

“She just got harder and harder to look after” -

A discourse analytic case study of elder abuse

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Abstract

As our population ages, it is anticipated we will see more and more cases of elder abuse (Young, 2014). With that said, elder abuse is often obscured from view because it typically takes place behind closed doors in family homes or in institutional settings. Victims are often among the most vulnerable members of society, many of whom have limited access to the outside world due to complex medical conditions which may render them physically frail, cognitively impaired, and in extreme cases, non-verbal. This thesis examines transcripts of the police interview with Ontario nurse Elizabeth Wettlaufer who pleaded guilty to murdering eight older adults in her care. Using the *Interactional and discursive view of violence and resistance* (Coates & Wade, 2007) as my theoretical frame, I will take a discourse analytic approach to demonstrate how the language of perpetrators of elder abuse can be used both to conceal their violence and the victim's resistance. I will further discuss how these narratives serve to mitigate the responsibility of the perpetrators of elder abuse and blame the victims.

Keywords: elder abuse, concealing violence, mitigating responsibility, response-based approach, victim blaming.

Preface

As I sit to write this, the world is in the middle of a global pandemic which has brought to the fore not only the inadequacies of our public health apparatus, but also, sadly, our long-term care system. In the early days of this crisis, grisly reports of vulnerable seniors being abandoned by staff at a long-term care facility in Quebec emerged in the media and shortly thereafter, the military was brought in to care homes in Ontario, where they found people living in unthinkable conditions of neglect. Once again, Canada's long-term care system has captured the public's attention in a horrifying way. The Premier of Ontario has called for yet another inquiry to better understand the systemic issues at play that have led to the mistreatment of Canada's most vulnerable older adults. I contend that underpinning these problems of staffing shortages and poorly trained workers, is a pervasive sentiment of ageism. As a society, we do not care enough about older adults, which is stunning given that all of us, should we live long enough, will be susceptible to this all too common prejudice and the mistreatment that potentially emerges from it. It is my sincere hope that those in power finally see that we need to do much better to care for our most vulnerable citizens.

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I would like to express my gratitude to my family – I have been truly blessed to have been raised in a loving, caring environment. As I embark on this career in counselling, I see ever more clearly, what a gift you have given me. I know I am loved; I know how to cope; and I know I can navigate the bumps in the road thanks to your love, guidance and support.

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Finally, to the victims and families, may we learn from these experiences and do a better job caring for our older citizens.

“She just got harder and harder to look after” –

A discourse analysis of a case of elder abuse

Elder abuse only entered the public discourse in the early 1970s and so it is said to “have remained hidden and taboo until very recently” (Mysyuk, Westendorp, & Lindenberg, 2012, p. 50). It emerged out of the burgeoning attention to child abuse and intimate partner violence and is often discussed as another form of family violence (Krug et al., 2002). Despite this, the most widely used definition of elder abuse is the one provided by the World Health Organization (WHO) (2008), which does not mention violence at all; instead, elder abuse is defined 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” (see also Krug et al., 2002; Garnham & Bryant, 2017 and Van Den Bruele, Dimachk, & Crandall, 2019). Given some of the horrendous cases of elder abuse and neglect to have surfaced in recent history, this definition seems a rhetorical use of understatement, to say the least.

Research question

I will seek to answer the question: What discursive operations are employed to obscure the perpetrator’s violence/abuse and the victims’ resistance in Elizabeth Wettlaufer’s accounts of elder abuse, thereby mitigating her responsibility and blaming her victims?

Rationale for study

Why is it important to examine the language used to describe instances of elder abuse? I believe it is important because these acts are already obscured by virtue of the fact that the victims are, generally speaking, extremely vulnerable older adults, and the abuse typically takes place behind closed doors. The way in which these abuses are often described, further obfuscates their intentional and violent nature. For example, the violence Wettlaufer’s victims

experienced is diminished because she uses medical terminology and discourses common to nursing care to conceal her cruelty and to mitigate her own culpability. In most cases the victims did not survive to give their own accounts of these events. Had they survived, their dementia would have likely inhibited their ability to describe what happened and to remember how they responded and so the victims' resistance is also concealed. We are left with Elizabeth Wettlaufer's version of events and while these cases are extreme, in that 8 of her victims died, the linguistic devices Wettlaufer uses are all too common when violence and oppression is described (Coates & Wade, 2004, 2007).

The thesis is comprised of four parts. Part 1 is this introduction, which includes a brief review of the literature on elder abuse, in general, and on the abuse of older adults with dementia, in particular. I believe it is important to look at the research on the abuse of people with dementia because there seems to be a widely held belief that caregiver stress or caregiver burden, both of which are significant in care providers of older adults with dementia, are correlated with an increased risk of abuse. Dementia is named as a risk factor in much of the scholarly literature on elder abuse and there is some suggestion, especially in the early research, that the stress of providing care to older adults with dementia is a "primary cause" of elder mistreatment (Wolf, 2000). While some of the more recent research finds that caregiver stress is not a primary cause of elder abuse (Brandl & Raymond, 2012; see Yan, 2014 and Yan & Kwok, 2011 for exceptions), Wettlaufer herself referenced her stress and feelings of anger and frustration with particular residents, in an attempt to justify her actions. Also, Wettlaufer specifically targeted individuals with diagnoses of dementia because she knew they would be unable or unlikely to report the abuse. If they did report it, she knew they would make unreliable witnesses and their allegations could be easily dismissed because these individuals were

“confused.” Many residents in long-term care have a diagnosis of some form of dementia making them particularly vulnerable to abuse. In British Columbia, 63% of residents of long-term care have dementia and 30% have severe cognitive impairment (Office of the Seniors Advocate BC, 2018).

Part 2 provides an analysis of the texts - Wettlaufer’s handwritten confession (Appendix A) and the transcript of the voluntary interview she gave to police. By examining Wettlaufer’s statements, I hope to demonstrate how she uses language to mitigate her responsibility and blame her victims. I will also discuss how the victims’ resistance is obscured. Wettlaufer does not once voluntarily acknowledge that her victims resisted in any way and it is only when the police press her for an account of a victim’s reaction that Wettlaufer concedes there was resistance.

Unfortunately, in this case, most of Wettlaufer’s victims did not survive to give their own accounts of their resistance, but resist, in some way, they surely did. Todd, Wade and Renoux (2004) assert that resistance to violence is ubiquitous, but victims are often misrepresented as passive recipients of abuse (p. 145). These misrepresentations are furthered not only by perpetrators of violence, but also often by the police, the legal system and the media who describe violent events.

Part 3 includes a discussion of these results in the context of the way elder abuse is defined and considered in the scholarly literature, in which much of the focus is on the victims and on developing taxonomies to better understand who is at risk; decidedly less consideration is given to perpetrators of abuse. In fact, much of the literature on elder abuse pays little to no attention to the perpetrators (Jackson, 2016; Quinn & Zielke, 2005). This can have the unfortunate and unintentional consequence of having a “blaming the victim” effect. While it is true that far fewer caregivers perpetrate abuse than those who do (at least according to reported

statistics); it is important that we have a better understanding of the types of people who are likely to abuse so that institutions can know what to look for, what the warnings signs are and, in turn, be more vigilant in their hiring practices and monitoring of staff. Furthermore, I think it is incumbent on us to consider how we define abuse and neglect. Long-term care facilities have staff-to-resident ratio requirements that are determined by the provinces, but these staffing ratios are at best, only satisfactory. Given that older and frailer adults are being admitted into long-term care, the level of care required by residents today is significantly higher than it once was, and yet the staffing ratios have not changed (Office of the Seniors Advocate BC, 2018). As a result, nurses and health care workers, who are responsible for the vast bulk of personal care needs of residents (e.g. toileting, bathing, dressing, teeth brushing, feeding, etc.) are often overworked and rushed to complete all of the requisite care. Abuses may happen when otherwise caring individuals find themselves overwhelmed; however, care providers may not consider their actions abusive because they do not fall under the current definition of what is commonly understood as elder abuse. The fourth and concluding section includes a consideration of future areas of inquiry.

The Wettlaufer case is an extreme example of elder abuse, because it resulted in murder; however, I think Wettlaufer's confession reveals some pernicious themes – namely, the notion that caring for elderly residents of long-term care is burdensome and when abuse does occur it is, the older adults are at least partially at fault because they are difficult to care for. This sentiment is situated in an ageist social construction of old age in which older adults are viewed as “slow, forgetful, unable to learn, set in their ways, retired, grumpy, lonely, weak, and sick” (Schmidt, 2011). Prejudice that emanates from these negative stereotypes can be relatively harmless (e.g. off colour, ageist jokes), but it can also have deleterious consequences. For example, research

has shown that ageism influences the type and amount of health care the elderly are offered and receive (Ouchida & Lachs, 2015). The elderly themselves often internalize harmful stereotypes, believing, for example, that fatigue, depression and pain are normal signs of aging, so they are less likely to raise these concerns with their medical practitioners (Chrisler, Barney & Palatino, 2015). Ageist attitudes can also lead to elder abuse and neglect (Canadian Network for the Prevention of Elder Abuse, 2011).

In the Wettlaufer confession, she alternates between using language that mitigates her culpability and at the same time blames her victims. She is not alone in employing these rhetorical strategies. As we shall see, whether conscious or unconscious, perpetrators of elder abuse employ the same discursive operations as perpetrators of other types of violence (Coates & Wade, 2007).

I hope that by examining the language of Elizabeth Wettlaufer we can better equip medical practitioners, the police, the courts and media to not repeat these narratives, thereby perpetuating the notion that because an older adult requires a high level of care they are somehow deserving of abuse, should it happen. I also hope that by educating caregivers to know what constitutes abuse, we can help prevent it from happening or spot it when it does.

There can be little doubt we need to do a better job identifying and preventing elder abuse. We also need to take care to use more accurate language when describing these events. By examining the language of an abuser of older adults, perhaps we will be better able to not let our own ageist biases influence how we perceive elder abuse and we will be better prepared to not perpetuate the way the abuse, perpetrators and victims are often misrepresented discursively.

Literature review – Elder abuse

Similarly to the WHO (2008), the Centers for Disease Control and Prevention (CDC) (2020) defines elder abuse as “an intentional act, or failure to act, by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult.” Wister and McPherson (2014) assert that “elder abuse occurs in situations in which a frail, dependent person is assisted or cared for by a person in a position of trust such as a relative, friend, or employee of an institution where the person lives” (p. 390). There is no universal definition of elder abuse, which has led some to assert that this has resulted in a lack of consistency in the research and in the ability to identify abuses when they occur (Nerenberg, 2008). Despite these limitations, it is generally agreed that the major types of elder abuse include physical abuse (e.g. hitting, pushing, kicking, inappropriate use of drugs and physical restraints), caregiver neglect or abandonment (e.g. not providing adequate food, water, housing or medical care), financial exploitation (e.g. misusing or stealing money or other assets), psychological abuse (e.g. insults, humiliation, threats, confinement, and isolation), and sexual abuse (e.g. sexual contact without consent) (WHO, 2016). The National Elder Abuse Incidence Study (1998) reports that “neglect was found to be the most common form of abuse, followed by psychological abuse, financial exploitation, physical abuse, abandonment, and sexual abuse (as cited in Hansberry, Chen & Gorbien, 2005, p. 317). Our understanding of elder abuse has been confounded by the fact that it entails this wide range of offences but is typically treated as a “unitary phenomenon” (Jackson, 2016, p. 266).

While it is difficult to determine the prevalence of elder abuse in Canadian society, population-based studies indicate somewhere between 4 and 10 percent of elderly people have experienced some form of abuse (Wister & McPherson, 2014) and the WHO (2016) found that

16.67% of older adults worldwide had experienced some form of abuse in the previous year. Elder abuse is increasingly considered a global public health concern and social problem (Acierno, et al., 2010).

The vast majority of abusers are family members of the victim, typically an adult child or spouse/partner. Beyond this knowledge, relatively little attention has been paid to the abuser in elder abuse research. One exception is Jackson's (2016) review which found that "elder abuse perpetrators are in fact heterogeneous with important differences across types of abuse" (p. 265) [and] "characteristics associated with both victims and perpetrators play a critical role in the incidence of elder abuse" (p. 269). Jackson's (2016) analysis yielded 19 perpetrator risk factors and found that abusers of community-dwelling older adults tended to have lower levels of education and higher than average rates of unemployment, were less likely to be married or had relationship problems, tended to be socially isolated, had a history of childhood family violence, struggled with substance abuse and mental health issues, and were often "panviolent," meaning they had a history of violence with someone other than the abused older person. More research is needed to better understand perpetrators, as these findings stem from a review of a relatively small sample of studies.

Abuse also takes place in institutional settings (e.g. nursing homes and long-term care facilities) and may be more prevalent than we know. One of the reasons we lack knowledge in this area is very little research has been conducted in institutional settings since Pillemer and Moore's (1989) seminal study. The WHO (2016) states, "data about elder abuse in nursing homes and other long-term facilities is scarce, but a review of available data suggests that rates are high" (p. 3). They found 33% of older adults living in institutions reported having suffered psychological abuse; 14% physical abuse; 14% financial abuse; 12% neglect; and 2% sexual

abuse (WHO, 2016, p. 3). Despite these staggering figures elder abuse in institutions remains obscured because it is often “covered up and seldom reported” (Wister & McPherson, 2014, p. 391). Moreover, victims of elder abuse are often reluctant or unable to report the abuse. They may fear retaliation from their abuser or be embarrassed or ashamed to speak out; they may distrust the systems in place to protect them or feel constrained by cultural and social values (Nerenberg, 2008). In some cases, victims may not know where to turn for help or may not have the ability, due to physical or cognitive impairment, to report abuse or they may fear making matters worse if they were to report it.

Elder abuse is associated with adverse health outcomes (Lachs & Pillemer, 2015), including increased rates of hospitalization (Dong & Simon, 2013a), nursing home placement (Dong & Simon, 2013b), depression (Roepke-Buehler, Simon, & Dong, 2015) and morbidity and mortality (McCarthy, Campbell, & Penhale, 2017). Yunus, Hairi and Yuen (2019) found in their systematic review of multiple studies that the most robust finding across all studies was an increased risk of premature death and overall, exposure to elder abuse and neglect “is likely to contribute to decline in both physical and mental health” (p. 207). For example, they found rates of “depression or depressive symptomatology was ranked first, followed by poor mental health, psychological distress, anxiety, and suicidal thoughts” in people who had been victims of elder abuse (Yunus, Hairi & Yuen, 2019, p. 201).

Literature review - Elder abuse and dementia

As noted above, cognitive impairment and dementia are frequently cited in the literature as risk factors in elder abuse. Dementia is a term to describe a set of symptoms such as memory loss, confusion, impaired judgement and problem-solving abilities, and language problems. Many diseases cause dementia including Alzheimer's disease, vascular dementia (due to strokes),

Lewy Body disease, head trauma, fronto-temporal dementia, Creutzfeldt-Jakob disease, Parkinson's disease, and Huntington's disease (Alzheimer Society of Canada, 2018).

While dementia is not an inevitable consequence of ageing, age is the strongest known risk factor and it is estimated that 50 million people worldwide are living with dementia with 10 million new cases every year (WHO, 2020). Many of the diseases that cause dementia, including Alzheimer's disease (AD), which accounts for 50% of cases, are progressive, degenerative and incurable. As a result, the physical and cognitive health of people with AD declines over time and eventually they require assistance with every aspect of their lives. In early to middle stages of AD, familial caregivers (e.g. an adult child or a spouse) and home support services are typically enlisted to provide this care, but as the disease advances, nursing home placement is frequently inevitable as the level of care becomes too much for most informal caregivers to manage.

According to the Canadian Institute for Health Information (CIHI) (2020), familial caregivers of older adults with dementia are more likely to experience distress (45%) than caregivers of older adults without dementia (26%). CIHI found that "38% of caregivers express the symptoms of distress, anger or depression and 21% feel unable to continue their caring activities (compared with 19% and 12% for caregivers of seniors without dementia, respectively)" (n.p.). This prevalence of distress among caregivers has resulted in the concept of "caregiver burden" to emerge in the literature.

Caregiver burden (CB) (sometimes referred to as "burden of care") denotes the physical, emotional, social, and financial toll experienced by familial caregivers. Eppers, Goodall, and Harrison (2008) report that "CB is associated with poor outcomes for caregivers such as depression, illness, and decreased quality of life (Schulz, Boerner, Shear, Zhang, & Gitlin, 2006)

and poor outcomes for dementia patients such as poor quality of life and early nursing home placement (Gaugler, Kane, Kane, & Newcomer, 2005; Yaffe et al., 2002)” (p. 423). It is important to note that while burden of care is typically considered in the context of familial caregivers, nurses and other formally trained caregivers can experience a similar phenomenon, however in these cases the terms “stress” or “burnout” appear in the literature (Rachel & Francesco, 2012).

One of the reasons caregiver burden and burnout is so prevalent in caregivers of people with dementia is the care needs of people with dementia can be overwhelming and in addition to the serious cognitive and physical health concerns that result, behavioural challenges can occur as well. These so called “responsive behaviours” are typically intentional responses to something in the person’s personal, social or physical environment and are the result of “changes in the brain affecting memory, judgment, orientation, mood and behaviour” (Alzheimer Society of Canada, 2020, n.p.). As these brain changes occur, a person with dementia may have difficulty communicating and may become increasingly anxious, fearful, angry or aggressive and may lash out with verbal outbursts (e.g. yelling, swearing, name-calling) or physical confrontations (e.g. hitting, pushing, scratching). Volicer (2018) states, “behavioural and psychological symptoms of dementia are common, and a recent study found that they occur in up to 90% of people living in residential care facilities” (p. 637) and these behavioural problems are said to contribute to “greater caregiver distress and depression” (Volicer, 2018, p. 637). Another study found that aggressive behaviour occurs most frequently during intimate care in 57% - 67% of dementia patients (Hansberry, Chen, & Gorbien, 2005). Yan (2011), in her study of familial caregivers, also reports an association between agitated behaviour in care recipients, caregiver burnout and caregiver’s abusive behaviours, finding that verbal and physical abuse were “highly

correlated” with care recipients’ agitated behaviours and caregivers’ emotional exhaustion and depersonalization (p. 1022). Furthermore, Schmidt, Dichter, Palm, and Hasselhorn (2012) found 75% of nursing home nurses surveyed, assessed their own distress stemming from residents’ challenging behaviour (most significantly, aggressiveness and depressive behaviours) as “moderate to high.” Increased rates of elder abuse are also strongly predicted by an increase in anxiety and depressive symptoms of caregivers (Cooper, Blanchard, Amber, Walker, & Livingston, 2010). Tronetti (2014) found that people with dementia experienced abuses ranging from subtle financial scams to outright physical violence, but importantly, *all* forms of abuse escalate as dementia progresses.

There is little doubt that caring for people with dementia can be stressful. It should also be noted, though it is not the focus of this thesis, that older adults can also be perpetrators of violence and there are instances when the abused elder is the spouse of the person receiving care (Beaulaurier, Seff, & Newman, 2008). Moreover, older adults with dementia are sometimes known to react violently toward their caregivers (see Åkerström, 2002; Sharipova, Borg, & Hogh, 2008). In nursing homes there are also frequently reported incidences of resident-on-resident abuse (see Castle, 2012; Streib & Metsch, 2002; Trompetter, Scholte, & Westerhof, 2011).

My intention is not to detract from the very real stressors experienced by familial and professional caregivers alike; however, stress can never be an excuse for perpetrating violence and yet, in much of the social gerontological literature, this is a persistent finding. Social gerontological research of elder abuse would be wise to begin examining elder abuse through a response-based framework (Coates and Wade, 2007; Wade, 1999); to do so would likely provide

a far more accurate account of the abuse and may yield more effective approaches for how to recognize and prevent it.

Methodology

This thesis assumes a social constructionist epistemological stance and takes a discourse analytic approach informed by the work of Potter and Wetherell (1987), Potter, Edwards and Wetherell (1993), Potter (1996) and others (Jaworski & Coupland, 1999; Schiffrin, 1994) to examine the transcripts of Elizabeth Wettlaufer's police interview and her handwritten confession in which she describes multiple accounts of elder abuse. These two texts form, in part, the foundational documents of *The Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System* (hereafter, the *Inquiry*) (Gillese, 2019), a commission convened by the government of Ontario to identify systemic flaws that may have contributed to Wettlaufer's ongoing abuses going unnoticed. In fact, had Wettlaufer not confessed, her crimes would have, most certainly, remained unknown (Gillese, 2019a).

Discourse analysis (DA) is an interdisciplinary method of examining how discourses, as part of the broader social context, influence the way people make meaning of their experiences and construct their identities. As such, "the analysis of language use cannot be independent of the analysis of the purposes and functions of language in human life" (Schiffrin, 1994, p. 31). DA draws from many different traditions and genres, but as Wiggins and Potter (2008) note, by making discourse the primary focus of investigation "and, in particular, the ways in which discourse is oriented to actions within settings, the way representations are constructed and oriented to action, and a general caution about explanations of conduct based in the cognition of individuals," (p. 74) discipline can be achieved with this approach.

My analysis also relies on the *Interactional and discursive view of violence and resistance* (Coates & Wade, 2007) to assess how language may be used to “(a) conceal violence, (b) mitigate perpetrators’ responsibility, (c) conceal victims’ resistance, and (d) blame or pathologize victims” (p. 512). I read and reread the texts, paying particular attention to the ways in which Wettlaufer describes her victims and her violent actions. It should be noted that where sections of these texts are reproduced, I have followed the transcription as it appeared in the original, so the transcription conventions which are typical of discourse analysis, are not used in this paper. This is a limitation of the present study – that I rely on another’s transcription and did not conduct the interview myself or have access to a videotaped recording of the interview. As a result, I am not privy to verbal pauses or hesitations, or extra-linguistic information (e.g. gestures, facial expressions, body language) that may have yielded additional insights. With that said, the transcript is rich in data and provides enough information that I was able to deduce quite a lot about Wettlaufer’s attitudes and views of herself and of the world. A further limitation of this study is that it is a case study, so the findings are not necessarily generalizable to other incidences of elder abuse. Regardless, I believe this is the first time a case of elder abuse has been examined using the *Interactional and discursive view of violence and resistance* (Coates & Wade, 2007) and so it adds to the body of research in this regard.

For the purposes of counting the four discursive operations, I only use the police interview transcript. A table of the instances of these discursive operations can be found in Appendix B. In some cases, an utterance may serve more than one purpose (e.g. both to mitigate Wettlaufer’s responsibility and blame the victim) in which case it is counted twice (i.e. as both discursive operations). Also, Wettlaufer may have blamed the victim, for example, across

several turns of talk, in which case, these were counted as a single instance of “blaming the victim.”

Results - The Wettlaufer Transcripts

As noted above, I rely on two source documents for my analysis of the discursive operations (e.g. concealing violence, mitigating responsibility, blaming the victim, and concealing resistance) that Elizabeth Wettlaufer employs when she talks about her crimes. These include Wettlaufer’s handwritten confession, written on September 24, 2016 while she was a patient for substance abuse at the Centre for Addiction and Mental Health (CAMH) in Toronto and the transcript of the police interview she gave voluntarily on October 5, 2016. Both of these documents form appendices of the final *Inquiry* (Gillese, 2019) report.

Who is Elizabeth Wettlaufer?

Elizabeth Tracy Mae Wettlaufer (née Parker) was born on June 10, 1967. She has one brother and grew up with both parents in Woodstock, Ontario, a small farming community approximately 125 km southwest of Toronto. Wettlaufer’s parents were devote Christians and she attended church with them every Sunday. She was married in 1997 to a long-haul truck driver named Daniel Wettlaufer, whom she met at church. When their marriage dissolved in 2007, she began a series of same sex relationships, though she later told friends she had “found God” and was no longer interested in women (Mcintosh, 2019, n.p.).

Wettlaufer obtained an undergraduate degree in religion and counselling from London Baptist Bible College before she transferred into a nursing program at Conestoga College in Stratford, Ontario. She was a Registered Nurse licensed through the College of Nurses of Ontario (CNO) from June 8, 1995 until her resignation on September 30, 2016. Over the course of her 21-year career in nursing, Wettlaufer worked for at least 6 nursing homes, group homes or

agencies that provided nurses by contract for homecare and to long-term care. Wettlaufer's career was fraught from the outset and she was terminated from at least two care homes, once for being incapacitated by narcotics she had stolen from the care facility where she worked, while on the job, for which she was also sanctioned by the CNO. In her testimony to police and the *Inquiry* lawyers she described various clashes she had with staff and management as well as her ongoing struggles with alcohol and drug abuse.

Wettlaufer had a years-long addiction to hydromorphone and she described herself as a "binge user." She often obtained this opioid by stealing it from her patients. Some were confused, she explained in her police interview, and she would give them a laxative so she could have the hydromorphone instead (Gillese, 2019 b, p.13). This, in and of itself, is a form of abuse as hydromorphone is prescribed for moderate to severe pain management so those patients who had to go without, likely experienced unnecessary pain as a result. She also admitted to stealing narcotics and using while on shift as frequently as several times a week; however, she claims to never have been intoxicated on the occasions when she perpetrated her crimes.

According to the *Agreed Statement of Facts* in this case, between 2007 and 2016, Elizabeth Wettlaufer assaulted 2, attempted to kill 4 and successfully killed 8 older adults in her care (Gillese, 2019d). In all cases she administered a non-therapeutic, potentially lethal dose of insulin to her victims and those who survived did so because they received medical attention from other staff. Seven of the 8 murders she was convicted of committing took place at Caressant Care Home where Wettlaufer was employed from 2007 until 2014. She was fired from Caressant Care in March 2014 for making a "medication error" (Gillese, 2019b). The following month she was hired at the Meadow Park Nursing Home where she murdered her last victim before taking leave in October 2014 to seek treatment for her addictions. In January 2015

she was hired by Life Guard Homecare where she did homecare visits and long-term care relief to facilities including Telfer Place, where she attempted to murder another resident. Finally, in June 2016 Wettlaufer was hired by Saint Elizabeth Health Care to conduct home visits and in August of that year she attempted to murder a 68-year-old woman who was at home recovering from leg surgery. It was only when Wettlaufer was assigned to oversee the administration of insulin to school aged diabetic children that she quit her job, stating that she did not trust herself not to begin killing these patients as well (Gillese, 2019b). The fact that Wettlaufer attributed greater value to the lives of these children than she did to the lives of the older adults in nursing homes, may point to an ageist bias she held.

In the late summer of 2016, Wettlaufer voluntarily admitted herself to CAMH citing depression and increased suicidality as her reasons for seeking treatment. According to the CAMH discharge documents prepared by her psychiatrist, Wettlaufer was diagnosed with recurrent major depressive disorder, although it is noted there was no evidence of a major depressive incident at the time of admission; alcohol use disorder; opioid use disorder; borderline personality disorder; evidence of adult antisocial behavior with many symptoms, but not enough to meet the criteria for a diagnosis of the disorder; and binge eating disorder (Gillese, 2019c).

The *Inquiry* sums up Wettlaufer thus:

She was a nurse for 22 years, during which time there were “ups and downs” in her personal life and in her work life. In her personal life, she faced issues common enough today – failed relationships, a search for her sexual identity and acceptance of it, mental health challenges, and substance addiction. In her work life, at times she enjoyed success and at other times she was viewed as sloppy, lazy, and prone to making insensitive and inappropriate comments to her colleagues (Gillese, 2019, p. 1).

A fuller portrait of Ms. Wettlaufer emerges when we examine her discourse, and in particular, the matter of fact way in which she describes her violent acts. At times she deflects responsibility and invokes the notion that she believed herself to be a servant of God; at others she describes a “red surge” in her stomach and the ensuing euphoria she felt after she administered a lethal dose of insulin. The way she nonchalantly describes her crimes and the people she murdered is macabre and while she acknowledges she was not acting out of mercy and recognizes that what she did was wrong, she rarely expresses remorse or regret.

It is clear from Wettlaufer’s psychiatric profile she was a very troubled woman, but in many ways, she is a very ordinary person. Perhaps it was this ordinariness that allowed her to literally get away with murder over so many years. Despite the numerous times throughout her career that her misdeeds and mistakes caused red flags and in spite of a number of unflattering characterizations of Wettlaufer made by past employers, no one ever suspected she was intentionally harming the older adults in her care.

Analysis of discursive operations

The six guiding principles of the *Interactional and discursive view of violence and resistance* (Coates & Wade, 2007) are: (1) violence is both social and unilateral – it is social in that it requires at least two people (a perpetrator and a victim), but it is unilateral because it involves actions by one person against the will or well-being of the other; (2) violence is deliberate; (3) resistance to violence is ubiquitous; (4) misrepresentations are common – not only do perpetrators and victims misrepresent themselves, but the social discourse about violence often misrepresents the facts and risks collusion with offenders; (5) “fitting words to deeds” – no account is impartial and all accounts of violence influence the perception and treatment of victims and offenders; and (6) there are four discursive operations in the social discourse of

violence – “language can be used to conceal violence, obscure and mitigate offenders’ responsibility, conceal victims’ resistance, and blame and pathologize victims” (Coates & Wade, 2007, p. 513). It is this last tenet – the four discursive operations - that I will consider with respect to Wettlaufer’s account of her actions.

Mitigating the perpetrator’s responsibility

There are many ways in which Wettlaufer uses language to mitigate her responsibility. She (i) portrays herself as a perfectionist who put undue pressure on herself to be a perfect nurse; (ii) describes herself as a servant of God, and; (iii) refers to a nebulous “red surge” she felt in her stomach.

Early in her interview with police, Wettlaufer states:

Excerpt 1

...just always feeling like I had to be the best possible person an [sic] very very stressful job giving medications to thirty-two people um making sure treatments were done on thirty-two people charting for thirty-two people, supervising four PSW’s who sometimes didn’t always get along and sometimes always didn’t always get along with me it’s a hard job any nurse will tell ya it’s a hard job and, uh, then they would add different things like oh you have to do this and that to say who’s here and counting the medications at the end of the shift and it’s a hard job and I did I always was putting this pressure on myself to be a really good nurse and to do everything perfectly. (as cited in Gillese, 2019 b, p. 16)

Wettlaufer offers this description as a way to explain her substance misuse and longstanding opioid addiction, but by complaining about the strenuous nature of her job and the various tasks she was responsible for, and positioning herself as a victim, she sets the stage for future assertions in which she complains about the stress and frustration she experienced with her

personal and professional life and, in particular, the anger she felt toward certain residents. As already discussed, burnout among caregiving staff is an established risk factor in elder abuse (McDonald et al., 2012), but it is not, and should never be, a justification for elder abuse.

Working as a nurse in long-term care is a challenging job and the responsibilities are many, but the idea that Wettlaufer's attempt to be "the best possible person" and the notion that she "...was putting this pressure on [herself] to be a really good nurse and to do everything perfectly" is a total misrepresentation of herself and her conduct as a nurse. She was far from a "perfect" nurse and as noted above she was formally sanctioned by the CNO and fired from more than one job. Coates and Wade (2007) assert, "perpetrators use language strategically, not only to conceal violence and to avoid responsibility but also "to manipulate public appearances [and] promote their accounts in public discursive space...; [thus], extreme violence can continue undetected for many years while the perpetrator builds a reputation as a model citizen" (p. 512).

Another way Wettlaufer mitigates her responsibility is by drawing from her religious upbringing and claiming that God was somehow calling her to commit these violent acts. When speaking about her first victim (Clotilda Adriano) Wettlaufer states:

Excerpt 2

...and I didn't really want her to die I just I don't know I was just angry and um had this sense inside me that she might be a person that God wanted back with him I honestly felt that God wanted to use me and he kept doctor [Dr. Kahn, Wettlaufer's psychiatrist at CAMH] kept asking me do you think God chose you for a special purpose I kept saying no cuz that does not sound like a special person you know so but yeah I just had a sense after my marriage broke up that God was gonna re use me for something and then after a

while I started to really wonder after some of the murders if it was God or if it was the devil fooling me. (as cited in Gillese, 2019b, p. 31)

Wettlaufer was raised in a Christian household and attended church every Sunday with her family. She also went to a Christian bible college. She worked, for a time, at a Christian denominated nursing home and even quit because she was in a same-sex relationship and she feared being discovered by her employer, because same-sex relationships were not protected under human rights laws within religiously affiliated organizations in Ontario at the time (Gillese, 2019b). It is difficult to imagine that over the course of her lifetime Wettlaufer had not encountered the Ten Commandments. When asked directly if she thought she was killing her victims as an act of mercy, she flatly denied she was acting with compassion in mind. She stated on more than one occasion that she knew what she was doing was wrong and yet, despite not being delusional in the psychiatric sense of the word, she deluded herself and she attempted to persuade her interlocutor that she had somehow been chosen by God to commit murder. This is an absurd and heinous attempt to conceal the violent nature of her actions. The problem is narratives such as these make their way into the public domain via the courts and media accounts leading others to be misled. Perhaps as a result of this misrepresentation one of the first myths about this case that the *Inquiry* dispelled was the notion that these were mercy killings. Gillese (2019) states:

Many have suggested that the Offences were “mercy killings” designed to end the victims’ suffering. Nothing could be further from the truth. When Wettlaufer committed the Offences, the victims were still enjoying their lives, and their loved ones were still enjoying time with them. It was not mercy to harm or kill these people. (p. 3)

Yet another way Wettlaufer attempts to diminish her responsibility is by making reference to the indefinable “red surge” she apparently felt in her stomach that would identify her victims for her.

Excerpt 3

Wettlaufer: And uh as always one evening I just got that red surging feeling that she was gonna be the one.

Hergott: Did you ever get that feeling going to work knowing that that something was going to happen that shift?

Wettlaufer: No it always happened at work.

Hergott: Okay so if I were to use the phrase spur of the moment would it be something...

Wettlaufer: (sighs)

Hergott: ...that you would just have that feeling come on or...

Wettlaufer: Yeah I guess you could say it was uh...

Hergott: ...would it build up?

Wettlaufer: ...spur of the moment but it would it would usually start happening you know focused on one patient and then this I would feel that red surge and which is what made me think it was God. (as cited in Gillese, 2019b, p. 57)

Wettlaufer mentions this “red surge” on numerous occasions as she describes the events leading up to her committing murder. This is another example of how she deflects responsibility, this time to some otherworldly feeling in the pit of her stomach. Coates and Wade (2004) note that “many offenders attempt to avoid responsibility even if they cannot avoid guilt in the legal sense, by concealing the deliberate nature of their actions” (p. 502). By constructing herself as an

innocent bystander or pawn of some external force, outside of her control, Wettlaufer attempts to conceal the volitional nature of her violence, thereby mitigating her responsibility.

Blaming or pathologizing the victims

In addition to discursively constructing herself as a perfect, if overworked, God-fearing nurse, another discursive operation Wettlaufer frequently employs is to blame or pathologize her victims. Unlike some perpetrators who can be subtle in casting blame and aspersions toward their victims, Wettlaufer is quite forthright. It is as though she feels justified in her grievances. She complains about the burdensome nature of her job and caring for particular residents whom she found challenging. She also calls out some of her male victims for inappropriately groping staff and she problematizes some of her female victims as non-compliant, “stubborn” patients. She never acknowledges that the challenging behaviours she may have experienced and observed in these residents were likely symptoms of the dementia they were suffering; rather, she seems to believe the feelings of anger and contempt she had for these residents made the murders she committed defensible.

When Wettlaufer describes Maureen Pickering, her 11th victim, she goes to great lengths to construct Ms. Pickering as a challenging patient who was difficult to look after. Excerpt 4 below demonstrates a blatant attempt to blame the victim while simultaneously mitigating her own responsibility. Wettlaufer states:

Excerpt 4

Maureen [Pickering] was a handful she would attack all the patients she would pull their hair she would hit them she would pinch them eventually it was decided that she needed a one-on-one staff so sometimes they would (unintelligible) PSW's [personal support workers] would be with her sometimes someone would come from the outside to be with

her, but when one, when one wasn't available it [was] the role of the charge nurse and that was nuts that was absolutely nuts so um she just got harder and harder to look after and one night when I had to look after her I got this idea like you know (sighs) I started to get the feeling, that surge again I thought no I don't want her to die but if I could somehow give her enough of a dose to give her a coma or something to change her brainwaves maybe make her less you know maybe make her less mobile less hard to handle so uh yeah I overdosed her. (as cited in Gillese, 2019b, p. 72)

Wettlaufer describes her victim as “a handful.” She goes on to say that “[Pickering] would attack all the patients” and “got harder and harder to look after.” In so doing, Wettlaufer constructs Pickering as a violent and troublesome resident who by extension, was deserving of the violence that was perpetrated against her. Wettlaufer also uses the fact that Pickering had dementia and required a high level of care as a justification for her violent acts and to avoid responsibility. She would have us believe perhaps that she would not have targeted Pickering had she been a more compliant patient.

Wettlaufer also states that Pickering needed “one-on-one” care and complains that one night that responsibility fell to her. Most residents of long-term care facilities are there because they require a high level of care. They can no longer care for themselves and their level of care has exceeded the abilities of familial caregivers at home. Personal care (e.g. bathing, dressing, toileting, etc.) is typically done *one-on-one*, so the implication that Pickering deserved what she got, because she was a burdensome patient is a clear example of victim blaming. Furthermore, it was Wettlaufer's job to look after Pickering and the other vulnerable older adults in her care; she was paid to do so and was entrusted to do so competently.

Once again in this excerpt, Wettlaufer further attempts to mitigate her responsibility by attributing her violent actions to “the feeling, that surge.” The implication here is that she was not acting of her own free will; rather some otherworldly “feeling” forced her to act violently. Todd, Weaver-Dunlop, and Ogden (2014) assert:

Abusive behaviour is a deliberate, conscious choice: Though it is often represented both clinically and theoretically in ways that suggest abusive behaviour is an effect of causes that a [person] could not reasonably be expected to control, close examination of abusive conduct reveals it is largely volitional. (p. 1118)

Wettlaufer tells police that she, “didn’t want [Pickering] to die” she merely wanted to “give her a coma or make her less mobile, less hard to handle.” Here, once again, we see how Wettlaufer’s choice of words clearly serves the purpose of diminishing her responsibility for killing Pickering.

The next excerpt is taken from Wettlaufer’s handwritten confession, which is chilling in its plain, candid style. About Arpad ‘Art’ Horvath, she states:

Excerpt 5

Art was physically abusive to the staff. He would pinch and hit. One evening I decided enough was enough. I felt angry, frustrated, vindictive and energized. I gave Art 80 units of short acting insulin and 60 units of long acting insulin at app. 8 pm. During the night he had a stroke and died 4-5 days later. (as cited in Gillese, 2019e, p. 819)

In this example, Wettlaufer employs the discourse of nursing in her confession of murder. “I gave Art 80 units of short acting insulin and 60 units of long acting insulin,” she writes. It is as though she was charting her patient care at the end of her shift, but she wasn’t; she had committed intentional homicide. To further conceal her violence, she writes that later that night Mr.

Horvath “had a stroke and died 4-5 days later,” attributing his death to a stroke, and by extension, distancing herself from the cause of his death.

Concealing the victim’s resistance

Renoux and Wade (2008) state, “accounts of violence cannot be considered accurate unless they convey the unilateral nature of the perpetrator’s actions and include a description of the victim’s resistance” (p. 2) and yet in Wettlaufer’s retelling of her violence, she never once voluntarily offers an account of her victims’ resistance. In fact, she could recall the wing of the nursing home her victims’ resided, where their rooms were located in relation to the nurses’ station, whether a resident lived in a double or single room, what their diagnoses were, and which family members and friends came to visit on a regular basis. She could remember these details years after the fact, but she never once voluntarily offers any details about how her victims resisted when she administered a lethal dose of insulin. Wade (1999) asserts that “whenever people are treated badly, they resist” (p. 127). One piece of evidence for the principle that resistance to violence is ubiquitous, is the lengths perpetrators go to suppress it (Coates & Wade, 2007). Wettlaufer certainly suppressed her victims’ resistance.

The third of Wettlaufer’s victims and the first to die as a result of her intentionally administered insulin overdose was James Silcox. In the following exchange with police detective Hergott, Wettlaufer describes the events which led to Mr. Silcox’s death, but she neglects to mention how he resisted:

Excerpt 6

Hergott: Okay alright and Mr. Silcox and where where did you inject the insulin into his body?

Wettlaufer: I’m not really sure I’m gonna say his arm or his uh torso.

Hergott: Okay and did he know what was going on at that point?

Wettlaufer: Not really.

Hergott: Was he uh was he uh a verbal patient like could he converse with you and...

Wettlaufer: Oh yeah he, he...

Hergott: ...communicate?

Wettlaufer: ...didn't really converse he did a lot of yelling out don't really remember him reacting when I gave it to him.

Hergott: So he didn't react?

Wettlaufer: I don't remember him reacting no.

Hergott: Okay would he maybe just think it's a regular portion of his day?

Wettlaufer: Probably.

Hergott: Uh receiving medication that he so required.

Wettlaufer: Probably cuz he had dementia.

Hergott: Okay.

Wettlaufer: Yup. (as cited in Gillese, 2019, p. 34)

This exchange is particularly revealing. Wettlaufer has been asked whether Mr. Silcox was “verbal” and whether he was able to “converse” and “communicate” to which she responds, “Oh yeah he, he didn't really converse he did a lot of yelling out *don't really remember him reacting when I gave it to him.*” It is as though Wettlaufer felt the need to qualify that while Mr. Silcox was known for “yelling out” that he had not done so when she injected him. This is doubtful as we learn elsewhere in the transcript that Mr. Silcox did call out. Wettlaufer states, “...[I] gave him an insulin shot [at 9:30 pm] and at 3:30 [am] the PSW, well throughout the night he was yelling out ‘I love you’ and ‘I’m sorry’ and that said, *not to me but just you could hear him*

calling out in his room and that's what he was calling out" (as cited in Gillese, 2019, p. 32).

Again, Wettlaufer feels compelled to explain that Mr. Silcox was not calling out to her. Her efforts to suppress the notion that he may have been resisting her violence with his cries, cannot be understated.

Excerpt 7

Hergott: Um do you remember any reaction from [Pickering] when you were injecting her?

Wettlaufer: No, none at all.

Hergott: Do you remember what type of, sorry I apologize, what part of the body you gave it to her?

Wettlaufer: Her arm.

Hergott: Left arm?

Wettlaufer: Um left, left arm.

Hergott: And no reaction she didn't...

Wettlaufer: Um

(simultaneously speaking)

Hergott: (unintelligible)

Wettlaufer: Oh yeah the first time I gave it to her she said, 'Hey what was that for?' and I said, 'That's your vitamin injection.'

Hergott: Which is like you said what you would typically tell people?

Wettlaufer: Yeah.

Hergott: Okay how long in between then that you gave her the next dose?

Wettlaufer: Probably an hour and a half two hours. (as cited in Gillese, 2019b, p. 75)

In Maureen Pickering's case we are not privy to how else she resisted. Perhaps she attempted to scream, perhaps she struck out at Elizabeth Wettlaufer, or perhaps her only other possibility for resistance was in the privacy of her mind (Coates & Wade, 2007). Wettlaufer does her best to suppress an account of Ms. Pickering's resistance; she certainly does not volunteer this information willingly. It is not until police detective Hergott asks her pointedly, "Do you remember any reaction from her when you were injecting her?" that Wettlaufer initially responds, "No, none at all," but when pressed she concedes, "Oh yeah, the first time I gave it [insulin injection] to her she said, 'Hey, what was that for?' and I said, 'That's your vitamin injection.'" (as cited in Gillese, 2019 b, p. 75). Perhaps it is unsurprising that Wettlaufer initially failed to mention Pickering's response because resistance is often only acknowledged when it has been used successfully to thwart a perpetrator's attack (Coates & Wade, 2007). It is clearly an afterthought for Wettlaufer and after initially asserting there was no reaction at all, she recalls that in fact, Pickering did, despite her frailty and advanced dementia, question what she was being injected with and why.

Concealing the perpetrator's violence

It is well understood that language can be used strategically to acquire and exercise power (Fairclough, 1989; Foucault, 1980), but as Coates and Wade (2004) assert, language can also be used to misrepresent violence. "Perpetrators often misrepresent their own actions to garnish support, avoid responsibility, blame the victim, and conceal their activities" (Coates & Wade, 2004, p. 503). Wettlaufer frequently misrepresents her acts of homicide using the discourse of nursing and caregiving. That is to say, she speaks in a very matter-of-fact way, using terms common to nursing and caregiving, which serves the purpose of concealing the intentional, violent nature of her actions.

Excerpt 8

Hergott: (unintelligible) so Gladys [Millard] oh so this takes us to November of 2011...

Wettlaufer: mm hmm

Hergott: ...at Caressant Care um it says here Gladys was a type-two diabetic um and had dementia.

Wettlaufer: Severe dementia.

Hergott: Did she yeah how old do you think Gladys was?

Wettlaufer: Ninety ninety-two.

Hergott: Ninety-two okay and where was Gladys within Caressant Care?

Wettlaufer: East wing um three doors down from the main desk in a double room.

Hergott: Tell me a little bit about Gladys what did shh what was she like when you cared for her?

Wettlaufer: Um well when I first started caring for her she was walking and talking and she had quite the spirit um she wa (laughs) she once punched a man...

[Note: several turns are skipped here for relevance sake]

Hergott: Right.

Wettlaufer: Yeah she was very spunky but she went downhill fast.

Hergott: Did she?

Wettlaufer: Eventually um she was just um dementia didn't take her pills well didn't eat well very stubborn woman.

Hergott: mm hmm

Wettlaufer: And uh as always one evening I just got that red surging feeling that she was gonna be the one...

Hergott: mm hmm

Wettlaufer: ...and um gave her insulin overdose. (as cited in Gillese, 2019b, p. 56-57)

In *Excerpt 8* Det. Hergott asks Wettlaufer to describe what Ms. Millard was like when she “cared for her,” thereby establishing the discourse of nursing care. Wettlaufer proceeds by using language one might expect from a nurse describing a resident in her care. She qualifies that Gladys Millard did not only have dementia, she had “severe dementia” and she describes a decline in Millard’s abilities from a resident who was “walking and talking” to a patient who “didn’t take her pills well” and didn’t eat well.” Then, after deflecting her own culpability to the “red surging feeling,” Wettlaufer offers, quite matter-of-factly, that she “gave her [an] insulin overdose.” Wettlaufer knew this injection of 60 or 80 milligrams of insulin (she could not remember exactly how much) would cause severe hypoglycemia (low blood sugar), which left untreated would result in Ms. Millard’s death, but by invoking the language of nursing she is able to conceal the violent nature of this act. Approximately 6 minutes later in her testimony, Wettlaufer is asked how Gladys reacted to the insulin. She states:

Excerpt 9

Wettlaufer: She relaxed and then um by the time the next nurse came on she was red she was sweating she was incoherent she her blood signs her vital signs were all down.

Hergott: And how do you know that?

Wettlaufer: Because I was just leaving when the next nurse came on and [the] PSW’s came to her and said something’s going on with Gladys and she said come with me they have to go check on Gladys.

Hergott: And did you?

Wettlaufer: Um actually I actually helped her move Gladys to the palliative care room...

Hergott: Okay and do you remember...

Wettlaufer: ...scared outta my gourd the whole time that she was going to say that it was something I did.

Hergott: ...thinking, okay was she still able to communicate at that point?

Wettlaufer: No. (as cited in Gillese, 2019b, p. 63)

Again, we see in *Excerpt 9* Wettlaufer describes Gladys' state in medical terms. After Wettlaufer administered a lethal injection of insulin, Gladys was "red," "sweating," "incoherent," and "her vital signs were all down." She even "helped move Gladys to the palliative care room."

Wettlaufer, whether consciously or not, is concealing the violence she inflicted on Gladys by speaking about these events in a benign way, using discourse common in nursing care. Similar descriptions likely appeared in the other nurse's notes to describe how she found Gladys when she reported for duty that night, but the other nurse and the PSW's were not privy to all the facts leading to Ms. Millard's declining state. That Wettlaufer ends her description with an indignant statement about being "scared out of [her] gourd" that Gladys would out her as the perpetrator, for "something [she] did" is particularly galling and further demonstrates her attempt to conceal her violence.

Another example of Wettlaufer concealing her violence is in her description of the murder of Helen Matheson. She provides details of doting on Ms. Matheson before killing her in the following exchange.

Excerpt 10

Wettlaufer: Helen I don't remember a lot about. She was very quiet, very determined um just seemed to be waiting to die and um I made a bit of a fuss about her that night because she was very lucid and we talked about how much she liked blueberry pie and ice cream.

Hergott: Okay.

Wettlaufer: So on my break I went to uh Walmart and I got a small blueberry pie and some ice-cream and brought it to her and she had three of four bites.

Hergott: Nice.

Wettlaufer: And then that night I overdosed her.

Hergott: Okay.

Wettlaufer: cuz like I said I had that feeling that it was her time to go.

It is as though with this exchange Wettlaufer is constructing herself as a loving, kind nurse who went out of her way to do something special for her resident, but it serves the explicit purpose of concealing the violence she perpetrated against Helen Matheson. She says while she remembered little about Ms. Matheson, she “just seemed to be waiting to die.” It is as though she would have us believe that hurrying Ms. Matheson to this untimely end was in itself an act of care. After detailing the sweet things she did for Helen that night, she very plainly states, that she “overdosed her.” This does not appear to be a decision she arrived at after the fact; instead, it would appear it had been Wettlaufer’s plan all along and she spoiled Helen, *because* she intended to kill her. Further to this point, Wettlaufer also states that she pampered Helen “because she was very lucid.” This suggests that she was anticipating Helen’s possible resistance (unlike patients with severe dementia, Helen was lucid and may have been more able or likely to report Wettlaufer) which is further evidence of the volitional nature of her violence and her need to conceal it. By constructing herself as a caring and kind nurse she was better able to conceal her violent intentions from Helen. In the retelling of events, Wettlaufer minimizes the severity of her violence and aggrandizes her acts of caring, thus deliberately concealing her violence and mitigating her responsibility.

Throughout the transcript and Wettlaufer's handwritten confession she uses medical jargon and discourses common to nursing care. In addition to the examples already provided, Wettlaufer is asked by Det. Hergott to describe the symptoms her victims exhibited after she injected them with a lethal dose of insulin. She states, "well usually they'd get very diaphoretic, red, um like they'd lose consciousness, they'd shake, some people, um one person had a seizure two people stroked right out and and actually three people cuz they believed James stroked out as well so" (as cited in Gillese, 2019b, p. 46). This terminology lends itself to what one might expect from an intentional lethal insulin overdose. Wettlaufer's victims did not peacefully pass away in their sleep. They were murdered and their murders were violent; however, when asked to describe their deaths part way through the interview, Wettlaufer again conceals her violence.

Excerpt 11

Wettlaufer: ...um all the people you've talked about so far died peacefully in my opinion.

Hergott: Okay.

Wettlaufer: And I am sorry, I'm sorry what the families went through at the time.

Hergott: Um hmm.

Wettlaufer: And I'm extremely sorry for what they're going to go through, I, it's awful.

Hergott: If you could say something to them what would you say to them?

Wettlaufer: What can you say to them that would matter, um I'm sorry isn't enough, I should've gotten help sooner, um I took something from you that was precious and taken too soon, um I honestly believed at the time that God wanted me to do it but I know now that's not true, and uh if I could take it back, if I could get help sooner I would've and I'm sorry. (as cited in Gillese, 2019b, p. 54)

Even in her attempt to deliver an apology to the families of the murder victims, Wettlaufer can't help herself. She conceals the violent nature of her assaults, ignores the accounts of diaphoresis, seizures, and strokes that she had reported only a few minutes earlier and says in her opinion all the victims "died peacefully." Her apology is given to the families, and she is sorry to have "taken *something*" from them "too soon." The fact that Wettlaufer uses the word "something" to refer to her victims is particularly revealing. Perhaps this is simply a rhetorical device to conceal her violence and mitigate her responsibility; but it may also reveal an unconscious bias. Perhaps Wettlaufer didn't view the older adults in her care as people, at all. Perhaps to her, they were merely bodies, "waiting to die" and about whom she felt "angry, frustrated, and vindictive."

Discussion

One of the reasons elder abuse is so difficult to detect is because there is a lack of consensus on what constitutes abuse. Another reason is that often the abusive acts perpetrated against vulnerable older adults are insidious and far more subtle than what might generally be defined as violence, and yet, they are abusive all the same. For example, I have witnessed care home staff forcefully and aggressively feeding cognitively impaired older adults (e.g. rushing, shovelling the spoon into a person's mouth), seemingly oblivious to the potential harm they may be causing; their only concern appears to be to complete the task at hand as quickly as possible. I have also observed a health care worker berate a frail elderly woman with advanced dementia for attempting to slap the health care worker's hand away at mealtime. In this instance, the woman was asleep in her wheelchair at the dinner table and the health care worker was attempting to feed her. The caregiver seemed to have little to no understanding that the woman was simply responding to having a spoon forced into her mouth when she was not expecting it. I later learned the resident had been labelled "aggressive." Labels such as these can have an

influence on how other staff relate to the resident. I have also observed health care workers deny personal care (especially toileting) because the timing of the resident's need was not convenient. I suspect that if I were to ask staff if any of these acts constitute elder abuse, the vast majority would say they do not; and yet there is an element of abusiveness in these acts and their potential to cause "harm or distress" to the older person cannot be denied. It is also true that dementia causing illnesses such as Alzheimer's disease result in memory loss, impaired cognition, and anxiety, which could result in forgetting one has already been to the toilet, for example, but this does not negate the apparent lack of understanding, empathy and responsiveness on the part of care workers which can be, at times, neglectful or even abusive. Care workers in Cooper, et al.'s (2013) study reported that while deliberate acts of abuse are rare, situations arise through the course of providing care that may have "abusive consequences." For example, "some care workers acted in potentially abusive ways because they did not know of a better strategy or understand the resident's illness; care workers made threats to coerce residents to accept care or restrained them" (p. 733). Health care workers are front line workers in residential care facilities. They are responsible for the majority of personal care (e.g. bathing, dressing, toileting, teeth brushing, feeding, etc.), which to a cognitively impaired older adult, who may be confused and anxious, can prove to be stressful. Residents may lash out in these moments (and frequently do), and if care home staff are not adequately trained to deal with these responsive behaviours, abuse may be more likely to occur.

Much of the scholarly literature on elder abuse concerns itself with risk factors. In an effort to identify who may be more at risk of abuse, researchers have developed various taxonomies of attributes. For example, Van Den Bruele, Dimachk, and Crandall (2019) assert that, "impairment/dementia, poor mental health, low income/socioeconomic strata, financial

dependence, gender, age, and race/ethnicity are some of the most commonly cited risk factors for elder abuse” (p. 103). Others have developed theories to explain the onset of elder abuse. These include “social learning of abusive behaviors, caregiver stress, social isolation of the victim, dependency between the victim and the abuser, and psychopathology of the abuser are commonly accepted theories” (Hansberry, Chen, & Gorbien, 2005, p. 318).

Bornstein (2019) in his examination of synergistic dependences (i.e. situations in which both members of a dyad manifest dependency of one form or another) as they relate to elder abuse writes:

Pillemer’s (1985) mutual dependency model of elder abuse postulates that economic dependency of a caregiver on a care-receiver increases maltreatment risk when this economic dependency is coupled with high levels of functional dependency in the care-receiver. According to the mutual dependency framework, an economically dependent caregiver feels “tethered” to the care-receiver, unable to attenuate or terminate caregiving for fear of losing the care-receiver’s financial support. As a result, stress and frustration build, leading to increased likelihood of momentary loss of control— or systematic abuse or neglect— by the caregiver. (p. 6)

The notion that a “caregiver feels ‘tethered’ to the care receiver [and, as a result is] unable to attenuate or terminate caregiving” may be true, but it is not only an inadequate explanation for abuse, but it also serves to mitigate the abusive perpetrator’s responsibility and conceal the volitional nature of abuse. As Todd, Weaver-Dunlop, and Ogden (2014) assert, people who have used abuse have the “pre-existing ability to make constructive behavioural choices, [but] those who have acted abusively often employ a language of effects to portray their behaviour as something over which they had little control” (p. 1118).

Furthermore, all people and especially all caregivers of medically frail older adults experience stress and there is an implicit mutual dependency in the acts of giving and receiving care, but very few caregivers resort to abusive behaviour as a result of this stress. The notion that “stress and frustration build” which can result in an “increased likelihood of momentary loss of control or systematic abuse or neglect” (Bornstein, 2019) sounds very much like an excuse and justification of abusive conduct (Todd, Weaver-Dunlop, and Ogden, 2014).

Statements such as those in Bornstein (2019) not only obfuscate the fact that abusive behaviour is deliberate and purposeful, but also make no comment whatsoever on how the abuse victim might resist the abuse. In other words, resistance is concealed (Coates & Wade, 2007). Not considering how the care receiver resists the abuse, further obscures the intentional nature of the abuse. Todd, Weaver-Dunlop, and Ogden (2014) write, “recognizing the many strategies that perpetrators use to suppress and conceal victims’ resistance reveals the volitional nature of abusive conduct” (p. 1120).

It is clear that we need to know more about perpetrators of elder abuse, as much of the research to date has focused on the victims, and not in a way that honours their resistance. In order to develop more robust theories of elder abuse, from which we can establish more effective remedies for these offences, it is incumbent on social scientists to examine elder abuse from a myriad of perspectives, including examining the discourses of perpetrators and the victims using a response-based lens.

Considerations for future study and conclusion

Much of the research on elder abuse to date has concerned itself with its prevalence in society. Indeed Garnham and Bryant (2017) posit that “establishing the scope of the problem is generally justified in the literature as a vital first step towards increased recognition and

awareness of elder abuse which in turn is considered a necessary platform to politicize the issue and galvanize further research and statutory and social policy responses to prevention and intervention” (p. 53). Much in the way these statistics become the “subject of elder abuse” thereby obscuring the *actual* victims of elder abuse (Garnham & Bryant, 2017), the language used to describe elder abuse, both by perpetrators of abuse and in reports by the media and in the academic literature, distorts the lived experiences of the abused person.

Future research would be wise to investigate a relationship between elder abuse and ageist implicit biases. Narratives of “burden of care,” “caregiver burden” and “challenging behaviours” in dementia patients, while all factors which need to be addressed when providing care to the elderly, may perpetuate ageist constructions of old age and older people as sick, needy, confused, and difficult to care for. These social constructions may result in self-fulfilling prophecies such that if people anticipate older adults to be burdensome and challenging, they will be. This may be especially true if staff are poorly trained and lack caregiving and communications skills for working effectively with people with complex care needs, such as residents with advanced dementia.

In Canada, our population is aging and people age 85 and older is the fastest growing cohort. Statistics Canada (2017) reports the population of citizens over age 85 “will likely continue to increase rapidly in coming decades because life expectancy is increasing and because the large baby boomer cohorts (people born between 1946 and 1965) will reach age 85 starting in 2031” (n.p.). It is this oldest group (85 years +) that constitutes the largest group living in long-term care settings and they are more likely to have some degree of cognitive impairment or other disabling condition (McDonald, et al., 2012, p. 139), making them particularly vulnerable to abuse.

One thing is clear, we need to better understand elder abuse in institutional settings. McDonald, et al. (2012) note, “awareness of a problem but not knowing the extent or nature of it makes it difficult to create evidence-based policies that would provide a blueprint for resources and programs necessary to ameliorate the abuse” (p. 140). This may require designing studies which enlist the help of family members as proxy subjects who can share their observations on behalf of their cognitively impaired loved ones.

Finally, more consideration should be given to understanding who the perpetrators of elder abuse are so institutions are better equipped to hire well and know what to look for if things go awry. The definition of what constitutes abuse and neglect should be re-evaluated and reworked. For example, the notion that abuse occurs “within any relationship where there is an expectation of trust” (WHO, 2008) may be misleading as the perpetrator need not necessarily be in a position of “trust.” Similarly, the heterogeneity of elder abuse needs to be contemplated. The fact that the 6 types of abuse are often considered together may lead to misleading or conflicting results. Psychological abuse, physical abuse, and sexual abuse should perhaps be considered separately from financial abuse, which is troublesome, but typically does not involve violence, and neglect, which may happen unintentionally. Jackson (2014) notes that “interventions for financial exploitation will surely differ from those cases involving caregiver neglect. It is predictable that a one-size-fits-all intervention for elder abuse perpetrators is doomed to failure” (p. 277).

One way to begin to better understand perpetrators of elder abuse is to examine their discourse. By examining Elizabeth Wettlaufer’s accounts of elder abuse through the *Interactional and discursive view of violence and resistance* (Coates & Wade, 2007) it becomes readily plain that language is routinely used to “(a) conceal violence, (b) mitigate perpetrators’

responsibility, (c) conceal victims' resistance, and (d) blame or pathologize victims" (Coates & Wade, 2007, p. 512). It is incumbent on scholars, caregivers, the police, and prosecutors to better understand the nature of elder abuse. This begins by acknowledging that abusive behaviour is deliberate and intentional, and victims invariably resist the abuse (Coates & Wade, 2007).

Elucidating elder abuse through a response-based lens will not only better inform clinicians, counsellors and policy makers, but it will also better attend to the dignity of older adults who are victims of abuse.

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Appendix A

Handwritten confession of Elizabeth Wettlaufer, September 24, 2016

Reproduced from: Gillese, 2019a

Sept 2007 Not a diabetic, had dementia

CareSant Care

Written Sept 24 -
Elizabeth Wetzel

① James Silcox - I was working a double shift. 3pm - 7am.

James was known for inappropriately touching the staff - [REDACTED]

[REDACTED], James was not diabetic.

That evening I got the urge to overdose James. I was angry that he was so inappropriate. At approximately 7:30pm I decided to overdose him with insulin, hoping he would die. I felt it was his time to go because of the way he acted. I remember feeling angry at him.

I went into the med room & used a spare insulin needle to prepare a dose of 50 units of short acting insulin. I gave it to him at app. 10:30pm.

Throughout the night, after I overdosed him, James called out "I'm sorry" and "I love you". At app. 3:00am, the P&W's found James vital signs absent. I called the attending physician and the James family to inform them of James' death. The physician ruled his cause of death to be a post surgery embolism.

Sept or Oct 2007

CareSant Care

② Maurice Granat - Not a diabetic, cancer patient

I was told by one of the nurses that Maurice had a bad habit of grabbing the staff's breasts and asses. One afternoon I was working and I felt angry. I gave Maurice app. 40 units of short acting

Maurice Granat (cont'd)

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insulin at around 8 pm. By the next morning he was in a coma. He died some time that afternoon.

October 2011

Helen Matheson Not a diabetic. Carissant Care, Dementia
 Helen was very quiet & reserved. One afternoon I gave her an overdose of insulin. I am not sure why I chose her, I was feeling angry and frustrated about my job. After the overdose she stopped talking and eating. The Doctor declared her to be palliative. She died 2 days later.

October November 2011

Mary Zerwinski - Not a diabetic, Carissant Care, dementia

Mary was spunky, thin and outspoken. One afternoon, around 4 pm, I gave her 50 units of short acting insulin and 30 units of long acting insulin. She begged me because she was outspoken & resistant to care. I was feeling very angry in general. She died the next afternoon.

November 2011

Gladys Millard - type 2 diabetic, Carissant Care, dementia

Gladys had severe dementia & no longer talked. She was very stubborn & horribly difficult to give pills to.

I was working 7-3:11 pm - 7 am. At around 5 am I gave her 40 units of long acting insulin and 60 units of short acting insulin. At app. 7 am she became unresponsive and diaphoretic. She died that evening.

Elizabeth Wettkunfer

October 2013

pg 3 of 4

Helen Young - Caressant Care - type 2 diabetic, - dementia

Helen was feisty and outspoken. She was constantly saying "help me nurse". She frequently yelled out "I want to die". One afternoon I felt like something snapped inside me. She kept yelling out she wanted to die. I thought angrily "fine, I'll help you die." I gave her 60 units ~~of~~ ^{of} short acting insulin just before supper. After supper I gave her 60 units of long acting insulin. At app 8pm the PSW^{thru} called me to her room. Helen was having a seizure. She was not epileptic. I took all her vital signs and pretended to take her blood sugar. She died 2 days later.

March 2013^{thru} March 2014

Maureen Pickering - Caressant Care - dementia, not diabetic

Maureen had a lot of behaviours. She would hit other residents or pull their hair. She was on one to one care. We didn't always have the needed staff for this. Sometimes I had to be with her 1 on 1 as well as give pills to 32 people, do paperwork and do treatments. One afternoon shift we did not have her 1 to 1 staff. I was angry, frustrated and irritated. She kept yelling out random ^{or} things. ^{After supper, on} I gave her a Haldol shot to calm her down. Then I got the idea that if I could cause her some brain damage she wouldn't be such a handful.

at app. 8pm I gave her 80 units of long acting insulin. That night she ~~went~~ ^{had} a stroke.

Elizabeth ^{for 11/1/13}

March 2013^{8th} March 2014^{15th}

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Maureen Pickering (cont'd)

She was sent to hospital where she became comatose. She died approx. 5 days later.

August 2014^{5th} Meadow Park Nursing Home

Arpad "Art" Horvath Dementia, Not diabetic

Art was physically abusive to the staff. He would pinch & hit. One evening I decided enough was enough. I felt angry, frustrated, vindictive, & energized. I gave Art 80u of short acting insulin & 60u of long acting insulin at approx 8 PM. During the night he had a stroke, ~~and~~ died 4-5 days later.

People who didn't die

Clotilda Adriano - dementia - diabetic - Caressant Care
September 2007

Albina Demidenos - diabetic - Caressant Care
October 2007

Wayne - dementia diabetic - Caressant Care
October 2008

Mike - Huntington's disease
2009

Sandra Fowler Telfer Place Paris Winter 2016
Survived. Dose her 80u long acting insulin, 60u short acting

Beverly ~~(?)~~ (?) diabetic

August 2016 Saint Elizabeth, Ingersoll, home care
Dose 180u long acting insulin via Picc line
Survived

Elizabeth Mettler

Appendix B

Table showing # of instances of the four discursive operations

<p>Mitigating responsibility</p> <p>31</p>	<p>Blaming the victim</p> <p>13</p>
<p>Concealing resistance</p> <p>13</p>	<p>Concealing violence</p> <p>41</p>

Note: This data is based on the voluntary interview Elizabeth Wettlaufer gave to police on October 5, 2016. The interview lasted 2 hours and 9 minutes (1714 hrs – 1923 hrs) and comprised 1530 total turns by Elizabeth Wettlaufer. If more than one discursive operation was committed by a single utterance (e.g. both blaming the victim and mitigating the perpetrator’s responsibility), it was counted twice.