Perceptions of Elder Abuse in Sweden: Voices of Older Persons

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The aim of this study was to explore the perceptions of elder abuse held by older persons in Sweden. Six focus group interviews were conducted. Through qualitative content analysis, the text revealed four themes: causes of elder abuse, conceptions of elder abuse, consequences of elder abuse, and coping with elder abuse. Changing society and families, as well as individual determinants, were believed to be causes of elder abuse. The main conception of elder abuse was that of robbery or assault, and the main consequence was fear. Coping with abuse included individual strategies and improvements in society. Issues of age discrimination were intrinsic in the findings. Gender differences were evident in the group dynamics. Nurses and other health care personnel need to be aware of what older persons believe to be the cause of elder abuse and what they consider abusive. Awareness of the results of this study can help in refining interview and assessment techniques and in designing training manuals. [Brief Treatment and Crisis Intervention 5:213–227 (2005)]

KEY WORDS: elder abuse, focus groups, qualitative content analysis, coping, robbery.

Elder abuse is a complex phenomenon. It was first described in the literature in the 1970s and provocatively called “granny battering” (Baker, 1975; Burston, 1977). Studies examining the prevalence of elder abuse have shown that 4% to 6% of older adults have experienced abuse (Ogg & Bennett, 1992; Pillemer & Finkelhor, 1988; Podnieks, 1992b). In an investigation of elder abuse in Scandinavia, Tornstam (1989) reported that 8% of a random sample of Swedish adult citizens knew of an elder abuse case. Tornstam’s study was the first to indicate the existence of elder abuse in Sweden. The recent report from the Swedish Crime Victim and Support Authority indicated that 16% percent of elderly women and 13% of elderly men had experienced some kind of abuse since turning 65 years of age (Eriksson, 2001). Research efforts have gained momentum the last 20 years, and elder abuse is a growing public concern (Kosberg & Garcia, 1995).
Although much has been published concerning elder abuse, very little has included older persons’ points of view.

The term elder abuse includes actions of violence or mistreatment (Hudson, 1991). The mistreatment can be an act of commission (abuse) or omission (neglect). It can be intentional or unintentional. Elder abuse entails violation of human rights, suffering, and decreased quality of life (Hudson, 1991). There are many existing definitions of elder abuse (Bennett & Kingston, 1993; McCreadie, 1996; Wolf & Pillemer, 1989), but no consensus on a standard definition has as yet been reached. Included in most definitions, however, are the types of abuse (e.g., physical, psychological, financial, neglect, self-neglect, and sexual), who does the abusing (perpetrator descriptions), who suffers the abuse (victim descriptions), and where it happens (e.g., domestic violence or institutional settings). The definition adopted by the World Health Organization and the International Network for the Prevention of Elder Abuse is as follows: “Elder abuse is a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person” (Action on Elder Abuse, 1995).

In recent years there has been an increasing interest in examining elder abuse within different cultural contexts (Hudson & Beasley, 1999; Moon & Williams, 1993; Pablo & Braun, 1997). Values and norms vary from culture to culture and from society to society. Without public input, definitions may be “ethically and pragmatically insensitive to the public they are intended to serve” (Hudson & Carlson, 1994, p. 57). Through incorporating different perspectives, confidence in how to define elder abuse will increase and provide practitioners with a basis for culturally sensitive decision making in elder abuse situations (Hudson & Carlson, 1994). It seems therefore to be a natural step to examine elder abuse as it is understood within the unique context of each culture.

Groundbreaking research on elder abuse within the Swedish context has been carried out in the field of nursing (Saveman, 1994). Nurses, by virtue of their training and responsibilities, can play a vital role in the identification, intervention, and prevention of elder abuse (Anderson & Thobaben, 1984; VanderMeer, 1992). In a study of patterns of elder abuse reported by district nurses, the typical situation involved family conflicts, financial concerns, alcohol abuse by the abuser, and mental disturbance in the victim. Psychological abuse was the most frequently reported kind of abuse (Saveman, Hallberg, Norberg, & Eriksson, 1993). Elder abuse in institutional settings is a current focus for Swedish elder abuse research. Saveman and coworkers (Saveman, Åström, Bucht, & Norberg, 1999) found that psychological and physical abuse related to caregiving activities formed the most commonly reported types of abuse in the residential setting. The abuser was typically described as being aggressive, hot-tempered, exhausted, or burnt out. The typical victim was a patient, over 80 years old, and mentally or physically handicapped (Saveman et al., 1999). There has not, however, been any research done in Sweden that has included perceptions of elder abuse in the general public or the views of older persons themselves.

This important perspective, the views of older persons themselves, has been missing from elder abuse research in general. Two studies have suggested that older persons have different perceptions of abuse than do professionals (Geboyts, O’Connor, & Mair, 1992; Kivelä, Köngäs, Kesti, Paikkala, & Ijäs, 1992). Yet only a few studies have researched older persons’ views (Nandlal & Wood, 1997; Podnieks, 1992a; Tsukada, Saito, & Tatar, 2001), and these have most often been based on reports from victims of elder abuse.
In conjunction with the "Global Response Against Elder Abuse," a global action on elder abuse initiated and coordinated by the World Health Organization and International Network for the Prevention of Elder Abuse, eight countries—among them, Sweden—have participated in a project designed to map out perceptions and views on elder abuse among community-dwelling older persons, using focus group interviews. The ultimate goal of this action is to increase awareness on the extent of elder abuse worldwide and to develop a global strategy within the context of primary health care for the prevention of elder abuse (World Health Organization, 2001). The aim of our study was to explore perceptions of elder abuse among older persons in Sweden.

Method

This study was carried out in four regions of southern Sweden, in rural, small-town, and large-city milieus. The design for this study follows global project guidelines (Perel Levin, 2001; Podnieks, 2003). These guidelines specified the data collection method of focus group interviews, the interview topics to be investigated, and the specifications for the focus group participants as well as the size and number of the groups. The study was approved by the chair of the Ethics Committee of the Faculty of Health Sciences at the University of Linköping, Sweden.

Participants and Settings

Participants were community-dwelling older persons above retirement age (63 years and older). Participation was voluntary. Recruitment of participants was through purposeful, snowball sampling and convenience sampling (Polit & Hungler, 1999). A total of 37 older persons participated in the study. Six interviews were conducted with two groups of older women, two groups of older men, and two groups of older men and women together (see Table 1). In three cases, recruitment was facilitated by third-party contacts in our network who each in turn contacted participants for a group. In the other three cases, participants were located through telephone or e-mail contact with local chapters of a national senior citizen organization (Pensioners' National Organization). Information packets containing a welcome letter and an informed consent form were provided for the participants before each interview date. The welcome letter described the project, presented the discussion topic, and included information that the interviews were to be recorded. Five

<table>
<thead>
<tr>
<th>Interview</th>
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<th>M age (range)</th>
<th>Single/cohabiting</th>
<th>Geography</th>
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<td>1</td>
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<td>6 single</td>
<td>Large city</td>
<td>Blue collar</td>
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<td>2</td>
<td>F (6)</td>
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<td>Small city</td>
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<td>3</td>
<td>M (6)</td>
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<td>1 single / 5 cohab.</td>
<td>Small town</td>
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<td>M (7)</td>
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<td>1 single / 6 cohab.</td>
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<td>5</td>
<td>F (4) / M (2)</td>
<td>82.0 (67–92)</td>
<td>2 single / 4 cohab.</td>
<td>Small town</td>
<td>White collar</td>
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<td>6</td>
<td>F (3) / M (3)</td>
<td>72.5 (66–82)</td>
<td>4 single / 2 cohab.</td>
<td>Rural area</td>
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TABLE 1. Description of the Focus Group Participants
interviews were held in public localities. One interview was carried out in the private home of one of the participants. Participants within all groups knew one another. Participants were offered a light snack but no other remuneration. The participants were informed that they were free to leave the interview at any time. They were also provided with telephone numbers to contact the research team after the interview if needed.

Data Collection

The format for data collection was focus group interviews (Kitzinger, 1995; Kreuger & Casey, 2000). Group interaction, capitalizing on group processes, helps people explore and clarify their views. The different forms of day-to-day communication help the researcher tap into people’s knowledge and attitudes that often remain unexplored by more conventional interview methods (Kitzinger, 1995). Focus groups are also considered to facilitate discussion of taboo subjects (Kitzinger, 1995; Robinson, 1999). This was of special interest in this study since elder abuse is still largely to be considered “hidden under a shroud of family secrecy” (Tatar & Kuzmeskus, 1996, p. 1).

As researchers (CE, BIS, AB), we cooperated in data collection as either moderator or assistant moderator. The interviews lasted between 70 to 90 min, were audiotaped and transcribed verbatim. Interviews were initiated by asking the question “What does elder abuse mean to you?” The moderator’s task was to facilitate involvement by all the participants and to stimulate conversation until the main topics had been touched on. These main topics were

- Defining elder abuse
- Exploring the context of elder abuse
- Prevention of elder abuse
- Intervention in abusive situations
- Challenges and views for the future

Although an interview guide was available from the World Health Organization/International Network for the Prevention of Elder Abuse, it was mainly utilized as a checklist for the moderator to ensure that all areas had been investigated. If discussions became too diverted or dried up, the moderator posed support questions, such as “Do you think there are more kinds of elder abuse?” “Why do you think elder abuse happens?” or “What do you think we should do about it?” The assistant moderator was a silent participant, operating the tape recorder, observing and taking memos on group dynamics. The moderator at the end of each interview presented a summary of the key points. This summarizing gave the participants a chance to verify the moderator’s impressions. After each focus group interview, the moderator and the assistant moderator compared and discussed their experiences. In this manner, they captured first impressions and highlights, and they compared their individual opinions to the general opinions of the group. This debriefing also allowed them an opportunity to contrast findings from previous groups.

Data Analysis

The interview text was analyzed by means of qualitative content analysis (Berg, 2001; Woods & Cantanzaro, 1988). The analysis involved several steps. First, two of us (CE, AB) listened to the tapes and read the transcripts straight through to get a sense of the whole. At this point, we compared impressions before continuing the analysis. The general impression was that the participants discussed causes of elder abuse, conceptions of elder abuse, consequences of elder abuse, and how to cope with the problem. The second step involved our (CE’s and AB’s) independently sorting each interview text using these four themes as a framework. Third, all of us (CE, BIS, AB)
critically analyzed, questioned, and compared text passages in each theme to achieve credible and trustworthy reasonableness (Guba, 1981). Fourth, the three of us compared our results and reflected on and discussed the findings. These findings were then presented and reviewed in a research seminar, which led to a final adjustment of the themes. Representative statements from the interviews have been used to illustrate the themes. These statements are referred to by interview number and gender of the participant. Credibility was dealt with here by our using a consistent method throughout the research process and by our working, at first, independently with interpretations and then comparing and discussing them with one another until consensus was reached. A foundation for credibility lies also within the examples of statements from the original texts offered in the Findings section (Berg, 2001).

Findings

There was a general consensus among the participants that elder abuse is unacceptable. It was named a taboo subject and described as invisible violence. Participants reported that their knowledge of elder abuse came from media coverage. Analysis of the interview text resulted in identification of four themes: causes of elder abuse, conceptions of elder abuse, consequences of elder abuse, and coping with elder abuse.

Causes of Elder Abuse

In the theme of causes of elder abuse, three issues dominated: the roles of changing society, changing families, and individual determinants. A lax society, “wrong” priorities on a governmental level, health care budget cuts, understaffing in the police force and in health care, overuse of uneducated personnel in institutions and home care, and immigration policies were named as societal issues that can lead to elder abuse. The school system was also pointed out as not preparing youths to be good citizens. Age discrimination, especially as a general lack of respect shown to older persons, was considered to be a factor in the evolution of abusive situations. “There isn’t the same respect for elders like there was 15 to 20 years ago” (3, man). “Everything has changed. Why has it become so negative, so lax in society? We were taught manners and had to work. We never were hit, but we had respect for our elders. I think things are so terrible today, all this nonchalance” (5, woman).

Changing family structure was also considered to be a cause of elder abuse. Criticisms of unstable family systems, where divorces are rampant and generations are divided by geographic distances, were discussed in all groups. Social isolation of older persons was considered a factor behind the occurrence of elder abuse. Parents were described as not being able to control their teenagers. Parents’ lax attitudes and children’s poor upbringing were actively discussed as leaving children with little respect for older persons and allowing for abusive actions. “Families don’t have time for the older generation today. Children see the old folks less or fewer times because no one has time” (4, man). “Parents don’t have a clue where the kids are. . . . The kids . . . they’ve been found drunk downtown. For sure this leads to violence” (2, woman).

When discussing the role of individual determinants as a cause of elder abuse, the perpetrator’s actions were often explained as being due to use of alcohol and drugs or to lack of education. “The old guy can get a little drunk so that it’s easy to slap the old lady around” (1, woman). It was the victim’s behavior, however, that was highlighted during the interviews. Older persons were thought to sometimes bring elder abuse on themselves.
Opening their doors to strangers, lending money to their children, not speaking up for themselves, carrying too much cash, or showing hostile behavior were situations named as those facilitating abuse. Also mentioned were being handicapped, suffering from dementia, or simply being too old and slow. “If you get older and turn surly, mean, and nasty to everyone, well you’re asking for it back” (6, man). “The nurses are in a hurry… The elderly in general talk slower, move slower. They don’t have a chance to do as they are told. Go there, do that, lift your arm… It takes time to react and act. Then there is irritation between staff and patient” (4, man). Here again was mentioned the isolation of older persons as a cause of elder abuse. In this case, it is not those who are unwillingly distanced from their families; rather, it is the situation of those who voluntarily isolate themselves from the world around them.

**Conceptions of Elder Abuse**

Several conceptions of abuse were apparent, such as physical abuse, societal abuse, psychological abuse, neglect, self-neglect, and financial abuse. The overwhelming amount of discussion in all groups described elder abuse as a physical act of robbery or assault. Women were described as being most at risk, and big cities were considered to be the riskiest settings for abuse. The perpetrators were most typically described as being youths, sometimes immigrant youths. “They [youths] were specialists at robbing older women. They drove their motorbikes, you know, and then took their purses as they drove by… in the big cities” (6, man). “And we [women] can be attacked, out on the street, by teenagers” (2, woman). Other examples of physical abuse included mistreatment of patients by institutional staff and, less seldom, wife abuse. “I believe the staff can get very irritated, and I don’t think it’s so hard maybe to hit them [dementia patients]” (2, woman).

Abuse on a societal level involved issues of human rights and curtailment of the older person’s autonomy. “They are always fixing things for us, even though maybe we are the ones with the greater knowledge. They decide for us in different situations. They tell us where we should live, how we should eat, how we should act, how we should travel, in what sort of transport. One becomes a sort of parcel… I view that as abuse to my person and to humanity as such” (4, man). Another form of elder abuse was age discrimination within health care. Waiting lists, giving priority to younger clientele, and physicians’ discrimination against older patients were named as examples. “If it were between a 90-year-old and a 40-year-old, it would take something extreme before the 90-year-old is chosen” (4, man). “And they [home care staff] just think, ‘You are too old, here is a little food, eat.’ Nothing more” (5, woman). Included in societal abuse was an issue that can be referred to as technological abuse. This was a general frustration expressed by the participants concerning new technology and their lack of skills to handle such situations as Touch-Tone phones, automated phone messages, and computerized banking. “The banks now are… on the Internet… But an older person doesn’t have that opportunity, and, quite simply, we can’t learn how when we get too old” (4, man).

Descriptions of psychological abuse focused on degrading treatment in institutions. “But they [institutional staff] are so short staffed they can’t even help them [patients] to the toilet. They just say, ‘Put on a diaper.’… I think that’s a serious sort of abuse for a person that’s still mentally capable” (4, man). Age discrimination was also involved in psychological abuse, such as name-calling, youthful pranks, and reduction in status after retirement. “When you retire, you don’t count any more” (4, man).
Physical and psychological aspects of abuse were often discussed concurrently and interwovenly, especially in discussions of abuse in institutions. Other types of abuse, such as neglect, self-neglect, financial abuse, and domestic violence, were seldom mentioned. The home as a setting for abuse was named in connection to burglary, youthful pranks, home care service, and wife abuse. The perpetrator was almost always described as being unrelated to the victim, either as a stranger or as health care staff.

Consequences of Elder Abuse

Consequences of elder abuse were described in terms of emotional and behavioral responses. The focus here was on victims’ responses. Victims’ emotional responses were thought to include fear, especially fear of robbery and assault. “That is probably the answer to the question why we discuss youths so often in this context. It is them we are afraid of, that something will happen, that they will harm us” (2, woman). Increased suspicion, such as unannounced visitors, and victims’ feelings of degradation after mistreatment in an institution were also considered to be consequences of abuse. Behavioral responses included older persons’ changing their routes when taking a walk, not going out at night, or avoiding places were someone had been attacked. Participants also reported that being suspicious and fearful of strangers leads to refusing to accept help, especially from younger people. “And we don’t dare go out at night alone in town” (2, woman).

Abusers’ emotional responses were described as remorse and guilt for their actions. Abusers’ potential reactions of revenge were also a concern. Participants described scenarios where a witness’s family could be threatened if the witness reported the abuse. “You are thinking both of your children and your family. They could be at risk for . . . well I don’t know what. That’s why one is a little scared to stand up to the person or get angry if one sees something. . . . They could find out who my family is and hurt them” (1, woman).

Coping with Elder Abuse

The theme of coping with elder abuse included individual strategies, improvements in society, and victim support. Individual strategies included the older persons’ being on their guard, taking responsibility to take themselves to the hospital when victimized, having courage to not back down in a confrontation with youths, and not carrying large sums of cash. Participants discussed how difficult it would be for a witness to trespass family boundaries. Many described how they would not want to get involved in an abusive situation. “You have to keep your guard up and watch out for yourself” (6, woman). “It’s really difficult to trespass into the private sphere. That is something doctors, teachers, and neighbors have difficulty with” (3, man).

Improvements in society included rather vague suggestions, such as “making help available,” to more concrete suggestions, such as forcing self-neglect victims to accept help, installing alarm systems for the elderly, increasing supervision in health care, and implementing better education for health care staff. The school system’s role was to improve children’s education so that they will appreciate and respect older persons. “I think that the way they look at older people has to change. Respect for the individual, that’s what I think” (5, man). Eliminating age discrimination through education and upbringing was repeatedly discussed as a way of preventing elder abuse. “I believe that educating children and teenagers to be good citizens is a great need for the future” (4, man). The family’s responsibility was about how parents should
Suggestions on where the victim could turn for help most frequently included friends and relatives. Police contact was also mentioned. Joining senior citizens organizations was mentioned as a way to cope in only the three groups recruited through such organizations. Other suggestions were infrequent and included hotline operators, district nurses, volunteers, and clergy. “No, I must say that I don’t know whom I would call. I could call my district nurse, but no, it isn’t ill health. And I couldn’t call my doctor and tell about it… and my children live far away” (5, woman).

**Dynamics in the Focus Groups: Thematic and Gender Aspects**

The climate in each focus group seemed relaxed and permissive, and the participants seemed to participate as much as they wished without any one individual being overbearing. The groups were similar in that, at the beginning of the interviews, none of the participants related having a personal or vicarious experience of an elder abuse situation. As the interviews progressed, however, and the group began to form a definition of elder abuse, several participants related events that they now believed could be called abusive. The issue most enthusiastically discussed in all groups was how society has changed. Immigration policies and immigrant youths as perpetrators were discussed primarily in the two groups located in areas heavily populated by immigrants. Neglect, self-neglect, and financial abuse were also predominantly discussed by women. Consequences of elder abuse were almost exclusively a women’s issue, focusing on fear of robbery and assault. Coping with elder abuse was discussed twice as much by women participants than by men. Women were quite involved in the discussions of individual strategies; improvement in society; and family, friends, and external support. It was primarily the issue of parents’ responsibility that dominated men’s discussions of coping with elder abuse. Age discrimination was an implicit factor in women’s discussions and an explicit concern of the male participants.

In discussions of societal issues, men discussed a lax society as a cause of elder abuse, and women discussed societal improvements as a means to cope with elder abuse. In discussions of family issues, it was predominately women who discussed poor upbringing as a cause of sexual abuse. If any conversation ensued, it was quickly turned to that of pedophiles and child abuse. Immediate response to a query about where to turn in cases of elder abuse was usually met with an initial silence, followed by comments of not really knowing where to turn. Suggestions for external support were mentioned only sporadically. The groups differed as far as how much each theme was discussed. Causes were discussed most in men’s groups and least in mixed groups. Conceptions of elder abuse were discussed most in mixed groups. Consequences of elder abuse were discussed most in women’s groups. Coping with elder abuse was discussed least in men’s groups.

Gender differences in the findings held true in both mixed- and single-gender groups. Men dominated discussions of changing society. With the exception of unstable family systems, which was a common concern, changing families and individual determinants were causes discussed primarily by women. Neglect, self-neglect, and financial abuse were also predominantly discussed by women. Consequences of elder abuse were almost exclusively a women’s issue, focusing on fear of robbery and assault. Coping with elder abuse was discussed twice as much by women participants than by men. Women were quite involved in the discussions of individual strategies; improvement in society; and family, friends, and external support. It was primarily the issue of parents’ responsibility that dominated men’s discussions of coping with elder abuse. Age discrimination was an implicit factor in women’s discussions and an explicit concern of the male participants.
elder abuse, but they did not strongly endorse improvement in this area as a way of coping. The inverse situation applied for the male participants, who strongly recommended improvements in upbringing as a method to cope with elder abuse. On the individual level, it was mostly women who believed that elder abuse could be the individual’s own fault. This also carried through to coping, where it was mainly women who suggested individual strategies.

Discussion

The aim of this study was to explore the perceptions of elder abuse held by older persons in Sweden. Through qualitative content analysis, the focus-group interview texts revealed the themes: causes of elder abuse, conceptions of elder abuse, consequences of elder abuse, and coping with elder abuse. Causes of elder abuse included descriptions of how elder abuse can be the older victim’s own fault—for example, by being handicapped, suffering from dementia, or being too old or slow. Conceptions of elder abuse included several types of abuse, but the major finding was the perception of abuse as robbery or assault. Consequences of elder abuse dealt mainly with fear, both fear of becoming a victim and that of retaliation if, as witnesses, the elders reported an abuser. Coping with abuse included family, social, and external support systems.

Older persons in this study considered themselves to bear part of the blame for becoming victims of abuse—for example, by opening their doors to strangers, being surly, and presenting problem behaviors when suffering from dementia—as can be seen in the theme of causes of elder abuse. This is interesting to compare to the finding that abusers, on the other hand, were given excuses for their actions, with mediating circumstances being heralded. Explanations of abuser’s actions were often lifted from the individual level to the societal level. For example, a home-help employee who abuses the client was described as being overworked or uneducated. Youths were also given excuses—for example, poor upbringing for violent behaviors against older persons. This is not mirrored in previous research where the temperament of the abuser has been shown to be a causative factor in abusive situations (Reis & Nahmiash, 1998; Saveman et al., 1999). That older persons do not blame the abuser and can consider themselves to carry blame for becoming victims, even at times provoking situations of abuse, are two important findings for which nurses and other care personnel need to be aware. An abused elder who feels at fault might be less likely to ask for help or report abuse. This applies to witnesses as well if they do not consider the abuser to be at blame. Grafström, Nordberg, and Winblad (1993) explained this behavior as follows: “Abuse is in the eye of the beholder” (p. 247). Saveman, Hallberg, and Norberg (1993) found similar results among district nurses. In witnessing situations of abuse in the home, the nurses had a hard time seeing the perpetrator as only a villain. These results indicate that frontline health care personnel need to take an active role in asking concrete, nonblaming questions when abuse is suspected. It seems to be important that the nurse be aware of these perceptions of elder abuse so not to lose sight of safety concerns and needed intervention for the victim.

Conceptions of elder abuse found in previous research and those found in this study were to some extent discordant. Instead of elder abuse being described as that within the context of domestic or interpersonal violence (Chez, 1999; Kingston & Penhale, 1995), as that happening in the victim’s home (Pillemer & Finkelhor, 1988; Saveman & Norberg, 1993; Saveman, Hallberg, Norberg, et al., 1993), and that most often
perpetrated by a spouse or grown child (Chez, 1999), the major conception of abuse in this study was robbery and/or assault, focusing on violence in the street. One explanation why crime dominated discussions of elder abuse could have been the participants’ possible interpretation of the Swedish word for abuse. Whereas the English word implies physical, verbal, and sexual misdeeds (Webster’s Third New International Dictionary, 1993), the Swedish counterpart term for abuse, våld, is defined as a criminal act of physical violence (Norstedts Stora Svenska Ordbok, 1986). Participants’ tendency to connect elder abuse to robbery and assault could have been only a question of etymology, which began to be resolved during discussions. Another possible explanation could be that participants recounted having gained knowledge of abuse from newspapers and television and that the findings are a reflection of the availability of media coverage of the aforementioned violence. A third possible explanation is that the focus on robbery and assault might also have reflected the taboo nature of the elder abuse issue. A discussion about crime between strangers was perhaps an acceptable and neutral ground for group discussions. An indication that this might be the case can be seen in the paradox that elder abuse was also named an “invisible violence.” This term better describes interpersonal violence in the privacy of the home rather than crime in the streets as reported in the newspaper or on the evening news. This perception of elder abuse as robbery and assault is something that nurses and other care personnel need to consider. Questions about suspected abuse should be phrased so that they will not be misconstrued. Nurses and other care personnel need to strive to convey an attitude of matter-of-fact openness in order to circumvent the taboo nature of elder abuse. Ideally, this would inspire victims and witnesses to be open and frank in their turn, daring to leave neutral ground and making elder abuse visible.

Becoming fearful was the number-one consequence of elder abuse reported in the findings. Discussions revealed an extreme reluctance as a witness to becoming involved, especially when abuse in the home was mentioned. This could have to do with resistance to invading the family’s privacy, as well as the expressed fear that the abuser could retaliate. Research by Saveman Norberg, and Hallberg (1992) indicates that this reluctance to intervene in cases of abuse is also experienced by district nurses. Nurses need to be aware of this potential reluctance in themselves. Nurses and other care personnel, keeping aware that witnesses can be fearful of getting involved, need to take an active roll when there is suspicion of an abusive situation.

Discordant findings, when compared to findings of previous research, were visible in the theme of coping with elder abuse. In previous studies, victims of elder abuse have given examples of support persons, including friends and relatives (Hirsch & Brendebach, 1999; Podnieks, 1992a); physicians (Hirsch & Brendebach, 1999; Pritchard, 2000); psychologists, police, and clergy (Hirsch & Brendebach, 1999; Pritchard, 2000); a confidant (Podnieks, 1992a; Pritchard, 2000; Schaffer, 1999); and nurses and social workers (Pritchard, 2000). In the present findings, physicians, psychologists, and social workers were not considered as potential sources for help. This perhaps is not so surprising, because older persons in this study primarily discussed elder abuse as robbery and assault or as that on a societal level. The findings could also bespeak a genuine lack of knowledge of where to turn for help. Nurses and other care personnel need knowledge of what help is available in the community in order to take the initiative in informing older persons about the local resources available to them.
Age discrimination was intrinsically interwoven in the findings. An area where this connection was especially evident was in the descriptions of lack of respect shown to older persons. Palmore (2001) has found that one of the most common experiences of age discrimination, so-called ageism, among older persons was lack of respect. Studies of elder abuse with other participants and within other cultures have also found that lack of respect is considered abusive (Hudson, Armachain, Beasley, & Carlson, 1998; Hudson et al., 2000; Saveman, Hallberg, & Norberg, 1993). In the present findings, the focus was most often on youth’s lack of respect. Youth’s ageist attitudes and lack of respect for elders was felt to open the door for committing abusive acts. Childs, Hayslip, Radika, and Reinberg (2000) have suggested that young people’s negative stereotypes about older persons contribute to their viewing older persons as being more deserving of abuse. Another common concern of the older persons evident in the findings was the widespread age discrimination within health care. Ageist attitudes among personnel and waiting lists that give higher priority to younger patients were examples described by the participants with strong dissatisfaction. It is interesting to note that lacking from the theme of coping with elder abuse was how older persons could combat ageism. It can be speculated whether this is due to older persons’ having bought into the idea of ageism, believing that older persons lack the influence and power to change their situation. Nurses can play a role here as patient advocates and by efforts to empower elderly patients. Perhaps more important, nurses and other health care personnel need to have a keen awareness of their own attitudes and the attitudes in society toward older persons in order to fight the ageism within health care, repeatedly described by the participants in this study as being abusive.

The findings in this study indicate that perceptions of elder abuse differ between men and women. Women and men participants voiced different concerns. These differences held true in discussions in mixed- and single-gender groups. One important finding was that the women participants voiced opinions that it is the responsibility of the victims as well as that of potential victims to protect themselves and seek help. This belief in combination with other findings—such as the perception that elder abuse could be the older person’s own fault and the reluctance of witnesses to get involved—describe a situation where victims could fail to receive help and support. These findings indicate the necessity to further explore perceptions of elder abuse held by older women and men in order to be able to help and ensure that the victims’ safety and intervention needs are met.

Methodological Considerations

Elder abuse is recognized as a potentially taboo subject (Marriott, 1997; Tatara & Kuzmeskus, 1996), and ethical implications of gathering participants to discuss a possibly threatening topic have been important to consider. We took precautions to protect participants, such as by providing access for postinterview support, giving options for declining participation and being able to leave during the interview, and ensuring confidentiality. However, we have no knowledge of whether the participants felt as though they were pressured into taking part in the study and the interview.

Participants within each group knew one another. This could have meant that the participants already had a shared system of values and similar opinions that might have limited the diversity and richness of the discussions. Conversely, that most participants within each group knew one another could be interpreted as enhancing a nonthreatening
discussion atmosphere when faced with a potentially menacing topic of elder abuse. It is interesting to note that though the groups had different moderators and different needs for supportive questions, the results did not dramatically vary from group to group. Ideally, this increased the trustworthiness (Guba, 1981) of the study. Although the number of persons who volunteered to assist with this study was small, it was balanced in that the groups represented different age ranges, geographical areas, and socioeconomic groups. That participants were small in number limits the transferability of the findings to the general population of Swedish older persons. Continued research is therefore recommended.

The findings reflected no general discussion of sexual abuse. This included the single-gender groups as well. Even though focus groups have been considered to facilitate discussion of taboo subjects (Kitzinger, 1995; Robinson, 1999), sexual abuse seemed to be an area where this was not the case. Sexual abuse is perhaps too taboo or simply not considered a topic for discussion in a group forum. Sexual abuse of older persons could also have been unfeasible or unknown to the participants. An individual interview may be a more suitable interview technique when conducting further research in this area.

Conclusions

Findings from this study will ideally lead to an increased awareness of older persons’ perceptions of elder abuse. Nurses are in a unique position to identify and intervene in actual and suspected cases of elder abuse by virtue of their daily contact with older persons. Nurses and other health care personnel need to be aware of what older persons believe cause elder abuse; what they consider abusive; and, perhaps most important, what factors could be keeping victims and witnesses from seeking help. Awareness of the results of this study could also help to refine interview and assessment techniques so that they are met with recognition by older patients, as well as address the apparent gender differences in women’s and men’s perceptions of elder abuse. The findings point to the importance of self-knowledge among nurses and other health care personnel, especially in the areas of ageism within health care.

Results from culturally sensitive research such as this study can be used to improve future programs of elder abuse detection and prevention. These results could also be useful when designing training manuals for health care personnel. We hope that this study has put into place one more piece of the puzzle that will one day show us the whole picture of elder abuse in Sweden. Continuing research is recommended on attitudes and perceptions of elder abuse within other Swedish contexts, such as those of the younger- and middle-aged public, health care employees, policymakers, and victims themselves.

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References

Saveman, B-I. (1994). Formal carers in health care and the social services witnessing abuse of the elderly in their homes. Umeå University Medical Dissertations. Umeå, Sweden: Department of Advanced Nursing, Umeå University.
Wolf, R. S., & Pillemner, K. A. (1989). Helping elderly victims: The reality of elder...