elicit difficult behaviors which are the precipitators of abuse (Jones et al., 1997; Lachs & Pillemer, 1995, 2004; Wolf 1997).

There is strong evidence that difficult behavior caused by mental disorder is directly associated with older adult abuse (Cohen et al., 2010; Cooper et al., 2013; Johannesen & LoGiudie, 2013; Lachs & Pillemer, 1995; Schiamberg et al., 2012; Pérez-Rojo et al., 2009; Post et al., 2010; von Heydrich et al., 2012). Individuals who are in contact with an older person displaying difficult behavior can experience heightened stress as a result of being abused, embarrassed, or having their workload increased. Abusive caregivers report difficult behavior, particularly violent, invasive and embarrassing behavior, to be the main problem they encounter and the cause of violent feelings and stress (Compton et al., 1997; Homer & Gilleard, 1990; Pillemer & Suitor, 1992). Correspondingly Özcan and colleagues (2017) found that caregivers who were being abused were more likely to perpetrate abuse and Johansson (2018) found that emotional abuse (but not physical abuse) by the victim toward the caregiver was a risk factor.

Mental health problems, and resulting difficult behavior, is one of the vulnerability factors with the most empirical support (Jones et al., 1997). It should be noted that mental health problems can also be the result of older adult abuse (Goldstein, 1995). Regardless of origin, mental health problems should be considered under this item as they impact the risk of future older adult abuse and its management. Cognitive impairment that compromises decision making capacity is also important to consider when implementing management strategies requiring victim consent (Lachs & Pillemer, 1995).

VICTIM VULNERABILITY FACTORS

V3. Problems with Substance Use

Definition

This vulnerability factor reflects serious problems in health, occupational, financial, social, or legal functioning resulting from the use of illegal substances or the misuse of legal substances (e.g., alcohol, prescribed medications).

Exemplars

- V has physical health problems due to substance use (e.g., V has liver problems due to alcohol use; V has been hospitalized due to abuse of prescription drugs; V's alcohol use is exacerbating his chronic illness)

- V has psychological problems due to substance use (e.g., V has experienced tolerance or withdrawal symptoms due to the misuse of alcohol; V has memory loss due to alcohol use or alcohol use is exacerbating a pre-existing problem with V's memory)

- V's substance use is affecting her social adjustment (e.g., V's alcohol use has caused problems in his relationships with P or others; V has financial problems because he spends all his money on drugs; V engages in provocative or aggressive behavior when intoxicated)

- V's substance use is impairing his ability to protect himself (e.g., V becomes too intoxicated to call for help; V becomes too impaired to leave when P is abusive; V does not realize the seriousness of his injuries when intoxicated)

Discussion

Related terms and concepts include drug and alcohol use problems, abuse, and dependence. Problems with substances can be pre-existing or the result of victimization.

Substance abuse is generally recognized as an important vulnerability factor to consider when assessing risk for older adult abuse (Peguero & Lauck, 2008; Schiamberg & Gans, 1999). Older persons who abuse substances are at greater risk of becoming the victims of abuse than those who do not abuse substances (Conrad et al., 2019; Erlingsson et al., 2003; Fulmer & O'Malley, 1987; Homer & Gilleard, 1990; Johannesen & LoGiudie, 2013; Kosberg, 1988; Lindert et al 2013; Macassa et al., 2013). For instance, Shugarman and colleagues (2003) found that in cases where the older adult abused alcohol, the prevalence of observed signs of potential older adult abuse was ten times greater than when the older adult did not abuse alcohol.

A number of hypotheses have been forwarded to explain the association between substance abuse by an older adult and older adult abuse victimization (Henderson et al., 2002). Some hypotheses suggest that the impact of substance abuse on the victim's living situation and abilities may account for the relationship. Henderson and colleagues (2002) suggest that an older adult who abuse substances may be more likely to live in a less stable environment (e.g., financially, emotionally) than someone who does not abuse substances. In addition, they posit that an older adult may be less aware that they are receiving inadequate or harmful care because of their addiction. It has also been suggested that intoxication or the long-term effects of substance abuse can reduce a victim's ability to protect themselves, escape, seek help, recognize the extent of their injuries, or realize when a situation is unsafe or about to become abusive (Kravitz, 2006; Manthorpe, 2015). Several other hypotheses suggest that the association may be the result of substance abuse promoting or co-existing with other risk and vulnerability factors for older adult abuse. Henderson and colleagues (2002) note that substance abuse may cause provocative or difficult behavior, which is a vulnerability factor for older adult abuse (see V2). Choi and Mayer (2000) found that older adults who abused substances were 70% more likely to engage in self-neglect, a factor that can increase the likelihood that an older adult will be targeted for abuse (see V5). Substance abuse has also been found to be associated with social isolation, another vulnerability factor for older adult abuse (see V8) (Ganry et al., 2000; Onen et al., 2005; Schonfeld & Dupree 1991). Substance abuse by caregivers is associated with abuse by care recipients (Shugarman et al., 2003). Thus, substance abuse by the victim may indicate substance abuse by the perpetrator, which is a risk factor for older adult abuse (see P3) (Homer & Gilleard, 1990; Hwalek et al., 1996; Sharon, 1991). A final hypothesis forwarded to account for the association is that substance abuse is a consequence of older adult abuse (Goldstein, 1995). Thus, substance abuse can be considered both a vulnerability factor and indicator of older adult abuse. As a result of the role that substance abuse plays in older adult abuse Choi and Mayer (2000) suggest that case management services include alcohol and substance abuse screening and treatment.

VICTIM VULNERABILITY FACTORS

V4. Dependency

Definition

This vulnerability factor reflects serious problems related to the victim's dependency on the perpetrator. Dependency can be functional, financial, social or emotional in nature.

Exemplars

- V is functionally dependent on P (e.g., V relies on P for transportation; V relies on P for household repairs; V relies on P for personal care)
- V is emotionally or socially dependent on P (e.g., V feels she cannot live without P; V is dependent on P for social interaction)
- V is financially dependent on P (e.g., P controls V's finances; P has power of attorney for V; P handles V's bills or taxes thereby controlling her finances or medical treatment; V depends on P to manage his money)

Discussion

Related terms and concepts include social, emotional, functional and financial dependence.

Disabilities such as cognitive impairment and mental illness can create dependency, as can life changes like immigration (Jones et al., 1997). Impairments that can cause dependency are considered under several other victim vulnerability factors; under the present item we evaluate the presence of the dependency alone.

The issue of victim dependency has been widely debated (Wolf, 2000). When research on the abuse of older adults first began, it was commonly believed that victim dependence led to caregiver resentment and stress, which in turn resulted in older adult abuse (Quinn & Tomita, 1997). In fact, several explanatory models of older adult abuse described this relationship (i.e., the caregiver stress model, dependency model, and web of dependency) (Jones et al., 1997; Quinn & Tomita, 1997; Wolf, 2000). Although research has since shown victim dependence to not be the predominant cause of older adult abuse (Asti & Erdem, 2006; Bristowe & Collins, 1989; Compton et al., 1997; Cooney & Mortimer, 1995; Homer & Gilleard, 1990; Pérez-Rojo et al., 2009; Phillips, 1983; Pillemer, 1985; Reis & Nahmiash, 1997; Wolf & Pillemer, 1989), it is still associated with older adult abuse victimization (Erlingsson et al., 2003; Jackson & Hafemeister,

2014; Johannesen & LoGiudie, 2013; Kosberg, 1988; Quinn & Tomita, 1986; Tatara, 1993; Yan & Tang, 2004). Two studies found the association to be present specifically for neglect (Wolf et al., 1984, 1986.). Further, victim dependency has important implications for help seeking among victims and case management. Specifically, researchers have noted that dependency can decrease help seeking, the ability to defend oneself, and can increase isolation (see V8) (Lachs & Pillemer, 1995; Pillemer et al., 2007). For instance, a victim who relies on the perpetrator for transportation, care, or financial assistance may be more hesitant to report abuse, knowing that the perpetrator may no longer be permitted to have contact with them. In addition, if following intervention, the victim's care needs are not being met elsewhere (e.g., through family, care services) they will be more likely to initiate or permit contact between themselves and the perpetrator. It has also been theorized that dependency can lead to learned helplessness (Villomare & Bergman, 1981). Therefore, considering dependency as a risk factor and management target may decrease abuse and contact between the perpetrator and victim, and increase reporting and the independence and coping skills of the victim (Jayawarneda & Liao, 2006; Lachs & Pillemer, 1995; Wolf, 1997). In fact, when comparing resolved and unresolved cases of older adult abuse, Wolf and Pillemer (2000) found that cases where there was a change in the victim-perpetrator interdependency were more likely to be resolved at follow-up than those where no change was present.

VICTIM VULNERABILITY FACTORS

V5. Problems with Stress and Coping

Definition

This vulnerability factor reflects serious problems with stress and the ability to cope with life problems. The problem may be a reaction to unusually stressful life events, abuse, or the consequences of and reactions to impairments caused by functional, cognitive, or emotional problems.

Exemplars

- V is feeling highly stressed (e.g., V feels too upset, anxious, or hopeless about the future to reach out for help; V finds P to be a source of a lot of stress; V has recently experienced a stressful life event; V is suicidal; V is having panic attacks)

- V is unable to cope (e.g., V is having great difficulty adjusting to life problems; V is avoiding or passively coping with the abuse or other life problems; V feels unable to make important decisions about the future)

- V is engaging in self-neglect (e.g., V is engaging in behavior that threatens his health and safety; V does not take care of her personal hygiene; V engages in hoarding behavior or lives in unsanitary conditions; V will not take prescribed medication or attend necessary appointments with his physician)

Discussion

Related terms and concepts include serious depression or despair, strain, suicidal ideation or intent, emotional problems, post-traumatic stress, severe withdrawal, avoidant or passive coping, failure to engage in self-care, and fear.

Diagnoses and problems with health and mental health are considered under V1 and V2, respectively. Under the present item, the impact of such problems and the abuse on stress levels and coping are considered. For instance, if V has been diagnosed with depression but is seeking treatment and planning for the future, this item would not be coded as present.

Problems with stress and coping can both precede and be the result of older adult abuse. With respect to the association between stress and vulnerability, Wolf and Pillemer (2000) determined that victims who found the perpetrator to be the source of a lot of stress were more likely to continue to be victimized. They also found that cases in which victims experienced a stressful life event involving the health or behavior of a

family member (other than the perpetrator) were less likely to be resolved at follow-up compared to cases where such an event did not occur. In addition, Roepke-Buehler and Dong (2015) found that older persons reporting the highest level of perceived stress were three times as likely to be the victim of abuse compared to those not reporting high levels of stress.

With regard to coping and vulnerability, Comijs and colleagues (1998) found that only a small percentage of victims used active problem-solving strategies when dealing with the perpetrator. Alternative strategies used by most of the victims surveyed included withdrawing from the abusive situation, terminating contact with the perpetrator, or doing nothing. Older adult abuse was associated with having less control over problem situations, a higher tendency to react aggressively when feeling angry or frustrated, and a passive and avoidant way of handling problems. These findings were echoed by De Donder and colleagues (2016) who found that poor coping (defined as giving up) was associated with increased older adult abuse severity. In addition, Comijs and colleagues (1999b) found that the coping style of victims of older adult abuse was more avoidant and passive than the coping style of non-victims.

One important manifestation of a failure to cope is self-neglect. Self-neglect is behavior by an individual that threatens their health and safety and comes about through neglecting one's own needs (National Center on Elder Abuse Website, 2006). Self-neglect has been shown to increase the risk of being victimized by others (Dong, 2015). Dong and colleagues (2013), found self-neglect to be a predictor of older adult abuse even after factors related to physical, psychological, and social well-being were controlled. Further, they found that the median time to abuse following the commencement of self-neglect was 3.5 years. One hypothesis forwarded by the authors for the association is that those who engage in self-neglect do not obtain medical help until a catastrophic event has occurred and subsequently become reliant on caregivers and are then more vulnerable to exploitation and abuse (see V1 and V4). Self-neglect has also been found to be associated with other risk factors for abuse. Problems with mental health (V2), particularly dementia and depression, are risk factors for self-neglect (Bartley et al., 2007; Dong et al., 2013). Choi and Mayer (2000) found that older adults who abused substances (see V3) were 70% more likely to engage in self-neglect.

Overall, research indicates that stress and coping are related to vulnerability and the effective management of older adult abuse should be considered as part of a comprehensive assessment (Campbell Reay & Browne, 2001).

VICTIM VULNERABILITY FACTORS

V6. Problems with Attitudes

Definition

This vulnerability factor reflects serious problems with the victim's minimization of and inconsistent attitudes toward the perpetrator, their behavior, and the risks they pose.

Exemplars

- V minimizes P's abusive behavior (e.g., V sometimes worries that maybe he is exaggerating the seriousness of the abuse; V sometimes blames himself for the abuse; V feels that she does not deserve help)

- V shows excessive loyalty to P (e.g., V says reporting P's abusive behavior to anyone would violate her role as a mother; V believes in showing family loyalty by not involving outside parties in family conflict; V refuses to tell her community about the abuse because she believes reporting P would bring shame or embarrassment to the family)

- V is ambivalent about P or P's abusive behavior (e.g., V wants the abuse to stop but feels responsible for looking after P; V will not have P removed from her residence; V thinks reporting P will only bring more problems to P's life)

Discussion

Related terms and concepts include denial, self-blame, self-depreciation, stoicism, and refusal to ask for help.

Problems with attitudes held by the victim are important to consider when assessing risk and developing management strategies. Research has shown that self-blame, excusing the abusive behavior of family members, a desire to protect the perpetrator, stoicism, self-depreciation, and apathy are risk factors for older adult abuse (Henderson et al., 2002; Jackson & Hafemeister, 2014; Kosberg, 1988). These attitudes increase the risk of harm because they can cause the victim to fail to place adequate value on their own safety, isolate themselves, deny that the abuse has occurred, fail to seek medical services, fail to report the abuse, or fail to engage in self-protective behavior (Campbell Reay & Browne, 2001; Eisikovits et al., 2004; Henderson et al., 2002). Further, such attitudes can result in the victim continuing to live with or have contact with the perpetrator and a lack of consequences for the perpetrator, all of which increase the risk of continued abuse (Jackson & Hafemeister, 2012b).

Victims may hold these attitudes, deny that abuse has occurred, or be reluctant to take action for many reasons. Such reasons include fear of reprisal or of being sent to a care home or other less desirable environment, fear that the abuser (a relative) will be arrested, fear of getting into trouble themselves, fear of not being believed, fear of losing social status, and fear that they will not be helped (Henderson et al., 2002; Kosberg, 1988). Victims may also feel shame, embarrassment or responsibility for the abuse perpetrated by their adult child whom they raised (Henderson et al., 2002; Jones et al., 1997; Kosberg, 1988). Shame can also play a substantial role in cultures where a great deal of value is placed on family and caring for older adults (Jones et al., 1997). Attitudes that favor family loyalty and situate abuse as a private family matter can also prevent reporting and help seeking by victims (Boldy et al., 2005; Eisikovits et al., 2004). Poor self-image and a belief that the abuse is deserved are also reasons that some victims deny or fail to report older adult abuse (Boldy et al., 2005; Kosberg, 1988).

The reason that a victim holds these types of problematic attitude does not impact vulnerability directly, but it does directly impact management. In order to prevent future violence, detect abuse, and encourage reporting and self-preservation behaviors, we must identify and change these problematic attitudes by making them targets for treatment (Henderson et al., 2002). Jackson and Hafemeister (2012b) suggest that to promote victim safety and maintain autonomy, it is best to understand the victim's reasons for engaging in ongoing contact with the perpetrator and to develop management strategies based on that information.

VICTIM VULNERABILITY FACTORS

V7. Victimization

Definition

This vulnerability factor reflects previous abuse experienced or witnessed by the victim at any point during their lifetime, other than the current episode of older adult abuse by the perpetrator. The abuse could have been at the hands of the current perpetrator or a different individual.

Exemplars

- V has previously experienced victimization by P, other than older adult abuse (e.g., V was the victim of intimate partner violence throughout her marriage to P)

- V was victimized by other individuals (e.g., V was the victim of intimate partner violence not by P; V was neglected as a child; V witnessed abuse in the family home)

Discussion

Related terms and concepts include childhood victimization, physical abuse, and neglect.

Prior victimization at any time during the lifespan has been shown to increase the risk of older adult abuse victimization (Brozowski & Hall, 2005, 2010; Erlingsson et al., 2003; Griffin & Williams, 1992; Jackson & Hafemeister, 2011; Johannesen & LoGiudie, 2013; Reis & Nahmiash 1998; Schiamberg et al., 2012). In fact, Acierno and colleagues (2010) found previous traumatic event exposure (including interpersonal and intimate partner violence) to be one of the most consistent correlates of older adult abuse victimization. Several studies have tried to more specifically identify which types of victimization are vulnerability factors for older adult abuse. Fulmer and colleagues (2005) found that older adult abuse was associated with childhood physical abuse as well as childhood neglect. Prior intimate partner violence has also been found to be associated with older adult abuse later in life (Lachs & Pillemer, 1995; Peri et al., 2008; Schofield et al., 2002). To account for the association between prior victimization and older adult abuse, Acierno and colleagues (2010) suggest that environments where individuals are exposed to traumatic events are likely to also contain abusive individuals over time.

VICTIM VULNERABILITY FACTORS

V8. Problems with Relationships

Definition

This vulnerability factor reflects serious problems with relationships, including those with the perpetrator and other social relationships (e.g., with intimate partners, friends, family), and the victim's living arrangements with these individuals.

Exemplars

- V and P had a conflictual relationship pre or post the start of the abuse (e.g., V and P often argued about finances; V and P are poor at communicating with each other)
- V has conflictual relationships with others (e.g. V openly expresses severe or unwarranted anger toward family or friends; V often argues with family)
- V is socially isolated (e.g., V has few social ties; V rarely leaves home; V is alone a lot or lonely; V is not at ease with others)
- V lacks social support (e.g., V does not have a trusted person who she can confide in; V lacks emotional support; V does not have anyone to turn to for advice)
- V lives with others (e.g., V shares a residence with P; V lives in a residence that is overcrowded or where there is a lack of privacy)

Discussion

Related terms and concepts include family conflict, poor pre/post-morbid relationship, social incompetence, lack of social ties, social maladjustment, and poor social networks.

A poor quality pre-morbid relationship between the victim and perpetrator is a vulnerability factor for older adult abuse (Campbell Reay & Browne, 2001; Compton et al., 1997; Henderson et al., 2002; Jackson & Hafemeister, 2011; Nerenberg, 2002; Serra et al., 2018; von Heydrich et al., 2012). Positive relationships with adult children are not only important to parents but also impact their health and well-being, both of which are vulnerability factors for abuse (see V1 and V2) (Bell & Bell, 2012). It is suggested that caregivers who shared a close and positive relationship with the older person become less stressed and are less likely to act abusively when providing care (Nerenberg, 2002; Wolf, 2000). There is also evidence that a poor post-morbid or current relationship between the victim and perpetrator is a vulnerability factor (Cooney & Mortimer, 1995; Erlingsson et al., 2003; von Heydrick, 2009). We suggest however, that most abusive

relationships are poor, thus the presence of a poor post-morbid relationship alone should not result in a rating of present for this item. The quality of the victim's other relationships is also associated with older adult abuse. Older adults who have conflictual relationships with family and friends, or who have trouble relating to others are at greater risk of victimization (Boldy et al., 2005; Cooper et al., 2006; Johannesen & LoGiudie, 2013; Shugarman et al., 2003).

Social isolation has been widely identified as a vulnerability factor for older adult abuse (Dong, 2015; Henderson et al., 2002; Jackson & Hafemeister, 2014; Lachs & Pillemer, 1995, 2004, 2015; Johannesen & LoGiudie, 2013; Roberto, 2016; Pillemer et al., 2007; Wolf et al., 2002). Manifestations of social isolation associated with abuse, include feeling lonely, a lack of companionship or left out, living in a rural area, having few visitors or friends, being widowed/divorced/separated, and a lack of formal or informal contacts (Brozowski & Hall, 2005; Burnes et al., 2015; Bužgová & Ivanová, 2009; Chokkanathan, 2018; De Donder et al., 2016; Dong & Simon, 2012; Dong et al., 2007; Shugarman et al., 2003; von Heydrich et al., 2012). Dong et al. (2011a) found that a low social network and low social engagement among victims was associated with mortality. The cause of isolation did not impact the association with vulnerability.

Many studies have identified a lack of social support as a vulnerability factor (Acierno et al., 2010; Buri et al., 2006; Phillips et al., 2000; Reis & Nahmiash, 1998; Roberto, 2016; Shugarman et al., 2003). Further, having social support has been identified as a protective factor against older adult abuse as well as a factor that increases the likelihood of case resolution (Comijs et al., 1999a; Dong & Simon, 2008, 2010; Wolf & Pillemer, 2000). Social support may be protective by acting as a buffer against stress, depression, and health problems, and by increasing the likelihood that abuse will be detected (Gottlieb, 1991; Henderson et al., 2002; Lachs & Pillemer, 1995; Pillemer 1985).

Numerous studies have identified living with others, particularly the perpetrator, as a vulnerability factor for older adult abuse (Cooper et al., 2006; Friedman et al., 2017; Jackson & Hafemeister, 2014 Johannesen & LoGiudie, 2013; Lachs & Pillemer, 2015; Roberto, 2016). Shared living arrangements, particularly when overcrowded, can negatively impact relationships since they provide greater opportunity for contact, conflict, and tension which can increase stress and anxiety and lead to abuse (Boldy et al., 2005; Henderson et al., 2002; Jones et al., 1997; Lachs & Pillemer, 1995, 2004; Pillemer et al., 2007). Changes to living arrangements, particularly those related to the abuse (e.g., not living with the perpetrator) decrease the likelihood of continued older adult abuse (Jackson & Hafmeister, 2012b; Wolf & Pillemer, 2000). Nevertheless, a recent meta-analysis found no relationship between living with others and the prevalence of older adult abuse (Ho et al., 2017) and Johansson (2018) found it to be unrelated for perpetrators who were caregivers.

COMMUNITY AND INSTITUTIONAL RESPONSIVITY FACTORS

R1. Problems with Availability

Definition

This responsivity factor reflects serious problems with the availability of resources and support in the community or institution in which the victim and perpetrator reside.

Exemplars

- Community lacks care facilities and staff (e.g., V is forced to rely on family for care due to unavailable resources; due to a shortage of staff, V gets little face time with staff to voice concerns or seek help; due to the risk posed by P, care facilities will not accept V as a patient)

- Community lacks treatment facilities (e.g., Community does not have treatment facilities that will treat P's anger and substance abuse issues; wait lists for treatment are very long)

- Community lacks transition homes (e.g., transition homes will not accept V because they cannot accommodate her care needs)

- Social services do not offer enough support for V (e.g., there are not enough social workers to properly monitor V's wellbeing by attending his home occasionally; community lacks support or social groups designed for older adults who are victims of abuse)

- Family is unavailable to assist (e.g., family refuses to provide V with adequate help, even in the short term; family refuses to assist police or other agencies in reporting or managing the abuse; family wants nothing to do with P and so refuses to be involved)

Discussion

Related terms and concepts include lack of resources, scarce resources, severely strained resources, lack of support workers, lack of support groups or agencies, and lack of familial support.

A lack of available formal and informal resources for victims and perpetrators has been identified as a risk factor for older adult abuse (Anme et al., 2005; Buri et al., 2006; Jones et al., 1997; Kosberg, 1988; Ogioni et al., 2007; Peri et al., 2008; Phillips et al., 2000; Shugarman et al., 2003; Wang et al., 2009). The reason for this association is that the lack of resources and assistance increases stress, decreases the physical and mental

health of the older adult, and decreases monitoring which can delay or prevent the detection of abuse (Gottlieb, 1991; Henderson et al., 2002; Peri et al., 2008; Pillemer, 1986; Wolf & Pillemer, 1989). It should also be noted that even the perception of fewer resources is a risk factor for older adult abuse as it may discourage help-seeking behaviors (Comijs et al., 1998). Thus, education to increase awareness of available resources can be a useful risk management strategy.

Owing to the complex nature of older adult abuse (i.e., the range of medical, psychosocial, economic and interpersonal factors), multiple resources are necessary to successfully meet the needs of the victim and perpetrator (Jayawarneda & Liao, 2006; Podneicks, 2008). In fact, no single discipline has all of the resources and knowledge required to address all aspects of older adult abuse (Jayawarneda & Liao, 2006; Mosqueda et al., 2004; Nerenberg, 2003; Podneicks, 2008). As such, multidisciplinary approaches that include cross-disciplinary communication and coordination are most effective at assessing and preventing older adult abuse (Jayawarneda & Liao, 2006; Quinn & Tomita, 1997). Coordinated responses also make it difficult for perpetrators to single out and retaliate against individuals or agencies involved in risk management (Quinn & Heisler, 2004).

COMMUNITY AND INSTITUTIONAL RESPONSIVITY FACTORS

R2. Problems with Accessibility

Definition

This responsivity factor reflects serious problems with the accessibility or ease with which victims and perpetrators can access resources and support in their community or within the institution where they reside.

Exemplars

- Resources are not physically accessible (e.g., P lives in a rural community and has to commute several hours to attend substance abuse treatment; V cannot drive but necessary services are only available by car; community facilities are not handicap accessible and V is in a wheelchair; family members live in another city so they cannot check-in on V)

- P cannot benefit from available services (e.g., services are only offered in a language that P does not speak; to be beneficial, treatment programs require a level of education above that which P has)

Discussion

Related terms and concepts include ease of access, proximity, ease of understating, and responsivity.

A lack of accessibility or barriers to resources has been identified as a risk factor for older adult abuse (Buri et al., 2006; Jones et al., 1997; Podneicks, 2008). Accessibility can act as a risk factor in several ways. For instance, geographic isolation was identified as a risk factor by Breckman and Adelman (1988) and Kosberg (1988). In addition, Peri and colleagues (2008) found the limited availability of interpreters to be a risk factor for abuse as it meant that health needs and abuse may not be identified.

COMMUNITY AND INSTITUTIONAL RESPONSIVITY FACTORS

R3. Problems with Affordability

Definition

This responsivity factor reflects serious problems with the cost of resources and support in the community or institution in which the victim and perpetrator reside.

Exemplars

- High cost of institutional care (e.g., V is forced to live with P because he cannot afford to move to a care home)
- High cost of treatment (e.g., P, who is unemployed, cannot afford counseling and does not have adequate insurance coverage to see a counselor as often as he needs to)
- Financial resources are lacking (e.g., V can no longer afford necessary care; family members are unable to assist V financially)

Discussion

Related terms and concepts include lack of funds, and high cost.

A lack of financial resources is a risk factor for older adult abuse (Buri et al., 2006; Jones et al., 1997). Several studies have specifically identified low victim income, economic deprivation, poverty, and financial strain as risk factors for older adult abuse (Burnes et al., 2015; Dong et al., 2007; Johannesen & LoGiudie, 2013; Lachs & Pillemer, 2015; Lindert et al., 2013; Macassa et al., 2013; Naughton et al., 2012). Further De Donder and colleagues (2016) found that low household income increased the severity of older adult abuse. Both the lack of resources themselves and the strain this can cause—by increasing depression, anxiety, and resentment—are reasons for the association between income and older adult abuse (Henderson et al., 2002; Lee, 2008). For instance, the high cost of services can result in an older adult being kept at home with inadequate care instead of being placed in a care facility (Peri et al., 2008).

COMMUNITY AND INSTITUTIONAL RESPONSIVITY FACTORS

R4. Problems with Acceptability

Definition

This responsivity factor reflects serious problems with the victim's or the perpetrator's willingness to accept, or satisfaction with, the available resources and support in the community or institution in which they reside.

Exemplars

- Assistance is not accepted (e.g., V refuses to attend counseling or support groups; P refuses to attend treatment; V refuses help from family members)

- Assistance is not satisfactory (e.g., Alcoholics anonymous is the only substance abuse program available but P does not accept its religious nature; P claims the only therapist in town is a quack and refuses to attend sessions; V refuses to move to a care facility because she feels the quality of the facility is low)

Discussion

Related terms and concepts include refusal, rejection, and unsatisfactory.

Victims who refuse resources and support are at a greater risk of continued older adult abuse than those who do not (Wolf & Pillemer 2000). Wolf and Pillemer (2000) found that abuse was significantly more likely to continue in cases where victims did not change their living arrangements. Perpetrators who refuse services are also more likely to continue to engage in abusive behavior. For instance, family members who did not follow up on offers for respite care were at greater risk of engaging in neglect (Jayawardena & Liao, 2006).

Several reasons exist for refusing resources and support. For instance, despite engaging in neglect, a perpetrator may refuse to place the victim in a care home for financial reasons (Jayawardena & Liao, 2006). Cultural sanctions can also influence whether the victim or perpetrator will accept services. For example, refusal of resources or support may be more likely where there are cultural sanctions against seeking help to care for an older family member or against revealing family problems to outsiders (Goldman, 1987; Jones et al., 1997). Even if this were the case, refusal of resources or support remains an impediment to effective case management, and education and motivational interviewing around this area may be helpful. The specific reasons for the refusal can assist in managing risk, but there is no evidence that they alter the likelihood of future older adult abuse.

Depending on the legal circumstances of the perpetrator and the mental capacity of the victim, their ability to accept or refuse resources will vary. This risk factor cannot assist in making such distinctions, it simply reflects the fact that refusal increases the risk of older adult abuse and should be a management target.

COMMUNITY AND INSTITUTIONAL RESPONSIVITY FACTORS

R5. Problems with Appropriateness

Definition

This responsivity factor reflects serious problems with the nature of the resources and support in the community or institution in which the victim and perpetrator reside.

Exemplars

- Institutions have problems related to staff (e.g., staff lack empathy for clients; staff are not adequately trained; staff are highly stressed; there is substantial conflict between staff and clients; staff are not satisfied with their jobs and it is creating problems with their job performance)

- Institutions have problems related to management (e.g., care facilities do not have clear policies regarding abuse; staff feel that there is no avenue to report abuse that they witness; hiring practices are negligent and do not appropriately screen for candidates with criminal or violent histories)

- Support is narrowly focused (e.g., treatment assumes all older adult abuse stems from caregiver stress and does not acknowledge dependent perpetrators with physical or mental health problems)

- Institutions lack adequate safety resources (e.g., there is no way to monitor who enters the facility; the facility lacks the means to put an appropriate safety plan in place for V)

- Family support is inadequate (e.g., family members do not believe P has done anything wrong and see no need for management or to protect V's safety; family members will not contest P's role as power of attorney for V)

Discussion

Related terms and concepts include quality, continuity, and focus.

Environments where there is coordination between agencies providing resources and support and large numbers of staff members, who are caring and well paid, are protective against older adult abuse (Peri et al., 2008; Pillemer & Bachman-Prehn, 1991; Wolf & Pillemer, 2000). Similarly, environments with inadequate or poor-quality services and support systems are risk factors for older adult abuse (Fulmer & O'Malley, 1987; Jones et al., 1997; Peri et al., 2008; Wang et al., 2009).

Risk factors specific to care facility staff include negligent hiring practices, high turnover or burnout, inadequate training or knowledge, high work stress, low pay, low empathy, low job satisfaction, and the perception of older adults as childlike (Bužgová & Ivanová 2009; Cooper et al., 2013; Jogerst et al., 2008; Marsland et al., 2007; Peri et al., 2008; Phair, 2009; Pillemer & Bachman-Prehn, 1991; Pillemer & Moore, 1989; Wang et al., 2009). Risk factors related to the overall care facility include poor policies or policy enforcement (particularly those related to the confidential reporting of abuse), poor leadership, high conflict, role ambiguity, role conflict, a lack of openness to hearing reports of older adult abuse, and poorly enforced standards (Bernoth et al., 2014; Marsland et al., 2007; Phair, 2009; Pillemer & Bachman-Prehn, 1991; Pillemer & Moore, 1989). Such factors can make the facility inappropriate to provide care for the victim.