Elder Abuse in Canada
A Gender-Based Analysis

Prepared for the Division of Aging and Seniors
Public Health Agency of Canada

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CONTENTS

1. INTRODUCTION

1.1 About This Paper

Purpose of the Paper

This paper provides a contextual gender-based analysis (GBA) related to elder abuse in Canada by exploring and documenting what is known and not known about the gender dimensions of elder abuse. It provides guidelines for creating bias-free, gender- and culturally-relevant research, policies and practices in elder abuse. Finally, it describes the relevance and application of the findings to public health research, policies, programs and practices, including gender-based indicators for incorporation into the evaluation of the Federal Elder Abuse Strategy.

The paper will serve as a model for future GBA of other aging and seniors-related public health issues such as falls prevention. A preliminary companion paper on this topic has been developed.

A gender-based analysis of elder abuse will allow the Division of Aging and Seniors to:

- have a better understanding of the importance of a GBA in developing elder abuse interventions and tools for health professionals; and
- incorporate relevant key input into a GBA evaluation framework as required by Treasury Board, in connection with the Division's responsibility for the public health component of the recently announced Federal Elder Abuse Initiative and its Results-based Management Accountability Framework.

The overarching objectives of the Federal Elder Abuse Initiative are to raise awareness of elder abuse throughout society, particularly among seniors, their families and key professional groups; and to provide information, resources and tools to frontline workers to enable them to identify and respond accordingly to cases of elder abuse.

Scope and Limitations

The author reviewed and analyzed the published literature related to elder abuse and gender to determine whether both men and women are likely to benefit from the various policies, programs, trends and legislation reviewed; and to identify existing provisions, and/or gaps that can impact differently on the health of older men and women. To the extent possible (due to limited desegregated data on age, gender and diversity) the analysis takes into account underlying factors such as social roles, socioeconomic factors and personal health practices, such as alcohol abuse.

Three key informant interviews were conducted to better understand the frameworks that might best apply in a gender-based analysis of elder abuse with the following people: Joy Johnson, Scientific Director, Institute of Gender and Health, Canadian Institutes of

Health Research; Mary Anne Burke, Senior Policy Analyst, Innovation Division, Human Resources & Skills Development Canada; and Margo Greenwood, Scientific Director, National Collaborating Centre on Aboriginal Health.

The literature search was based on several bibliographies supplied by the Public Health Agency, as well as extensive use of the National Clearinghouse on Family Violence, which houses a Library Reference Collection of more than 10,000 overview papers, books, periodicals and videos on family violence (www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence).

The author did not have access to microfiche data from population surveys, which would provide more detailed information related to gender, age and diversity. Unfortunately, published reports on these surveys contain little analysis that takes into account both gender and age, let alone analysis on diversity related to socioeconomic, ability or race and gender and age. For example, the chapter in *Family Violence in Canada* on violence against older adults has only one table with a gender breakdown.

Publications that focus on gender often fail to provide the aging lens. For example, the Chapter on Violence Against Canadian Women in the *Women's Health Surveillance Report,* the comments related to age are primarily related to the decline in reported cases of abuse with advancing age; no tables with an age breakdown are provided.

Similarly, the overview documents housed at the National Clearinghouse on Family Violence are mostly gender-neutral. For example, while the paper entitled *Abuse and Neglect of Older Adults: A Discussion Paper* reviews a wealth of evidence, the only reference to gender occurs in a discussion of feminist models of analysis. No gender distinctions are noted in what is otherwise a thorough overview of definitions and categories, settings, characteristics of victims and perpetrators, risk factors, interventions and legislative approaches.

There is even less information on violence among older women and men from diverse cultures and Aboriginal identity. For example, the chapter on violence and Aboriginal people in *Family Violence in Canada* is primarily concerned about the experience of younger women—the tables group adults in a category of age 35 and over, which does not provide any clear information on the abuse of adults age 65-plus.

The author made a special attempt to find and review some of the more recent studies on older men and abuse. Women live longer than men and Canadian culture traditionally views women as less powerful than men—both factors that are likely to increase vulnerability to abuse. Thus, one would expect that the published findings come mainly from research with women. However, the majority of reports on elder abuse do not clarify this and generalize the findings to all older people.

Examining gender issues in elder abuse is complicated by several other factors:

Two distinct areas of research and practice. Research and practice on the mistreatment and abuse of older people is found in two quite distinct areas: elder abuse and domestic/family (or intimate partner) violence.

In the 1980s, a small cadre of health and social service practitioners and researchers carried out the first substantial work on the abuse of older adults, which was labeled "elder abuse". Thus, elder abuse has been largely defined by health care and social service professionals, rather than by older men and women themselves. Studies in this area have increased substantially, with results tending to be published in government reports and medical and clinical journals, including The *Journal of Elder Abuse & Neglect*, which is devoted to the study of the causes, effects, treatment, and prevention of the mistreatment of older people.

Although elder abuse includes the types of behaviours attributed to domestic violence, it also includes additional types of abuse such as neglect and financial exploitation. It also occurs in a wider range of settings and relationships. Perpetrators can be spouses but can also be children, grandchildren, other relations, friends, residents in an institution and paid caregivers. Issues related to individual cognitive and physical functioning are central concerns in elder abuse and consequently frail older people have become identified with this perspective.[1]

In comparison, the study of domestic, family or intimate partner violence has its roots in efforts relating to violence against women, which spans at least five decades and is published in a variety of media related to feminist research, interpersonal violence, family violence and violence against women. The domestic violence paradigm sees violence as a social problem rooted in unequal power relationships rather than an individual or family problem. Thus, while women must have immediate protection, long-term solutions require an understanding that intimate person violence is a public, criminal issue and that social structures that perpetuate power imbalances need to be changed.[2]

Most scholars have taken the approach that domestic violence is primarily an issue for younger women and that spouse abuse in older age is a form of wife abuse "grown old."[3] More recently, it has become apparent that domestic violence does exist in old age and that this is likely to become a growing problem with an aging population.[4] Further, domestic violence can manifest as long-standing wife abuse, but also violence that starts only in older age or as violence that begins with a new relationship in older age.[5]

A small number of researchers have begun work on how to incorporate a more gendered understanding of elder abuse; however, practice remains rooted in the risk or vulnerability mode, which does not take feminist theories into account.[6] Ironically, feminist theories holding that the real issue is the power imbalance between partners[7,8] may help to explain why both female and male spouse abuse occurs among older people.

Under-reporting and gender differences in reporting. As is the case in all surveys about sensitive issues, respondents may be reluctant to disclose their experiences due to shame, fear or lack of trust. Older women who have less resources and independence than men,

may be particularly afraid of leaving their home or accusing someone who provides for their daily needs. Older men, on the other hand, may be embarrassed or ashamed that they are no longer in a position of control in their home. Masculinity traits espoused since childhood underscore the need for older men in the current generation to be strong and self-sufficient. Admitting weakness or seeking help flies in the face of messages to "tough it out" or "pull yourself up by your boot straps" that so many older men have embraced. There may be a shift in this with the aging of the baby boomers as the stigma associated with masculine need for help lessens.[9]

Some studies suggest that women and men may differ in their tendency to report abuse and may interpret questions about abuse in different ways. For example, women seem to be more willing than men to identify themselves as perpetrators of emotional abuse.[10]

Survey exclusions. The standard use of random digit dialing in population-based surveys excludes older people without access to telephones. These include those who are isolated in the home, and those who are institutionalized or very poor (all of whom are more likely to be women). These older people (both men and women) may be the most vulnerable to abuse and yet their experiences are missing from the survey literature. In addition, many population surveys exclude Aboriginal people living on reserves, and in some cases, residences of the Yukon, Northwest Territories and Nunavut.

Limited amount of information on important variables. Even when gender is addressed, other important determinants of health are not included. This means it is impossible to analyze the relationships among abuse, gender, disability, race and ethnicity, disability and socioeconomic status. For example, a critique of Canadian prevalence studies (from 1974-2000) on intimate partner violence and health found that age, ethnicity/race and socioeconomic status were not consistently documented, making meaningful comparisons between older women and men difficult.[11]

Gender neutrality and discrepancies in language and definitions. Studies on elder abuse have been plagued by variations in the definitions of what constitutes abuse. Some also question the shift from language that identified gender, such as "wife abuse", to gender-neutral terms such as "elder abuse". Vinton (1991), in asking if older women experiencing domestic violence should be called "battered women" or "abused elders" highlights the tensions inherent in the two perspectives described earlier. A "battered woman", which is a common term in domestic violence is grounded in a gender perspective and feminist tradition but does not take age into account. An "abused elder" is grounded in an aging perspective but does not take gender into account.[12]

Gender roles in care. Because women tend to marry older men, and because of traditional expectations that women be the primary caregivers, older women are more likely than men to be in the caregiving role in domestic settings. Because of their strong care ethic, it may be extremely difficult for an older woman to leave a dependent, abusive husband.[13]

The delivery of care tasks is still divided along gender lines. In 2007, nearly 40% of women caregivers and fewer than 20% of men caregivers provided personal care, which includes intimate activities such as bathing and dressing. Women were far more likely than men to take on medical care and care management, as well as tasks inside the house, such as cooking and cleaning. On the other hand, more men than women provided assistance with tasks outside the house, such as house maintenance or outdoor work.[14]

The implications for elder abuse of gender roles in care are not known. What is clear is that women are more likely to take on family caregiving roles of an intimate and time sensitive nature that may compete with the demands and time of paid work. This is likely to add to the burden and stress of caregiving. At the same time, there is a need to recognize some men are providing intimate care to their aging spouses and may be just as vulnerable to physical and emotional stress.[15]

Women are also far more likely to be caregivers than men in a long-term care institutional setting. Sometimes elder abuse is dual directional with the caregiver and older person abusing each other.[16] In such situations, women may be involved as both victims and perpetrators.

Keeping all of the above limitations in mind, it is possible to begin to outline what we know about gender and elder abuse, and equally important to discuss how these limitations can be overcome in future research, programs and policies.

1.2 Key Concepts

About Elder Abuse

Abuse of older adults is also called elder abuse or abuse of seniors. The World Health Organization defines elder abuse as "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".[17]

This definition suggests that acts such as theft, physical assault, rape, and burglary **by a person outside of a trusting relationship with an older person** usually would not be classified as elder abuse but rather as crimes. Crimes against the elderly include some, but not all, forms of elder abuse.[18,19]

Different forms of elder abuse are most commonly grouped into five types:[20]

Physical abuse involves inflicting physical discomfort, pain or injury. It includes behaviours such as slapping, hitting, punching, beating, burning, and rough handling. Such maltreatment as the inappropriate use of drugs, and physical restraints and force-feeding are also considered physical abuse.[21]

Sexual abuse, which is usually subsumed under physical abuse, is defined as non-consensual sexual contact of any kind with an older adult. Sexual contact with any person incapable of giving consent is also considered sexual abuse. It includes, but is not limited

to, unwanted touching and all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing.[22]

Emotional or psychological abuse diminishes the identity, dignity and self-worth of the older person. Examples are name calling, yelling, insulting, threatening, imitating, swearing, ignoring, isolating, excluding from meaningful events and deprivation of rights.

Financial abuse, also known as material or property abuse, involves the misuse of money or property. Examples include stealing money or possessions, forging a signature on pension cheques or legal documents, misusing a power of attorney, and forcing or tricking an older adult into selling or giving away his or her property.

Neglect is the failure of a caregiver to meet the needs of an older adult who is unable to meet those needs alone. It includes behaviours such as abandonment and the denial of food, water, medication, medical treatment, therapy, nursing services, health aids, clothing and visitors.

Self-neglect or self-abuse is characterized as behaviour by an older adult that threatens his or her own health and safety. Self-neglect usually means that the older adult refuses or fails to provide himself or herself with the necessities of life such as water, food or essential hygiene.[23] There is some question as to whether self-neglect should be included in a consideration of the abuse of older adults, because no perpetrators are involved.

This paper is confined to an exploration of the four most common categories described above and does not address self-abuse. Having said this, it is important to look at the broad social conditions that may precipitate self-abuse such as homelessness and isolation, and the cultural and gender implications of policies and programs to address these conditions.

Abused older adults may experience more than one type of abuse at any given time.

Specialists in the field of abuse of older adults also recognize other forms of abuse, including systemic, spiritual, medical, civic and human rights abuse.

Spiritual abuse is of particular concern for Aboriginal seniors. Spiritual abuse refers to "The erosion or breaking down of one's cultural or religious belief systems".[24] From an Aboriginal perspective, family violence is understood as "a consequence of colonization, forced assimilation, and cultural genocide; the learned negative, cumulative, multi-generational actions, values, beliefs, attitudes and behavioural patterns practiced by one or more people that weaken or destroy the harmony and well-being of an Aboriginal individual, family, extended family, community or nationhood".[25]

Studies on elder abuse focus on two settings:

- ***The home and community*** setting where the victim knows the perpetrator.

- ***Institutions*** such as hospitals, and long-term care facilities, including nursing homes and homes for the aged. Institutional abuse refers to "any act or omission directed at an older resident of an institution that causes harm, or wrongfully deprives that person of his or her independence".[26] Institutions may also be the scene of systemic abuse and neglect, which refers to harmful situations created, permitted, or facilitated by procedures within the institution that are ostensibly designed to provide care.[27] As is the case in domestic settings, many acts of abuse or neglect in institutions are also crimes, such as assault, sexual assault, theft, and forgery.

1.2 About Gender-Based Analysis

While the term "gender" has been used in the social science literature for decades, its introduction to the medical and public health lexicon is more recent. As a result "gender" is sometimes mistakenly used as an updated version of the term "sex".[28] It is important to understand the difference.

Sex refers to the biological characteristics such as anatomy (e.g., body size and shape) and physiology (e.g., hormonal functioning) that distinguishes males and females.[29] Elements of sex may influence the health outcomes of injuries caused by abuse and on the likelihood of developing chronic diseases and disabilities, which may increase risk for elder abuse.

Gender refers to the array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis.[30]

This paper considers both sex and gender as part of a gender-based analysis.

Gender as a determinant of health. The Public Health Agency of Canada recognizes gender as a determinant of health in its own right. This is in keeping with an approach that recognizes that factors outside the healthcare system have a strong effect on health status. In addition to gender and health services, these factors include income and social status, employment and working conditions, education, social environments, physical environments, healthy child development, personal health practices and coping skills, social support networks, culture, and biology and *genetic endowment (including age, sex and ability).*[31] In the case of elder abuse, many of these factors may interact. For example, an older woman who is poor and frail and lives in a crowded housing situation with unemployed family members, or an older man with chronic disabilities, poor coping skills and a weak social support network may both be more vulnerable to abuse.

The World Health Organization positions gender and culture as cross-cutting factors that affect each and all of the determinants of active (healthy) aging (see below).

Figure 1. The determinants of active ageing

Source: World Health Organization (Edwards). *Active Aging: A Policy Framework*

Gender-based analysis (GBA) is a tool for understanding social processes and for responding with informed, effective and equitable options for policies, programs and legislation that addresses the needs of all Canadians.[32] The use of a "gender lens" identifies how public policies, programs and practices differentially affect men and women, and guides decision-makers so that adjustments can be made to achieve fairness and justice (equity) when gender differences cause inequalities and disadvantages.

GBA recognizes that treating women and men identically will not ensure similar outcomes because women and men occupy different socioeconomic statuses and experience different living conditions. GBA views women in relation to men in society rather than in isolation. GBA offers policy makers an accountability process by helping them determine if allocated resources are reaching the intended populations, efficiently and effectively.[33]

GBA and diversity. GBA is meant to be applied within the context of a diversity framework that attends to the way that ability and disability, race, ethnicity and culture, and socioeconomic status interact with sex and gender to contribute to various risk factors, and the outcomes of various policies and interventions.[34] Health Canada's Gender-based Analysis Policy states that the GBA framework should be overlaid with a diversity analysis.[35] In reality, this is very hard to do because of the lack of published disaggregated data that takes gender, age and diversity into account.

Recently, the Native Women's Association of Canada and the Pauktuutit Inuit Women's Association of Canada,[36] have suggested that the present use of GBA does not adequately take the effects of culture and indigenous history into account, especially when examining systemic forms of violence facing Aboriginal women.[37] Similarly, the "bias-free" framework developed by Mary Anne Burke and Margrit Eichler provides a tool for identifying and avoiding biases in health research, policies and programs that derive from social hierarchies, including gender and sex, ability and race/ethnicity/culture.[38] These approaches are further explored in Section 3 of this paper.

1.3 Stereotyping and Misconceptions

Due to social norms and the lack of solid information on elder abuse, gender and diversity, practitioners and decision-makers need to be wary of stereotyping and misconceptions.

1. Misconception: Wife abuse stops at age 60.

   Reality: The majority of domestic violence abuses against older women involve their older male partners as perpetrators. While surveys show that reported cases of wife abuse declines with age, some researchers suggest that a senior abuser may escalate his abusive behaviour after retirement when feelings of isolation add to his sense of a lack of self-worth.[39]

2. Misconception: Older men are not abused by their spouse and/or children or in long-term care facilities.

   Reality: Women are more often victimized by family members and people they trust, both proportionately to men [40]and in absolute numbers because of gender ratios in the population. But they are not the only victims. Men also experience abuse in institutions and at the hands of their partners and children. Some studies suggest that men are more likely than women to suffer financial and emotional abuse.[41]

3. Misconception: Certain cultural communities are immune to elder abuse.

   Reality: Elder abuse can occur among all cultural heritages, races and religions, even when a particular group traditionally emphasizes respect for its older members.

4. Misconception: Elder abuse is the result of deviant personalities—victims who make life miserable for their caregivers, and perpetrators that are sociopaths with cruel personalities.

   Reality: While certain personality characteristics may exacerbate situations leading to abuse, the fundamental problem is one of power differentials between dominant and non-dominant individuals and groups. The exceedingly high prevalence of abuse against women with disabilities (at all ages) is a classic example of this power differential.

5. Misconception: Elder abuse is primarily the result of caregiving stress. Looking after sick people who are demanding and difficult can be very difficult and it is understandable how a caregiver might "lose it" on occasion. Since women are more likely to be caregivers than men, they are more at risk of becoming abusers.

Reality: While caregiver stress is sometimes a factor in abuse, studies suggest that most caregivers cope well with this role. When abuse does occur in difficult caregiving situations, justifying it can result in victim blaming and minimizing the responsibility of the abuser.[42]

2. GENDER DIMENSIONS IN ELDER ABUSE

This section describes what we know and don't know about gender dimensions in elder abuse.

2.1 Incidence and Prevalence

There are two main surveys in Canada that measure the extent and characteristics of violence against older adults: The General Social Survey on Victimization (self-reports) and the Incident-based Uniform Crime Reporting Survey (police reports). While both surveys capture data on criminal offenses, neither permits a full analysis of financial abuse or neglect, nor the prevalence of abuse in institutions.

Unless noted otherwise, the information in this section is taken from the Statistics Canada Report—*Family Violence in Canada: A Statistical Profile 2006*, which summarizes results from the two main surveys named in the preceding paragraph. [43]

In 2004, 3,370 incidents of violence against Canadians aged 65 and over were reported to police services. However, it is misleading to say that these occurred almost equally against senior men and women, since men were more likely than women to be victims of crimes committed by strangers (and therefore outside the common definition of elder abuse as occurring "within any relationship where there is an expectation of trust").[44]

Over one quarter (29%) of reported incidents against older people were committed by a family member. Senior women were more likely than senior men to be victims of family violence: four out of ten women (39%) were victimized by a family member, compared to two out of ten men (20%). Common assault (including pushing, punching, slapping and threatening to apply force) accounted for 55% of the offenses committed by a family member.

Gender differences in the prevalence of family-related elder abuse has held steady for the past five years. In 2004, the rate of violence against older women (44 per 100,000) was 22% higher than the rate of violence for older men (36 per 100,000). In 2000, the difference reported was 46 versus 38 per 100,000.

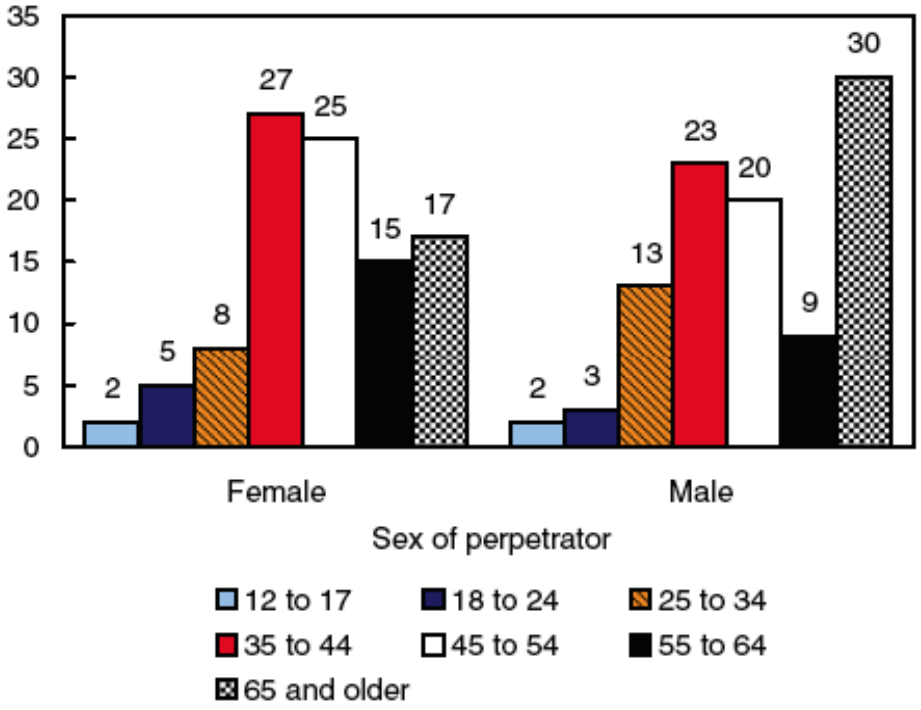
Family members accused of violence against seniors tend to be men (79%). This holds true despite the fact that women are more likely to be the informal caregivers of seniors.[45] Male perpetrators were often 65 years or older (30%), reflecting the finding that a significant portion of senior violence is spousal violence.

Male spouses and adult children were most often accused in family-related violence of seniors. Over one third of the accused were male spouses (current and ex-) (36%), followed by adult male children (34%), and extended male relatives (15%), such as brothers and uncles. The average age of spouses accused of victimizing their partners was 66 years of age, while the average age of accused adult children was 40 years of age. In

contrast, male senior victims were more likely to be victimized by their adult children (38%), while a smaller proportion were victimized by their spouse (22%).

As senior women grow older, spouses represent a smaller proportion of abusers. This may be because older women outlive their abusive spouses, or that the spouses are no longer physically capable of violence. For senior men, the proportion enduring spousal violence decreased slightly with an increased age of the victim.

Nearly one in three male family violence perpetrators are 65 years and over, 2004



Source: Statistics Canada. Incident-based Uniform Crime Reporting, 2004.

Data on ***financial abuse*** are difficult to find. In the classic 1990 Canadian national telephone survey of 2,000 older adults in home settings**,** Elizabeth Podonieks and colleagues found that financial abuse was equally common among males and females, living alone and whose abuser was a distant relative or unrelated.[46]

In the 1999 General Social Survey a higher proportion of older men (9%) than older women (6%) reported being victims of emotional or financial abuse (related to stealing of household property) by adult children, caregivers or spouses.[47]

In 2004, there were 50 ***homicides*** (23 men and 27 women) committed against seniors. Older women are more likely than older men to be killed by a family member. Among solved homicides between 1994 and 2003, more than two-thirds (67%) of older females were killed by a family member, usually a spouse (29%) or an adult son (24%). On the other hand, half of older men (49%) were killed by an acquaintance or neighbor. Among the 31% of older men who were killed by a family member, about half were killed by their sons.[48]

Between 1994 and 2003 family related homicides against seniors most commonly resulted from the escalation of a quarrel or argument (29%). Frustration, anger or despair accounted for another 26% of homicides. Police reported a history of family violence among 32% of family related homicides against seniors.[49]

The author was unable to find any specific information on elder abuse among ***gay, lesbian and transgendered older adults***. However, it is well established that domestic violence happens between same sex couples as well as between heterosexual couples. Some writers have suggested that older lesbians and gay men would benefit immensely from the added protection of policy initiatives that incorporate homophobia as grounds for elder abuse. In particular, the knowledge of one's same-sex orientation could easily be used to intimidate, harass, humiliate, or shame an older individual living in a long-term care institution.[50]

There are few studies on the ***sexual abuse*** of seniors. Those that do exist show that predators in the community are primarily male family members and range in age from teenagers to the very old. Characteristics of the offenders include mental illness, substance abuse, sexual deviancy and paternalistic views of wives as property.[51]

The US national study of sexual abuse of adults age 18 and older in care facilities found that 29% of cases involved victims over the age of 60. Among these cases, the vast majority of confirmed sexual predators were male (88%). Three were female (2 were residents and one was a direct care worker). The majority (77%) of perpetrators were age 60 and older, White, and residents of the facility (78%). Only two of the accused 46 staff members were confirmed as sexual predators. One was a man and one was a woman; they were White, and aged 30 and 32. Five visitors to facilities (male family members) were accused but not confirmed by investigators.

The confirmed sexual abuse victims ranged in age from 63 to 95 (mean age of 82). Six were men and 26 were women. The victims had significant vulnerabilities: 67% had dementia, only one-third had the ability to walk without assistance, and more than half had trouble with communicating.[52]

Elder Abuse in Métis, First Nations and Inuit Communities

In this section, “Aboriginal” and “Indigenous” people refers to Canadians who identify with the following groups: First Nations, Inuit and Métis.

Little statistical data on the incidence and prevalence of elder abuse in the Aboriginal

population could be found. In one 1997 study, over half of Aboriginal female seniors revealed that they had been or were victims of more than one type of abuse.[53] Overall, spousal violence against Aboriginal women remains more than three times higher than for non-Aboriginal women or men. They also are more likely than non-Aboriginal women to report the most severe and potentially life-threatening forms of violence.[54]

It is well known that violence is higher in the Aboriginal population and the known contributing factors to violence would suggest that older Aboriginal people, and in particular women, are abused at a rate that is similar or higher than in the mainstream population. Some of these factors include the experiences of colonization, feelings of devaluation among Aboriginal people, destruction of traditional ways of life, and a history of abuse in residential schools.[55] Many older Aboriginal people experience the long-lasting effects of physical, sexual and emotional abuse in residential schools and were denied the opportunity to be exposed to examples of positive parenting.[56] This may contribute to higher rates of violence in Aboriginal communities across generations.[57]

Other factors that may increase risk for Aboriginal seniors include higher rates of dependency at younger ages due to poor health, family breakdown, sub-standard living conditions, such as overcrowded housing, poverty and lack of social and health services.[58]

Elder Abuse in Immigrant and Refugee Communities

Currently, there is a lack of evidence to confirm if risk factors for elder abuse change in relation to ethnicity, race and culture of a particular group or community.[59] The author was unable to find data related to age, abuse and gender in the published survey findings on the experiences of senior immigrants and refugees in Canada. However, some or all of the following factors may contribute to either increased or reduced risks for immigrant seniors:

- Recent immigrant seniors are more likely than long-term immigrants to need help with everyday tasks such as making meals or running errands and looking after their personal finances.[60]
- In 2003, only 10% 0f recent immigrant seniors received home services from the government, compared to 20% of Canadian-born and long-term senior immigrants. Informal sources (family and spouse) were most likely to provide care to immigrant seniors with long-term health conditions.[61]
- In the age group 55 to 64, the proportion of heavy drinkers was half that of non-immigrant seniors.[62]
- According to the 2001 Census, among female immigrants aged 65 and over who lived alone and who landed in Canada after 1990, 71% were in a low-income situation (compared to 42% of Canadian-born senior women living alone and 58% of male immigrant seniors).
- In 2003, immigrant seniors were neither more nor less likely than non-immigrant seniors to say that they had been victims of a crime in the past year (about 10%).[63]

Some studies have named the emotional isolation experienced by immigrant and refugee women as an important factor in being abused. Isolation may be increased for older women who may not have Canadian citizenship and may be very dependent on their husband and children. Laws in Canada may be very different from laws in their respective countries. [64]

Focus groups with abused women who do not speak English or French show that women in their 50's and 60's felt the most despair. Many of these women also have health problems because of years of beating. As a result, daily life is difficult for them and the limitations imposed by their health problems compounds their isolation and painful lives. They have lived with abuse for many years. Even for those women who are living essentially separate lives from their husbands, they are still living in the same house because they cannot afford to move, they do not want to leave the house they worked so hard to buy and because they would feel even more isolated outside their language community.[65]

Elder Abuse in Institutions

Most publications, including the *Abuse of Older Adults in Institutions* from the National Clearinghouse on Family Violence contain no information on gender and diversity differences related to elder abuse in institutional settings.

Studies with health professionals confirm that elder abuse is a problem in facilities, but shed little light on the gender dimensions. One survey of 1,027 Ontario nurses found that 42 percent had witnessed at least one incident of older client abuse in the past three years, and another nine percent had heard of one. Nurses report older client abuse in all practice settings: hospitals, the community, and in psychiatric and long-term care facilities: 61% of reported victims were women, 67%of victims were 65 or older, 73 % of victims were stressed, and 52% of victims were medicated and/or confused.[66]

Increasingly, the oldest seniors in Canadian society are the ones most likely to live in a long term care institutions; the majority of those seniors are women. Women on average live longer than men, and women are more likely to be widowed so they do may not have support to live in the community. In 1996, nearly forty percent (38%) of all women aged 85 and over lived in an institution, compared to one quarter (24%) of men aged 85 and over. Even at younger ages, there are many more older women than older men in long term care facilities.[67]

Some studies suggest that seniors who are the most impaired are the most vulnerable to being abused in this setting. They display greater capacity for dependence and it may be harder for staff to relate to them and for them to defend themselves against abusive residents. Other studies conclude the opposite- that the seniors in care who are the most active (and therefore, the least "compliant") run a greater risk of harm.[68]

2.2 Characteristics of Victims and Perpetrators

Studies have shown that the characteristics of older victims include living with others, being depressed, being socially isolated and suffering from impaired health.[69] All of these characteristics could apply equally to men and women; however the concept of dominant and non-dominant groups applies. The victim's characteristics reflect an imbalance of power and having few resources to deal with abuse.

Perpetrator characteristics include being male, a spouse or adult child, being an alcohol abuser, being dependent on and living with the victim, being dogmatic in caregiving with rigid standards, having a deteriorating perception of the older person, having a history of deviant behaviour and having a high level of external stress in the past year.

Generally, men and women differ when gripped by anger and frustration: men use physical abuse more often to vent their emotions, while women rely more on verbal and emotional abuse. It is not clear whether or not biological make-up (i.e., sexual hormones) plays a part or whether cultural expectations primarily account for these differences.[70]

In contrast, victims of financial abuse tend to be unmarried (widowed, divorced or never married), both male and female but slightly more often male, lacking in social confidants and limited in their activities due to health problems or depression. Their perpetrators tend to be younger, more distant relatives who have emotional problems and have difficulty functioning independently (may be financially dependent on their victims) [71]

Spousal violence affects all socio-demographic groups. However there are certain segments of the population that are more vulnerable: those who are young, who live in a common law relationship, who have been in a relationship for three years or less, who are Aboriginal and whose partner is a frequent heavy drinker.[72]

Some studies show that ***substance abuse*** in a man is often linked to physical violence, whereas substance abuse in a woman may arouse physical or sexual abuse.[73]

Studies consistently show that the great majority of sexual abusers of older women are male in both community and institutional settings. In the institutional setting, residents and staff have ready access to their victims. An analysis of the cases involving older people in the US national study of sexual abuse revealed that among the 116 alleged perpetrators, six had histories of past criminal activities and two had previously been accused of sexual assault. Six were substance abusers. Despite the fact that police were notified in the alleged cases, none of the 32 confirmed sexual predators were arrested. One perpetrator in an alleged case was arrested even though the victim was unable to confirm the assault because of observed burns on his arm and the tearing of his rectum.[74]

Women are at much higher risk for sexual abuse than men and more vigilance is required to protect them. On the other hand, the finding that female sexual offending does occur in long-term care facilities underscores the need to protect both women and men from sexual offenders. Facility administrators cannot assume that residents cared for only by female staff will not necessarily be protected from sexual abuse, nor that male residents are never vulnerable to sexual abuse.

In the institutional setting, careful screening (particularly of criminal records) and reference checks of both residents and staff is required. In both community and institutional settings it is crucial that law enforcement officials become more involved and that collaboration between civil and criminal investigators is enhanced.

2.3 Effects on Health

In 2004, one-third of senior victims sustained a minor injury (33%) as a result of an offence perpetrated by a family member. Minor injuries require first aid but no professional medical treatment. Major injuries (requiring medical assistance) were experienced by 3% of victims. Women were slightly more likely than men to sustain some form of injury (41% and 37% respectively).[75]

Studies on violence against women of all ages maintain that women are more likely than men to report more severe violence. Women are also more likely than men to be injured in a violent confrontation because of their generally smaller bodies, and their higher risk of breaking a bone when a fall results from violence. Among female victims of violence, older women (32.5%) are far more likely than younger women (18%) to use medications.[76] However, this is also true of women who are not exposed to violence.

Elder abuse has many painful psychological, emotional and social effects on both men and women. More research is needed to determine these effects among both genders and in diverse populations.

2.4 Feminization of Aging and of Care

In 2005, women accounted for 52% of Canadians aged 65 to 69, and 75% of all persons aged 90 and over were women. This is a comparatively new phenomenon. Fifty years ago there were more senior men than senior women. It is estimated that the current situation will remain quite stable over the next few decades although differences in life expectancy between men and women have begun to narrow. By 2056, men are expected to account for 46% of 80 to 84 year olds.[77]

Even though the amount of male caregivers is growing, caregiving is still considered mainly women's work. Caregivers paid and unpaid are mostly women, and research tells us that when a family member needs care, a spouse will be the number one choice to fill that role, followed by a daughter, or daughter-in-law. For example, daughters are three more times more likely to help older parents with personal care than sons.[78]

Family Caregivers

Back in 1960, among Canadian women over 50, 16% had a surviving parent. This number is expected to change to 60% in 2010. As a result, family caregivers are getting older as their parents live longer.[79] Women expect that they may be required to provide home care to their aging partner or relatives, and that their male partners may be unable to assume the caregiver role. A large number of women in need of home care are not

covered by health insurance, because their paid work was frequently part-time, or contract work without benefits. Their lower lifetime earnings result in the inability to afford purchasing insurance benefits and home care services. So, again, they rely upon the women in their lives to become caregivers.

In 2007, most eldercare in the community (75%) was provided by those between 45 and 64 years of age. Nearly 6 in 10 caregivers were women (57%); 43% were men.[80]

This seemingly high percentage of male caregivers and low percentage of female caregivers needs to be interpreted with caution. Caring for senior men can be invisible since many are cared for by their wives, often without the wife reporting it as caregiving.[81] According to the Canadian Caregiving Coalition, three out of four home caregivers are women between the ages of 50-65 years, 10% are over 75.[82]

Two thirds of unpaid Canadian caregivers work outside the home. Twenty percent of these caregivers report health impacts, and 40% incur personal expenses.[83] Employed female caregivers are more likely to make workplace adjustments than male caregivers.[84]

Caregivers can be found across all income strata, however, it has been reported that families who provide care have household incomes below the national average.[85]

Paid Caregivers

Stresses have increased for paid homecare workers in recent years. Privatization of home care has led to lower wages for providers and loss of control over standards. Licensed Practical Nurses in home care are sometimes getting half of what they received in institutions. The numbers and types of client care are increasing, meaning workers must deal with more severe illnesses, medical conditions or levels of disability. Home care workers are facing increased risks of injury, harassment and aggression from clients.[86]

Ninety-five percent of paid homecare workers are women and they are disproportionately women of colour, Aboriginal and immigrant women. An increasing number are trained, experienced nurse imported from countries such as the Philippines as low-paid domestic workers.[87]

Paid homecare workers, particularly professional nurses, function within a hierarchy of power related to their educational/occupational status. However, nurses also experience powerlessness within the home care context, where the client is in charge. For clients, being able to control one's own environments a source of power, but this power is often over-shadowed by the powerlessness experienced in relationships with nurses. Nurses who are willing to reflect on and change those disempowering aspects of the client-nurse relationship, including a harmful hierarchy, will ultimately be successful in promoting the health of clients in home-based care.[88]

Care in institutions such as nursing homes is also provided primarily by women. While power differentials are even stronger in these settings because the residents tend to be

more disabled, this work too is most often assigned a low value and low pay, and workers face increasing pressure to take care of more people, many of whom have serious health conditions such as dementia.[89]

The downloading and de-valuing of care appear to operate through two gendered pathways—a gendered occupational hierarchy and a gendered transfer from paid services to unpaid family members. Regardless of whether caregiver stress is a direct factor in elder abuse or not, this downloading can seriously compromise the health of both the caregiver and the recipient of care. When a 70-year old woman becomes the principal resource for her frail and unwell mother, the health of both is placed at risk. This points out how crucial the presence or absence of public resources (such as government sponsored homecare and respite care) in shaping the experiences and health of women with family members requiring care.[90]

2.5 Factors That May Precipitate or Prevent Elder Abuse

The available literature reveals some common contributing factors related to elder abuse, although some are still in dispute among experts and researchers in this field. Some are interpersonal factors; others are part of the broad social determinants of health. This section identifies the gender dimensions of these factors that the author was able to find.

Ageism and Sexism (Social Environment)

Ageism is pervasive in Canada and many other societies. It is common to see the individual and broader social problems that older people face, being rationalized or discounted. Abuse and victimization by family, staff, or people in positions of authority may be characterized as "rare events". Ageism can occur when people in authority do not believe older adults, or do not consider the harms as serious. Older adults may have their credibility questioned because of assumptions about the reliability of their memories. The Ontario Human Rights Commission notes that abuse of older adults occurs in large part due to negative attitudes towards older people or their economic or social vulnerability.[91]

Ageism can be reflected in social policy that assumes all women (and some men) are willing, able and capable of providing care to aging parents, even though in reality, some of these relationships can be strained from the outset and can become abusive.

Both men and women experience ageism in the form of stereotyping; however the differential effect of ageism on men and women has not been well examined. Typically, older men are stereotyped as increasingly feminine (and weak and dependent), and women as asexual, unhealthy, and dependent.[92]

Ageism and sexism is readily apparent in language against both men and women, which may contribute to the dismissal of the seriousness of abuse for both genders. For example, the term “little old lady” suggests incompetency and impotency based upon age and gender. “Old hag” or “old witch” commonly refers to a woman who is physically unpleasant to look at and who has a disagreeable personality. Old men are commonly

described by such terms as “old coot” and “codger”. These terms suggest that old men are slightly odd or quaint. The commonly used term, “dirty old man”, suggests some sort of unnatural sexual perversion in older men.[93]

Chronic Illness, Disability, Dependency and Able-bodyism

Some researchers suggest that chronic cognitive and physical illnesses, coupled with the need for greater care, places seniors at higher risk of maltreatment and abuse.[94] The oldest seniors (age 80 and older)—who are mostly women—are most likely to experience these illnesses and accompanying disabilities.

In 2007, senior women and men identified as the primary care receivers by the GSS respondents were more likely to receive care because of a “physical problem only.” This percentage declined with age as more care receivers had mental health problems as well.[95]

About half of Canadians with Alzheimer's disease or other dementing illnesses live in the community; the other half live in institutions. The prevalence of dementia is directly linked to age, and climbs to more than 34% for those over 85 years of age. Currently there are many more women than men over age 85. With the aging of the population and the baby boom cohort in Canada, the absolute number of individuals with dementia—both men and women--will increase dramatically over the next two decades.[96]

Because of the progressively debilitating nature of the condition, caregivers of persons with Alzheimer’s disease or related dementia face unique challenges. The burden of physical care increases over time and many caregivers report that they are virtually on call around the clock. There is typically a deep sense of loss, which often is linked to depression for both caregivers and care receivers.[97]

It is estimated that from 57 to 67% of dementia patients manifest some form of aggressive behaviour. Therefore, dealing with caregiver abuse- and responding retaliation--is an important consideration in these situations.[98]

It is estimated that women with disabilities (all ages) are 1.5 to 10 times as likely to be abused as non-disabled women, depending on whether they live in the community or in institutions.[99] Women with disabilities are vulnerable at all stages of their lives because they are women and because they have a disability. Growing old increases the likelihood of becoming disabled, which can increase the likelihood of abuse.[100]

Older women and men with disabilities must often depend on a variety of people to provide them with assistance in carrying out their everyday lives. This large number of people and the intimate physical and emotional contact involved in the care they provide greatly increase the risk of abuse to persons with disabilities.[101]

Those who live in institutional settings and who are profoundly disabled may be most vulnerable to abuse because they are more dependent upon even larger numbers of people, and less able to get away. While a disability can make it more difficult for a

woman or a man to escape or report abuse, social attitudes towards persons with disabilities are probably a bigger factor in their increased vulnerability to violence.[102]

"Able bodyism" is based on an ability hierarchy constructed on the medical model of disability, in which people are assigned an order on the hierarchy on the basis of biology and functioning in relation to what is deemed normal. The BIAS Free Framework described in Chapter 3 of this report calls the ability hierarchy into question by challenging the concepts, systems and practices that have contributed to the discrimination and exclusion of disabled people.[103]

Dependency is a pervasive feature of both the victims and perpetrators of elder abuse. For victims, physical and cognitive dependency may increase the risk of abuse. Caregiving abusers may also be dependent (e.g., economic reliance on the victim) especially if they suffer from drug dependency, limited skills or cognitive deficits that limit their eligibility for paid or more lucrative work. The literature reviewed for this paper does not shed light on the gender or diversity dimensions related to dependency.

History of Canada's Aboriginal People

Canada's Aboriginal peoples (First Nations, Inuit and Métis) have a unique history that many argue is a specific determinant of health. The Native Women's Association of Canada and other Aboriginal women's groups believe that because of history, strategies against gender violence must be linked with strategies to restore indigenous peoples' rights. This requires integrated solutions that address the root causes related to both historic and contemporary forms of oppression.[104]

The International Indigenous Women's Forum prioritizes the rights of survivors and the accountability of abusers, and looks beyond the criminal dichotomy of victim and perpetrator to inquire about the reasons that battering occurs, including the conditions that shape abusers' psychological, moral, and spiritual dysfunction. For Indigenous men, that dysfunction is rooted in the violation of their collective rights, including the loss of territories, traditions, livelihoods, food supplies, sources of medicine, social networks, and other elements that support emotional health and a positive masculine identity. At the same time, Canada's Indigenous women reject the notion that violence committed by Indigenous men is simply a negative consequence of colonization. Rather, such violence is an enforcement mechanism used to shape relations of power within Indigenous families and communities.[105]

This view takes into account the impact of historical wrongs against Aboriginal peoples and, at the same time, calls on all individuals and communities to be accountable for their actions against others.

Caregiver Stress

Attempts to explain elder abuse have often pointed to the stressful nature of the caregiver role, which is predominantly performed by women. While it is clear that perpetrators have an inadequate ability to deal with stress, this model has been criticized for its inability to explain the absence of abuse in most caregiving relationships.[106]

Some researchers have suggested that individuals who abuse older adults may have learned this behaviour through either witnessing or suffering abuse themselves. For example, adult children who abuse their parents may have learned this behaviour from their parents. However, not all caregivers who were abused as children in turn abuse older adults.[107]

Single theories that focus on caregiver stress reflect the fact that elder abuse has been defined and conceptualized mostly by professionals who deal with frail and vulnerable populations. Gender issues often become obscured. The focus on the "caring" fixes the attention on vulnerability related to age rather than on the context of family violence or the wider contexts of sexism and ageism – the discrimination and stigmatization of older people.[108] Woolf claims that rigour is needed in the language in order to clarify what is understood by "care" and "vulnerability", that "carer" should not be used as a euphemism for abuser and that we should not confuse "caring" with co-residence.[109]

Socioeconomic Status

The author was unable to find any information that ties together gender, age and socioeconomic status. There is a need to fill this gap in our knowledge. An analysis from the 1999 General Social Survey did not find income a predicted factor in elder abuse.[110] It showed that emotional and financial abuse of older adults occurs in all socioeconomic groups, and the characteristics associated with experiencing higher rates of emotional and financial victimization did not show a clear pattern They included being divorced or separated, having an income of $30,000 to $39,999, or $60,000 or above, having some post-secondary education, and residing in a rural area.[111] Some studies in the United States show higher rates of reporting of elder abuse is associated with lower socioeconomic status of the older population, but it is not clear if this is related to under-reporting among higher socioeconomic groups and other confounding factors.[112]

Some writers suggest that living conditions associated with low income, such as overcrowded housing can exacerbate problems in interpersonal relationships,[113] and that abusers may have a low income and be financially dependent on the victim.

Women inevitably lose financial status after *divorce*, and in fact, divorced older women are more likely to be poor than widows because they do not have access to the pensions or properties of a deceased husband.[114] This may mean they are less able to leave or report an abusive situation since they do not have the resources to live on their own.

Fractured Relationships

Stratton and Moore[115] explore the dynamics of "fractured relationships" and find several patterns that may increase an older man's risk of being neglected by adult children when his need for support increases. Fractured relationships seemed to stem from early harsh or emotional distant fathering, personality clashes and/or conflicts involving the father criticizing the adult child, or a child not willing to accept the widowed father's re-partnering.

While many men have very positive family relationships and the authors are careful not to adapt a deficit model for older men overall, they point out several common patterns among men that have the potential for increasing relationship fractures. These include:

- *Refraining from "kinkeeping".* Women are more likely to keep contact with family members and arrange family activities, and are more likely to have a sense of filial duty than men.[116,117] Lawton found that father-child relationships in later life tend to be more obligatory than affectionate.[118]
- *Masculine minimizing*. Self-reports may reflect a male tendency to minimize injury and emotional impact due to the culture of masculinity that underscores the cultural expectations that men be strong and in control.[119] Boxer, Cook and Cohler found grandfathers to idealize their relationships and to perceive less conflict with sons and grandsons than was perceived by the younger generation.[120]
- *Not seeking help.* While men and women do share some coping behaviours when they experience trauma, there are also some notable differences. Women are more likely to seek professional help; whereas men are more likely to self-medicate with alcohol or to self-abuse, including suicide.[121,122]
- *Not trying to repair fractured relationships*. Again, the tendency to avoid expressiveness might keep men from attempting to repair relationships. A particular concern is an inability to cope with the loss of one's wife and deal with the feelings associated with grief. When a basic loss cannot be faced, then resulting relationship fractures cannot be understood and dealt with.[123]
- *Difficult personalities*. Numerous fathers in the study by Stratton and Moore were negative about life in general, and critical and controlling of their adult children, particularly their sons.

Living Alone Versus with Another Person

Older people are most likely to be abused by those with whom they live, although those who live alone may be more likely to suffer neglect. In 2004, the majority of family-related assaults reported to police took place in their home and the victim and the accused were often sharing living quarters. About eight out of ten older visits assaulted by an adult child were living with the assailant.[124]

On the other hand, the 2004 General Social Survey showed that the overall victimization rate in multigenerational households with children less than 15 years and seniors was three times lower than the rate for households with children and no seniors. This suggests that having the older generation in the home may act as a protective factor against overall violent victimization. This is likely to be when younger seniors play an active and supportive role in the daily running of a home, as opposed to a dependency role.[125]

Older widowers are more likely than widows to remarry. ***Late life remarriages*** may be problematic. A new wife who suddenly finds herself thrust into the caregiver role if her older partner becomes ill may be disillusioned with the marriage and the freedom she has

given up. Children may also feel alienated, distressed or "cut out" financially by a father's quick re-marriage, and be unsure of their caregiving responsibilities in light of the new relationship.[126] The financial abuse of older men by younger women in later life marriages is frequently reported in the media.[127] Older men may seem special "marks" because of their tendency to keep quiet about an abusive situation and because they have more financial resources than older women.

Studies show that father-child relationships deteriorate more after ***divorce*** than mother-child relationships, which may have negative effects on men's contacts with their adult offspring and on their perceptions of adult children as potential sources of help in times of need.[128] Also, parental divorce in older age appears to weaken a child's sense of obligation to support parents, whereas widowhood appears to strengthen it.[129]

2.6 Screening and Diagnosis

Universal screening means assessing everyone; selective screening applies only to those who meet specific criteria. In 2003, the Canadian Task Force on Preventive Health Care stated there was insufficient evidence to recommend for or against routine universal screening for violence against women.[130] In the same year, the United States Preventive Services Task Force stated that it could not find enough evidence to determine the balance between the benefit and harm of screening for family and intimate partner violence among children, women and older adults and therefore did not recommend one way or the other.[131]

Since then a heated debate has ensued among health professionals around the issue of screening for family violence, including elder abuse.[132] Several useful assessment tools have been developed. It was beyond the scope of this paper to assess these tools in terms of a gender and diversity analysis. This would be a useful thing to do.

Studies show that most women (including older women) find screening for violence acceptable if it is done routinely, sensitively and in confidence.[133]

Primary healthcare workers are in an ideal position to recognize, manage and help prevent elder abuse and neglect. However, most do not identify it, as it is not part of their formal training and does not appear in their list of diagnoses. More emphasis on elder abuse prevention and management through skills training that incorporates gender dimensions and interdisciplinary community approaches is recommended.[134]

Abused older women may seek treatment for different reasons. Women are most likely to present with depression; older men may also present with bereavement and substance abuse. When an older man or woman seeks treatment for a mental health issue, prior and current trauma needs to be addressed.[135]

2.7 Programs and Interventions

Critiques of interventions related to domestic violence against older women suggest that neither elder abuse nor domestic violence services provide what is needed, and that older women fall between the cracks of a safety net because of this.[136]

In Canada, emergency shelters are the first line of defence for women and children in situations of domestic violence. Shelters are based on the grassroots principle of women helping women.[137] In addition to offering a safe place to live, women's shelters provide a range of services, programs and community outreach efforts, including support groups, counseling, legal information, advocacy, referrals and accompaniment.

Studies have shown that there are numerous barriers to the use of shelters by older women. Many older women are not aware of existing resources for domestic violence, and if they are aware, many believe they do not serve older women. Second, most women's shelters do not provide resources and programming specifically adapted for older women, nor are most shelters physically accessible for women with disabilities. Third, professionals and shelter workers are likely to have no training about the needs for support and feminist approaches to working with older women. Lastly, shelter interventions that encourage a woman to leave her abusive partner may not be appropriate for older women who generally have much more invested in their marriages and whose financial and emotional barriers to leaving are likely to be much higher.[138]

There are only four emergency shelters for older men in Canada, their establishment is a direct recognition that traditional safe houses do not reflect the needs of abused men. In addition, societal and self-imposed expectations of male behaviour continue to have a negative effect on the ability of older men to seek help.

The few studies on interventions with older women suffering domestic violence suggest that support groups specific to older women are an important source of peer support, validation and self-help[139] and that workers need to need to speak about empowerment and choice in language they understand.[140]

Group settings have also been shown to be an effective treatment model for men.[141] A review of clinical outcomes for men versus women in short-term individual therapy confirms that women do better in supportive therapies characterized by empathy, affiliation and affective expression. Male clients tend to realize better outcomes with interpretive, narrative techniques allowing for emotional distance and independence.[142] Outreach community-based services may also be particularly effective for men. When service providers come to the home, an older man remains comfortable on his "own turf" and is less likely to encounter the stigma associated with going out for help.

Elder abuse services include adult protection services and support from the health and social services sector. The latter commonly use a team approach and case management model, which provides a means of addressing the complex, multidimensional needs of an older abused person.[143] Cases of domestic violence can thus be missed because professionals are focusing on health and caregiver issues rather than paying attention to power and control dynamics in the relationships of older couples.[144] When legal

interventions are used, it is normally to resolve questions of cognitive capacity and guardianship rather than to prosecute an abuser.[145]

2.8 Legislation and Protective Services

It was beyond the scope of this paper to conduct a GBA of issues related to elder abuse and legal and protective services. This will be carried out by other departments involved in the federal elder abuse strategy.

Based on the findings of this paper, a few observations can be made:

- There are four main types of laws used in Canada to protect older adults from abuse and neglect. These are family violence laws, criminal law, adult protection laws, and adult guardianship laws. As discussed, the domestic violence paradigm is most effectively used in addressing violence against women. However, even where provinces or territories have family violence laws, they are not used very often for abuse of seniors. For example, of the 28,000 cases coming before the Winnipeg Family Violence court between 1990 and 1997, only 1% involved abuse of older adults.[146]
- As discussed, professionals involved in domestic violence (including lawyers, judges corrections officers and community service workers) are less likely to have received training specific to abuse among older people than for younger women. A 2001 Nova Scotia report also highlighted the problems that can arise when the legal and other resources are not adequate to help make the available family violence prevention laws work.[147]
- Older adults may be reluctant to lay charges or cooperate with criminal prosecutions. This applies to both older men and women even though their reasons may be different. Older men may not want to admit that they have lost control and/or feel a sense of duty to their children, which results in failure to report or to minimize the degree of abuse.[148] Older women, who have few financial resources and/or are socialized to expect a secondary position in the family, may be unable to report abuses.
- Nova Scotia, New Brunswick, Prince Edward Island, Yukon and Newfoundland each have special adult protection laws. Part 3 of British Columbia's Adult Guardianship Act is another form of adult protection law. Some adult protection laws have mandatory reporting, others rely on voluntary reporting. As discussed earlier, compassion for beleaguered and under-valued caregivers (who are mainly women), as well as the complexities in identifying elder abuse may affect the reporting behaviours of health and social service workers who encounter situations that may indicate the abuse and/or neglect of an older person.
- In recent years, some provinces have seen major cuts (and in some cases elimination of services) for victim services, legal aid and lawyers who cover poverty law (which can be important in helping low income older adults have their rights respected).

These service cuts affect older men and women, but may especially hurt abused older women who have fewer financial resources than men.[149]

3. GUIDELINES FOR CREATING BIAS-FREE, GENDER AND CULTURALLY RELEVENT POLICIES AND PRACTICES IN ELDER ABUSE

This section discusses the use of gender-based analysis in the development of policies, programs and research in elder abuse in the Federal initiative, including key questions to ask at each stage of project and policy development.

3.1 The Gender Analysis Process

This paper has begun the GBA process by examining what is known and not known about gender differentials related to elder abuse. This includes looking at other factors related to the determinants of health, including Aboriginal identity, socioeconomic status, culture/race, and ability.

A template for measuring desired outcomes needs to examine three factors:

- *Access*: ability for both older men and women of diverse cultures, abilities, varying socioeconomic status and Aboriginal identity to have equal access to policy, program and legislative activities. This includes eliminating barriers to access and/or not creating barriers.
- *Inclusion*: representation throughout the policy/program process of diverse groups of women and men
- *Benefits*: advantages/gains intended from a policy, program or law are equally available to both older men and women and diverse cultures, those with Aboriginal identity, those with varying levels of socioeconomic status and various levels of ability.[150]

Status of Women Canada and Health Canada suggests that each of these outcomes be measured throughout the following steps:[151,152]

1. Preliminary assessment of gender equality impacts: Explore how existing or proposed policies and programs may affect outcomes for diverse groups of women and men. Reframe the issue to avoid assumptions and stereotypes.
2. Development of outcomes, goals, objectives and indicators: Be inclusive but do not generalize. Take men and women and diverse groups into account when setting goals, objectives and indicators.
3. Research: Choose methods that are sensitive to the determinants of health and ensure that all data is sex- and age-disaggregated.
4. Consultation: Design a gender and diversity-sensitive process that encourages participation from all groups and both genders.
5. Development of policy options: Assess the implications (health, legal, social, cultural, political and environmental) of each option for women and men and diverse subgroups.

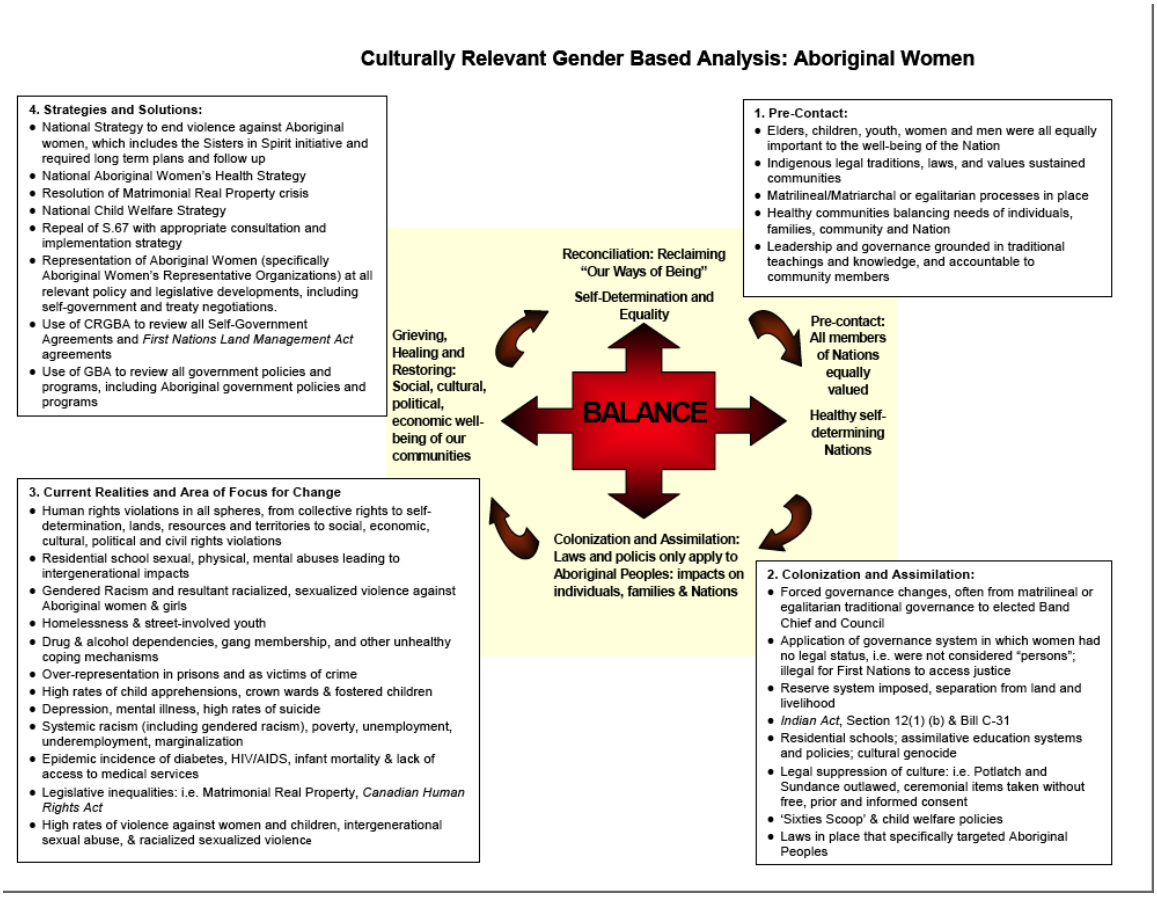
6. Making recommendations. For each recommendation, identify implicit assumptions about gender roles, explain the gender and diversity analysis rationale for the chosen option and offer ways to mitigate any potential negative effects.
7. Communication: Target messages to women and men and diverse groups; use examples, symbols and language that is sensitive to gender and diversity.
8. Program/service design. Keep differences in mind between men and women and diverse groups when designing programs and services.
9. Program/service delivery: Ensure that programs and services are equally accessible and appropriate and have the desired effect on women and men and diverse populations
10. Evaluation: Use sample sizes large enough for data to be disaggregated by age, gender and diversity. Identify data gaps and unintended outcomes.

3.2 A Culturally Relevant Gender Based Analysis

The Native Women's Association of Canada has identified the need to use a Culturally Relevant Gender-Based Analysis (CRGBA) on all legislative, policy and program development, which ensures that the "diversity and different circumstances of Aboriginal women within based on their distinctive cultures and cultural practices within the First Nations, Métis and Inuit peoples" is fully captured.[153] Work on this model stresses the essential need to include Aboriginal women in all stages of project and policy development and follow-up. Core elements include:

- Acknowledging and linking the roots of oppression, such as the effects of racism and sexism
- Honouring a holistic approach that includes respect for self, others, and the values of roles played by men and women in society as well as respecting traditions and a relationship to the land
- Valuing traditional teachings including those that offer a greater degree of equality between men's and women's roles as compared to non-Aboriginal values
- Honouring a holistic approach to respecting relationships, including those between and among individuals, communities and Nations; and
- Taking a rights-based approach with a strong emphasis on teaching the youth about these inter-relationships.[154]

The framework below is intended to ensure that programs and services are developed in a balanced fashion that captures the reality of history: the equality of men and women and young and old before contact with European settlers; the effects of colonization and assimilation; the current realities (e.g., gendered racism and violence, intergenerational abuse); and strategies and solutions (e.g., a national strategy to end violence against Aboriginal women of all ages).[155]



3.3 A Bias-Free Framework[156]

The BIAS FREE Framework — developed by Burke and Eichler—is a tool for identifying and avoiding biases in health research, policies and programs that derive from three social hierarchies: gender, race and ability. BIAS FREE stands for Building an Integrative Analytical System for Recognizing and Eliminating inEquities. The Framework aims to combine, co-ordinate and consolidate the various analytical lenses that have emerged from these various fields of study into a unified whole. It uses a set of questions to alert one to the presence or absence of a bias that derives from gender, race and/or ability. The Framework identifies three main problems:

- Maintaining a hierarchy, for example, efforts that maintain a hierarchy of power based on gender, ability or race. Victim blaming (for example asking an abused woman "what she did to provoke him?") is one way of maintaining a hierarchy. Appropriation, for example by colonizers of Native peoples lands, cultural knowledge and way of life, is another form of maintaining hierarchies. If we simply use a GBA to point out differences without questioning the hierarchy that gives rise to these differences, we have failed to identify the hierarchy as a problem--and thus have served to maintain it.

- Failure to examine differences, i.e., to examine the relevance of one's position on the hierarchy and not accommodating ensuing differences. Decontextualization happens when researchers and decision makers fail to take differences into account. This leads to overgeneralization, which is rampant in the published literature on elder abuse. Information about the dominant group (sometimes men and sometimes women) is extended to the non-dominant group without questioning its applicability.
- Using double standards, i.e. problems associated with treating different groups differently because of their position in social hierarchies. Under-representation contributes to double standards; for example most research on elder abuse has traditionally been carried out with women leading to a relative scarcity of information about older men's experience of abuse. Another form of double standard is the denial of agency, for example treating older people with disabilities as incapable of participating in research and policy and program development. Double standards are also created when stereotypes are treated as an essential aspect of group membership rather than as socially constructed; for example when Aboriginal identity is seen as indicative of excessive drinking that leads to abuse (stereotyping).

Failing to examine differences (the F Problem) and Using Double Standards (the D problem) are two sides of the same coin. The solution to the F-Problem consists of recognizing and accommodating existing differences by treating people differently, while the solution to the D-problem consists of recognizing and eliminating unwanted differential treatment. The key to understanding which type of problem we are dealing with is whether *different* or *same* treatment reduces or enforces different hierarchies.

Historically women, disabled people and others belonging to certain classes or racial or Indigenous groups have tended to be disadvantaged relative to men, non-disabled people, Whites in mainstream Canada and other dominant groups in society. The Bias-Free Framework uses the terms dominant/non dominant group in lieu of male and female.

4.IMPLICATIONS FOR EVALUATION IN A FEDERAL STRATEGY ON ELDER ABUSE

There is serious gap in the current published information. To better understand this issue we need access to data that are disaggregated by sex AND age, as well as on culture/race, socioeconomic status, Aboriginal identity and ability. More culturally relevant research that addresses the age and gender dimensions of oppression and vulnerability in older age is badly needed. To do this, we need to learn more about:

- How women and men understand elder abuse
- How women and men believe that elder abuse can be prevented
- How abused older women and men understand their experiences, how they respond, where they go for help, what happens when they ask for help and the effectiveness of that help
- How policies, legislation and protective services differentially affect older men and women.
- How practitioners understand the gender dimensions of elder abuse, how various interventions and programs and approaches differentially affect women and men, and how we can develop better tools and resources that take gender into account
- How the two paradigms of domestic (intimate partner abuse) and elder abuse can best be combined to ensure that the strengths of each approach are incorporated in practices and training.

In terms of the evaluation for the Federal Strategy on Elder Abuse, the author recommends the addition of a gender, culture and bias-free lens when using the indicators noted in the preliminary evaluation matrix. These indicators are noted below.

These indicators need to be incorporated into the measures normally used to track results and not as a time-consuming separate exercise.

NOTE: Aboriginal identity refers to First Nations, Inuit and Métis

Indicators identified in the existing matrix	Additional indicators
• Level of awareness of elder abuse by public and frontline workers • Level of understanding about what constitutes elder abuse • Changes in the above	• Differences in awareness and understanding between men and women surveyed • Level of awareness among public and professionals of how men and women, different cultures/races, older people in Aboriginal communities and older people with disabilities experience elder abuse

	• Involvement of diverse populations in surveys including immigrants, people with Aboriginal identity, people with varying degrees of socioeconomic status and education, and people with disabilities • Level of beliefs about assumptions and stereotypes related to gender, culture/race, Aboriginal identity and socioeconomic status • Level of acceptance or denial of hierarchies and of victim blaming of the non-dominant group • Extent to which dominant and non-dominant groups are treated differently or the same • Data analysis segregated by sex, age, culture/race, Aboriginal identity, socioeconomic status and ability • Changes in the above
• Number and type of resources available and developed • Perceived usefulness and adequacy of resources available and developed • Identification gaps in available resources and addressing these gaps in developed materials	• Involvement of diverse populations in reviewing materials, including immigrants, people with Aboriginal identity, people with varying degrees of socioeconomic status and education, people with disabilities • Number and types of resources that include information about gender • Number and types of resources that are relevant to Aboriginal women and men and that take history of Canada's indigenous people into account • Number and types of resources that are relevant and accessible to visible minority seniors • Literacy level of resources and their effectiveness for older

	people with limited levels of education or disabilities that impede reading • Differences between men and women and different cultures/races in perceived usefulness and adequacy of resources • Attention to changing biased assumptions and stereotypes related to gender, culture, ability and socioeconomic status • Identify and correct gaps in resources specific to gender, culture/race, Aboriginal identity, education and ability • Data analysis segregated by gender, age, culture/race, Aboriginal identity, socioeconomic status and education levels, and ability • Degree to which barriers to access and understanding have been reduced • Level of generalization of information from dominant to non-dominant groups
• Strengths and weaknesses of the initiative's design and delivery	• Degree of sensitivity to gender, culture/race, Aboriginal history and ability in the design and delivery of the initiative • Degree to which the design and delivery includes the participation of diverse groups of both older women and men • Degree to which the initiative avoids perpetuating existing stereotypes or overstating/ understating the situation of either dominant or non-dominant groups • Data analysis segregated by gender, age, culture/race,

	Aboriginal identity, socioeconomic status and education levels, and ability • Degree to which the program design incorporates available information about differences related to gender, culture/race, Aboriginal history and ability • Degree to which the initiative takes into account the different life experiences of men and women and diverse cultures (e.g., income and other social determinants of health) • Degree to which barriers to access and understanding have been reduced
• Number and types of networks and partnerships established • Type and scope of network and partnership activities • Perceived contribution of networks and partnerships	• Degree of inclusion of networks including representatives of two genders, older people with different levels of socioeconomic status, different cultures/races, older people of Aboriginal identity, and older adults with disabilities • Degree to which barriers to participation have been reduced • Number and types of partnership activities involving representatives of two genders, older people with different levels of socioeconomic status, different cultures/races, older people of Aboriginal identity, and older adults with disabilities • Degree of collaboration between networks in elder abuse and networks involved in family violence
• Number, type and scope of outreach activities funded • Number of participants engaged in outreach activities	• Number and types of outreach activities involving representatives of both genders, older people with different levels of socioeconomic status,

	different cultures/races, older people of Aboriginal identity, and older adults with disabilities • Degree to which barriers to participation have been reduced
• Number, type and scope of capacity development activities funded • Views on extent to which national professional organizations' capacity to support their members has been strengthened	• Number and types of capacity development activities addressing gender, socioeconomic status, different cultures, Aboriginal identity, and ability. • Degree of adoption of a bias-free approach that takes into account the social realities of both dominant and non-dominant groups • Degree to which barriers to participation have been reduced for non-dominant groups

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