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## How general practitioners and aged care workers perceive incidences of elder abuse

Paul Howrie  
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**How General Practitioners and Aged Care Workers  
Perceive Incidences of Elder Abuse**

**Paul Howrie**

This thesis is presented for the degree of  
Master of Social Science (Leisure Sciences)

School of Marketing, Tourism and Leisure  
Edith Cowan University  
Perth, Western Australia  
2000

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## **ABSTRACT**

As the Australian population is expanding and ageing, there is an associated need for a focus to be placed on the individual rights of elderly people, and for the general population to be made more aware of areas related to our older generation. Elder abuse, as an area of concern, developed as an offshoot of investigations into child abuse and general domestic violence, and initially surfaced in the 1970s and 80s.

Some sections of the medical profession were made specifically aware of the problem initially in 1975, through a letter that was sent to the British Medical Journal. However, throughout some of the literature, GPs have been criticised about their level of awareness of the issue of elder abuse, and for their lack of involvement in this area.

The purpose of this study was to explore how General Practitioners and Aged Care workers perceive incidences of elder abuse. Due to the limited amount of research which has been undertaken on elder abuse within Australia, the study looked at exploring the issue rather than trying to measure its cause, or trying to identify the extent of the problem. The study investigated the perceptions of general practitioners (GPs) toward the area of elder abuse, and looked further to explore how general practitioners were perceived by aged care workers.

The approach used for data collection consisted of circulating 100 mailed out questionnaires to general practitioners within metropolitan Perth, and follow up face-to-face interviews with some of the respondents to this questionnaire. Additionally, face-to-face interviews were also held with key informants who worked in the aged care industry, to ascertain their perceptions of elder abuse.

The mailed questionnaires were analysed by adding the frequencies of responses given to each question. The data from the face-to-face doctor interviews and the key informant interviews were transcribed verbatim from the tape recordings and then assessed by looking for consistent regularities from each response made, therefore using a cross-case analysis. From this analysis, patterns emerged in the data, from which themes were developed.

The recommendations from the data suggest that a clear and concise definition of elder abuse needs to be developed, to assist in clearly identifying the prevalence of the problem. The data further recommended the need for an awareness campaign on the area of elder abuse to be undertaken. This should focus on raising the awareness of the possible characteristics of individuals who are vulnerable to being abused, as well as the characteristics of likely perpetrators of abuse. This study also recommended that a coordinated approach to dealing with the area of elder abuse should be developed, which should include the development of specific roles that should be undertaken by professional and non-professionals.

Training of people across the Human Services field in the area of elder abuse, and in particular GPs, social workers and paraprofessionals who work with elderly people, was identified as a recommendation of the study. Areas of training should include: awareness of the problem's existence; providing people with the required skills to detect cases of abuse; providing insight to referral agencies who may be able to assist; having a clear and exhaustive list of interventions to use to assist with addressing the problem; and having knowledge of the characteristics that abused individuals, and perpetrators are likely to have.

This study also identified that more research is required to ascertain if the amount of time which GPs spend with elderly people, is sufficient for them to identify cases of elder abuse, and if the allocated time from Medicare is adequate for GPs to identify elder abuse.

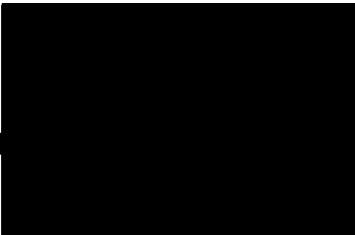
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Signed



Date

21/2/00

Paul Howrie

21<sup>st</sup> February 2000

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## **CHAPTER 1**

### **Introduction**

This thesis is an exploratory study about the incidents of elder abuse and neglect as perceived by general practitioners (GPs). The phenomenon of elder abuse, while not new to Australia, has been relatively unexplored compared to countries such as the United States and Canada.

The study will therefore endeavour to ascertain the views on elder abuse from GPs. It also will obtain the views from aged care workers who come in contact with elderly people, about their perception of GPs, and elder abuse.

### **Views Held About Elderly People**

Individuals view elderly people in many ways. Several authors such as Russell (1981) and Picton (1991) respect elderly people for what they have achieved, while other people, according to Aronson (1984) may show no interest in elderly people, because they view them as no longer productive. Aronson (1984) outlines these views as being two sets of beliefs which people accept as being true, primarily because they cannot believe any other concepts of the world.

Aronson (1984) further states that due to the fact that we live in a society with sexist and racist overtones, as well as negative views of the aged, that stereotypes of the elderly occur without individuals being consciously aware of them happening. When born into a prejudiced society, "we often accept those prejudices uncritically" (p.239).

Therefore, almost habitually, any relevant scientific data which is presented and refutes the prejudice which is held, is not looked at critically, and conversely often used to reinforce the prejudice (Aronson, 1984).

Some discriminatory views held about elderly people can be traced back to the Industrial Revolution. Lenski (1970) suggested that during the period 1760 - 1830s, several innovations with regard to technology and economics were introduced to society. With the advent of the Industrial Revolution came the introduction of retirement from the workforce, which resulted in age discrimination being institutionalised. Concurrently, this also had an impact on the family home, with the role of the male changing from being at work, to now being at home during retirement.

With Australia experiencing a depression in the 1890s, Davidson (1993) suggested that Old Age Pension schemes were introduced, as a method of dealing with the crisis of aged care. However, while rewarding elderly people for "their contribution to the development of the country, it reinforced conceptions, then becoming popular among physicians, of the aged as weak and dependent" (Davidson 1993, p.1). Therefore, the pension was seen by some as a reward for contributions that elderly people had made in their youth, and the focus was starting to be one of youth, "reinforcing the belief that it was the young who had most to contribute to the progress of the nation" (Davidson 1993, p.21). This further reinforced the notion of the young being productive and old people being put on the "scrap heap".

From these historical perspectives offered by Davidson, it is possible to trace the origins of some of the current beliefs that are held about elderly people. Russell (1981)



suggested that many individuals associate old people with biological decline. Commonly held attitudes and prejudices about biological decline are that elderly people have a decreasing efficiency, are inevitably slower and less energetic, are associated with fading memories and declining intelligence, have a reduced learning capacity, are withdrawn and isolated from society, are sexually uninterested, and incapable of sexual activity. Picton (1991) suggested that other attitudes held about old people are that they are characterised as being rigid in thought and manner, senile, and generally old fashioned in morality and skills. Additionally, often it is thought that one's value to society is centred on productivity. This thought process is embedded in the notion that "useful is good" and that good is entrenched in being productive in a work environment (Edgar, 1991). However, due in part to attitudes towards seniors, and the factual reality of some biological decline, older people are often required to retire from the workforce.

In contrast to these negative attitudes held about elderly people, is the view that they are valuable members of society, and that they are also productive, but not necessarily in the sense of work output. Edgar (1991) suggested that one can look forward to "a fit and productive" older generation, which will be a "rich resource" for society (p.15). He further suggested that "old people are not useless, not role less, and not even undervalued in most families" (Edgar, 1991 p.17).

Despite these views, Edgar joins a consensus that views Australia as faced with structures, work regulations and retirement and superannuation provisions, that are dated, and out of focus with the current requirements. Edgar also pointed out that Australian society is "struck in the cult of youth and pushing an image of 'the aged' that

denies their status as elders whose resources can and should be drawn upon” (1991,17). He maintained that there is a need to review the meaning of productivity, and to place emphasis on the human potential of people, as being productive members of society, as opposed to viewing people only in relation to their ability to contribute to the workforce.

Like Edgar, this author supports the view that elderly individuals have a lot to offer society. The negative and ageist views, which are held about elderly people by some individuals, are often based on the notion of productivity in relation to employment. Many of these beliefs have remained unchallenged. Despite this however, there is little doubt that as one becomes older there is an element of biological decline attached to the process. The extent of this decline cannot be generalised across the elderly population, as it is specific to individuals and their circumstances. These views guide this author, and are based on the notion of elderly people being valuable and productive members of society, regardless of whether they have work options or not.

While many elderly people are loved, valued and cared for by their families, friends or professionals, as they age however, they can become susceptible to many considerations including their own biological decline, which can lead to being abused. The way people perceive elderly people can have an impact on the manner in which they deliver a service, or take an interest in areas, that are related to them.

## Background to the Study

Australia has an expanding and ageing population. The Australian Bureau of Statistics (ABS, 1999) has published data that suggests that by the year 2057, Australia will have a total population of between 23.5 million people and just under 26.4 million people. This is a significant increase compared to 1997 when the population was 18.5 million people, and could represent a rise of up to 42% or nearly eight (7.9) million people from the years 1997 - 2051 (ABS, 1999, p.1).

During this same period of time, it is anticipated that the number of people aged 65 and over will significantly increase from 12% in 1997 to somewhere between 24 – 26% in 2051. Furthermore, the number of people aged 85 and over is expected to almost double from 10% in 1997 to around 19% in 2051 (ABS, 1999, p.3). Therefore, the age structure of the population over the next 50 years will be noticeably changing. ABS figures suggested that in 1997 the medium age of the Australian population was over 34.3 years of age, however, this is expected to increase to over 46.2 years in 2051 (ABS, 1999, p.2)

The main reasons for the increased number of older individuals in Australia include the basic demographic processes such as mortality, fertility, and migration (ABS, 1999). The ageing of a population can result from the long-term effects of declines in fertility, and this has dropped dramatically in Australia over the past decade. If the present fertility trends continue the implications are that "the proportion of dependent children in the population will decline and the older population will increase" (ABS, 1988, p.75).

Thus, with less children being born, and the prospect of people over 60 years of age living longer, the population will continue to age.

Built on the notion that Australia is increasing both in terms of the median age within the country, and as a percentage of the overall population, Gately and Whalley (1990) have suggested that the focus needs to be placed on the individual rights of elderly people. Gately and Whalley (1990) further suggested that increasing attention to the "physical, financial and emotional protection which should be afforded" to elderly people, has risen in prominence (p.18). Linked with this concern, is the issue of abuse of elderly people.

The concept of elder abuse developed as an offshoot of investigations into child abuse and general domestic violence. Initially the area surfaced in the 1970s and 80s in the United Kingdom and the United States. However this does not mean that the problem has not been around for much longer in Australia (Daniels, Baumhover & Clark-Daniels, 1989).

Sections of the medical profession were made specifically aware of the problem of elder abuse, through a letter sent to the "British Medical Journal" in 1975 (Wolf 1988). Since this article, interest in the area overseas has steadily grown, with the 1980s being referred to by some people as the "decade of elder abuse" (Kurrle, Sadler & Cameron 1991, p.150). In Australia however, Sadler (1992) suggested that "abuse of the elderly is a relatively recent addition to the study of ageing and of family violence (p.1).

## **Why General Practitioners?**

Daniels et al. (1989, p.324) suggest that general practitioners "are among the first professionals who come into contact with cases of elder mistreatment, yet they are rarely the first to identify it". Adelman, Green & Charon (1991) has suggested that the interaction and relationship between a GP and a patient is an area of interest for the social scientist. However, little research has focused on the GP - elderly patient relationship, and "sufficient attention is not paid to the special concerns and needs of the older patient group" such as the issue of elder abuse (Adelman et al. 1991, p.128).

For these reasons, GPs have been selected as a human service group, who could have an important position to undertake in the area of elder abuse and neglect. Much of the literature however has been critical of the involvement, knowledge and awareness that GPs have of elder abuse, and this study will explore these issues.

## **Statement of the Problem**

This study intends to investigate the perceptions of GPs toward elder abuse, and further explores how aged care workers perceive them. It is not designed to provide an exhaustive measure of the extent of elder abuse. Therefore the problem examined is:

How do GPs and Aged Care workers perceive incidences of elder abuse?

The major research questions have several sub-questions that will arise from it. They include the following variables: perception of abuse; quantification of abuse; types of

abuse; restrictions on identifying abuse; definition of abuse; causes of abuse; characteristics of perpetrators; and characteristics of victims. Each of these variables has been addressed in the results chapter.

### **Approach Utilised in This Study**

Due to the limited amount of research on elder abuse that has been undertaken in Australia, this study is intended to explore the issue of elder abuse, rather than measure its cause or to identify its extent. The literature suggests that there are problems associated with the development of a suitable definition of elder abuse, and this would therefore make it difficult to measure the rate and prevalence of the area. Therefore data from this study can be used, amongst other purposes, as a basis for further research into the area.

In order to deal with the problem, 100 mailed out questionnaires were forwarded to GPs. Five face-to-face follow up interviews were also held with several of the GPs who responded to the mailed out questionnaire. Furthermore, 11 face-to-face interviews were held with key informants who work in the age care industry, to ascertain their perceptions of elder abuse and GPs.

This study will only focus on general practitioners working in private practice within the metropolitan area of Western Australia. Within this study, the terms doctor, general practitioner and GP will be used interchangeably to assist with reducing repetition.

## Definition of Terms

The following definitions have been provided to assist with outlining areas within this study:

*Elderly*: The age of 60 years and above will be used to define people as being elderly. There is no universal definition of what either chronologically or physiologically constitutes being elderly. The Office of Seniors' Interests (OSI), a Western Australian State Government bureau, which also provides information services to elderly people, have also used 60 years of age to define seniors.

*General Practitioners*: "A general practitioner is a doctor who is in general practice, treating most cases of illness, but sending patients requiring more specialised treatment to a hospital or a consultant" (Ilson, 1998).

*Elder abuse*: The term 'elder abuse and neglect', at times has been referred to as 'elder abuse', although it also includes neglect.

"Elder abuse/neglect is the wilful infliction of physical pain, injury, or debilitating mental anguish, unreasonable confinement, or deprivation by a caregiver of services that are necessary to maintain mental and physical health" (O'Malley, Everitt, O'Malley & Campion, 1983).

## Need and Justification of the Study

It has been well documented that the number of elderly people who live in Australia are increasing. Associated with the ageing process, and demographic changes to

Australia, is the possible issue of elder abuse. General practitioners are in an ideal position of being able to assist with the detection of abuse, to outline and recommend interventions, and to assist with policy development. As was the case in the child abuse movement where GPs played such a prominent role, their skills and community position are again required, to assist with the detection and amelioration of elder abuse (Brewer & Jones, 1989, p.1217). One concern however, is their apparent lack of recognition of elder abuse, that can influence their perceptions of the problem. This could have an effect on not only the health and welfare of many of their patients, but also individual's who abuse, as they too may be under enormous stress. Pagelow (in Ohlin and Tonry, 1989) suggested that unless "policymakers realise the extent and seriousness of the problem, they will not provide mechanisms to deal with it" (p.277). For this to happen however, the problem of elder abuse must be brought to the attention of the individuals who make policies, through studies such as this one, by those people who not only witness it (consciously or non-consciously), but who also are in a respected societal position from which they can influence policymakers. General practitioners meet both of these requirements.

### **Structure of This Thesis**

This introduction chapter is followed by a broad review of the current and past literature related to ageing and elder abuse. Areas include theories relating to gerontology, interventions for perpetrators and abused elderly people, and definitions of elder abuse.



The methodology chapter details the approaches used to gather data for the study, the rationale for the approaches used, and the research question.

The following chapters present the data analysis. The data are presented in three distinct chapters, which represent each technique used to gather information from the GPs and the key informants. Chapter seven then draws the conclusions from the three data chapters before presenting some recommendations from the study.

## **CHAPTER 2**

### **Review Of Literature**

#### **Introduction**

This chapter presents an overview of some of the current and past literature related to ageing and elder abuse. Sections include theories relating to gerontology, definitions of elder abuse, and interventions. Other sections within the chapter include an overview of the literature relating to the characteristics of abused elderly people and perpetrators of abuse, caregiving, mandatory reporting, non-reporting of elder abuse, and general practitioners.

#### **Theories Relating to Gerontology**

Within the field of gerontology, there are theories on ageing spanning across the disciplines of psychology and sociology, through to the biological aspects of the human body. The theoretical perspective that one may take, is often associated with the discipline into which they have been indoctrinated. Regardless of the type of theory which may have been constructed, the main purpose of developing theories in the area of gerontology, has been essentially to provide outlines to assist with understanding ageing.

While varying theories on ageing exist, currently however they have not been able to provide any conclusive outcomes with respect to explaining the process.

Consequently, there is no one dominant theory for the ageing process, and this has led to a pluralistic approach (Minichiello, Alexander & Jones, 1992)

### **Theories Relating to the Biological Mechanisms of Ageing**

Hayflick (1968) developed a theory on ageing which was named 'programmed senescence', or developmentally programmed ageing. This theory is based on the premise that ageing followed a "genetically programmed sequence akin to the events of growth and development" (Brown, in Minichiello et al., 1992, p.20). Harman (1955) outlined the free-radical theory of ageing, which is based on chemical reactions in one's body, which can produce end products. These products can affect the lipofuscins (ageing pigment) and connective tissues in the body. To protect one from these end products causing the enhancement of the ageing process, vitamin E and A are recommended. However, Brown (in Minichiello et al., 1992) suggests that it is still unclear just how much affect the free-radical reactions have on the ageing process. Other biological based theories include the error catastrophe theory of Orgel (1963) based on abnormal protein levels, and the immune theory of ageing, which suggests that as one ages, the immune system becomes increasingly vulnerable as its structure and functions change. It is suggested in this theory, that vulnerability is an effect of the ageing process (Brown, in Minichiello et al., 1992).

The caloric intake theory relates to an individual's nutritional rate with longevity, while the neuroendocrine regulation of ageing "speculates that there are centres which regulate ageing change" (Brown, in Minichiello et al., 1992, p.23). This may consist of interaction between the endocrine system and the nervous systems for example, and

the role that each of these areas has in the body's functions. The wear and tear theory on ageing suggests that "the repair and replacement of losses experienced by body tissues in the course of normal function declines with ageing" (Brown, in Minichiello et al., 1992, p.20).

The above outline is not intended to be an exhaustive overview of the theories within the area, but rather an example of the diversity of their range. In summary, all of the theories which are associated with the biology of ageing, focus on the ageing of the organs or cellular systems of the human body, and see this as the primary method of explaining the process of ageing (Brown, in Minichiello et al., 1992).

### **Psychological Theories of Ageing**

In general, psychology as a discipline is primarily concerned with an individual's behaviour. This may include areas associated with identifying changes in cognitive functioning as one ages; determining people's ability to cope with stress at various chronological age ranges; identifying how well-being is associated to one's personality; and measuring an individual's ability and speed in processing visual reaction time to tasks. There are many theories that are related to each of these areas, and several will be discussed below (Browning, in Minichiello et al., 1992).

One psychological theory is adult cognitive development, which suggests that individuals pass through stages of development, and that each stage is characterised by the acquisition of particular skills and abilities. Those individuals, who are demarked as being in old age, are said to have reached the reintegrative stage. People who

reach this stage, tend to focus "on pragmatic issues", therefore "paying less attention to problems that lack meaning or do not contribute to the overall adaptive process" (Browning, in Minichiello et al., 1992, p.77). Essentially, individuals are concerned with issues that they face as a part of adapting to the ageing process.

Another theory is the dual process theory of intellectual functioning. This theory is based on two processes of adult functioning for intellect, those being the mechanics and pragmatics of intelligence. Mechanics is concerned with "the basic cognitive operations and cognitive structures associated with such tasks as perceiving relationships, classification, and logical reasoning" (Browning in Minichiello et al., 1992, p.72). As a process, it is defined as being ontogenetic (indicates existence). In contrast, pragmatics of intelligence, is related to the "adaptive use of intelligence and is therefore dependent on the context or ecology for its operation" (the relationship between organisms and their environments) (Browning, in Minichiello et al., 1992, p.72). As a theory, it is thought that the mechanics of ageing do not change greatly during later life, but that the pragmatics of intelligence can change during adulthood and old age. "This change is driven by changes in the life goals of the individual and the changes in social context experienced by the individual" (Browning, in Minichiello et al., 1992, p.72).

Another psychological theory includes 'locus of control', which focuses on internal and external locus of control (Rotter 1966). Dependent on how one reacts, the outcomes of different situations are seen as either being as a direct result of the individual involved, (such as it happened that way because I made it happen), or from factors outside of the control of the individual (I could not do anything about it, it happened as a result of

the earthquake). This theory has been applied to the area of health, and the outcomes of people's health (during the ageing process) applied to either the internal or external locus of control of the individual involved, to identify in part, their behaviour towards the ageing process.

Other theories include the 'learned helplessness' theory developed by Seligman (1975), which "assumes that people who experience uncontrollable events act in an inappropriate way and learn to be helpless" (Browning, in Minichiello et al., 1992, p.72). When analysed with the ageing process, which may be seen as an uncontrollable event, people may behave inappropriately (for example rely on others to assist them even though they don't require it), and consequently they may then learn to become helpless, as they let their own skills regress to a point where they no longer use them.

The 'self-efficacy' theory, developed by Bandura (1977) suggests that one's motivation, thought patterns, and emotional responses to certain situations, are related to one's own perception of his / her capabilities. It is specific to each behaviour, and therefore one's responses to one situation can be varied to that of another situation (Browning, in Minichiello et al., 1992). As opposed to the learned helplessness theory, this theory is actually specific to each situation, and not generalised across all areas of an individual's life.

In summary, psychological theories of ageing are specifically concerned with the relationship of "differences in behaviour between individuals and behaviour changes within individuals as they age" (Browning, in Minichiello et al., 1992, p.72).

## **Sociological Theories of Ageing**

Theories constructed under the sociological rubric of ageing are concerned with structural and societal factors. They can be separated into either structural functionalism or interpretative approaches (Browning, in Minichiello et al, 1992).

### **Structural functionalism**

Within theories of structural functionalism, the primary unit of analysis is society. Such theorists argue that to fully understand any element of society, one must understand its relationship to other elements of society, as well as understanding society itself.

Essentially, [a] researcher needs an analysis of the parts, their relationship to other parts, and the role they play in the maintenance of the whole society. (Aroni and Minichiello, in Minichiello et al., 1992)

One theory, which is based on the structural functionalist approach, is the 'activity' theory (Havinghurst 1963). Under the rubric of this theory, an elderly person is thought to adjust more easily, if they maintain the same level of activity that they had in their middle years. This can be achieved either by continuing existing roles, or re-introducing past activities, which currently are not undertaken. "The initial assumption is that there is a positive relationship between activity and life satisfaction" (Aroni and Minichiello, in Minichiello et al., 1992, p.125).

Disengagement theory (Cumming & Henry 1961) is embedded in the maintenance of the equilibrium of society, through elderly people relinquishing roles and partnerships. The theory focuses on the old being replaced by the young. This two-way process, of the individual redrawing from society, and society withdrawing from the individual, is seen as being positive, as it releases the individual from the rigours and obligations once held when being more involved in society (ie: work), and these are then undertaken by younger people. During this process, the older individual is said to become egocentric, and to reminisce on events from the past (Aroni and Minichiello, in Minichiello et al., 1992).

The 'age stratification' theory (Riley, Johnson & Foner 1972) has as its central element, "that age operates as a universal criterion for the distribution of roles as individuals move from one stratum to another" (Aroni and Minichiello, in Minichiello et al., 1992, p.123). Throughout life, individuals are afforded certain roles and rights as they reach certain ages. These may include being able to go to school, drive a car, and enter licensed premises, upon reaching a specific chronological age. The age stratification theory similarly groups people into areas such as "young", "middle aged", "old", and "old old". It then associates certain roles with people who fall within each of the cohorts. For example, a common belief is that older people are less productive than younger people in a work environment are. Therefore, when elderly people reach a certain age, they are forced to retire from the workforce, as they are no longer seen as productive. This theory focuses on the collective approach to ageing, more so than the individual approach outlined in the role theory method.



`Conflict' theory (drawn from the work of Marx 1975) is concerned with "the way in which social structure and social change impinge on the individual and collective processes of ageing" (Aroni and Minichiello, in Minichiello et al., 1992, p.123).

Theorists using this model essentially believe that conflict is a normal process of society. Through conflict, people can arrange themselves into different groups, and respond to an issue. Therefore, researchers using this model are interested in how people respond with relation to conflict situations, in regards to preserving their particular interest area. The approach is used predominantly to focus on areas of policy, with a view to analysis.

`Role' theory (Mead 1934) is associated with age appropriate behaviour, where people are expected to play roles associated with their age, or are seen by others almost in a stereotypical manner of only being able to fulfil tasks based on their age. For example, people who may be 55 years of age, and frequent a disco, may be told by a family member to `act one's age', and to recreate in a more `appropriate' location. As people age however, they are subjected to several role losses, and indeed role changes. The most noticeable of these is that of loss of employment, and a gain of retirement. "How well individuals adjust to ageing, is assumed to depend on how well they accept the role changes typical to later years" (Hooyman, 1988, p.63). These may not only consist of retirement, but also widowhood, status and power losses, to mention a few.

## Interpretive Theories

Theories under the rubric of this area are sometimes referred to as 'microscopic' theories, as they are interested in small-scale interactions within specific settings. They place a high emphasis on communication, and symbols (usually language) also become very significant (Aroni and Minichiello, in Minichiello et al., 1992).

It has been argued:

That these symbols become significant to the extent that people attach common meanings to them and are able to communicate shared meanings.

The focus of symbolic interactionist research is understanding the way in which people perceive their world and others in it and the meanings which they attach to their experiences (Aroni and Minichiello, in Minichiello et al., 1992, p.131).

'Labelling' theory (an interpretative theory Goffman 1961) is based on the assumption that behaviour is motivated, and that an individual's behaviour can be constructed from a group of various possibilities. The theory therefore acknowledges that the understanding of a situation can be different for each individual and the way that two people see the same situation can be entirely different. Consequently, researchers who use this theory endeavour to interpret situations from the perspective of the individuals involved, and therefore they try to obtain their definitions of the situation.

With regard to ageing, researchers:

Focus on the meanings, relationships and interactions that occur as part of the lived experience of older people. They examine the impact of being old on the self-conceptions and interpersonal relations of individuals who live in a society which stigmatises that status (Aroni and Minichiello, in Minichiello et al., 1992, p.132).

It is seen as being important to researchers who use this theory, that the interpretation of the situation comes from the perspective of the individuals being analysed, especially, when one considers that labels are usually applied to any individual by another person.

Individuals can interact in particular ways, in an endeavour to influence other people, and this is the basis of the 'social exchange' theory. A researcher using this theory may want to identify how certain patterns emerge between individuals (or groups), and why they arise. It is also involved with a rewards versus cost scenario, which has significant relevance to the area of gerontology. Such theory outlines that if one individual does something for another, they are then rewarded in some way. When an elderly person retires however, they essentially lose two important factors, those being their position of authority within society, and material possessions - which are reduced as a result of having a regular relatively large income substituted for a pension. This however, can vary from person to person. With these reductions, the elderly person has less bargaining power, and is also less likely to be able to reward people for their services, (which may include family members). This can then lead to unequal power situations. Consequently, elderly people may be forced to live in places which they don't like, to do things which they feel uncomfortable doing, or to be treated in ways

which may not be socially acceptable, simply because they cannot reward people for better services or assistance. Researchers using this theory to guide a study, look to examine why elderly people are in the type of situations which they may be in, and then relate it to the bargaining power which they have.

As mentioned in the introduction to this chapter, there currently is no one dominant theory on ageing, but more a pluralistic approach to the area. It has been argued by Minichiello et al. (1992) that in fact, a biopsychosocial approach to ageing should be undertaken by researchers. Such an approach endeavours to understand the interactions which are involved in the ageing process from each of the three major areas outlined, those being the biological, psychological, and sociological perspectives. There will still be some disagreement however, as to the correct mix, which should be given to each of the areas in arriving at the one overall theory. With this in mind, there is little doubt that a pluralistic approach to the theory of ageing exists. As outlined in the overview of the sociological theories, the theory chosen by a researcher, is more likely to be adopted to fit the situation being researched, as opposed to be used because it is the dominant theory in ageing. Additionally, with the area of gerontology being a multi-disciplinary field, and drawing researchers from various fields, each who may have different paradigmatic views based on their discipline, there is still less likelihood of one dominant theory emerging.

Each of these theories can have an important association with the area of elder abuse, and assist in part, with identifying why abuse of elderly people may occur. The biological mechanisms of ageing, suggests that the ageing organs and the cellular systems of the human body, can be a method of explaining the process of ageing.

People supporting this theory, suggest that if systems and organs within the body decline with ageing, an elderly person may be in a dependent situation, where they require some element of assistance from a caregiver. In many cases, caregivers initially could be members of the family, who either do not have the skills required to be carers but may have been forced into the caregiving role, or they may themselves have some form of biological decline, which restricts their capacity to be a carer. This too may be a reason why they may abuse the person whom they are looking after.

Psychological theories of ageing are concerned with the behaviour changes in people as they age, and this too can have an impact on the area of elder abuse. People who espouse this theory, may suggest that theories such as learned helplessness, where an elderly person may rely on someone to help them even if they do not require assistance, may frustrate a caregiver, who then could abuse the elderly person they are caring for. Additionally, the theory of locus of control, where elderly people feel that the behaviour which they demonstrated resulted as a consequence of something which was outside of their control, can also frustrate a caregiver and be a catalyst for abuse to occur.

People who support sociological theories on ageing may suggest that these can be used to explain why elder abuse may occur. The disengagement theory, where people relinquish roles and partnerships, may result in some elderly people becoming isolated or dependent on a caregiver. Due to the isolation and dependency, the elderly person may not complain about the abuse that they are receiving, as it may be the only interaction they have with anyone. Interpretive theories, such as social exchange theory may also explain why elder abuse occurs, insomuch as caregivers may expect

some financial (or other) reward for undertaking the caregiving role, and if this is not forthcoming, they may abuse the elderly person.

While theories relating to why caregivers abuse elder people will be discussed in more detail throughout this chapter, it is evident that the theories of ageing outlined above have an important impact on the discussion of elder abuse. Theorists may well argue why elder abuse exists, specifically based on their own theoretical views or background on the ageing process. However, the area of elder abuse, and the discussions relating to this, require a multi-theoretical approach, similar to theories on ageing, as the area of elder abuse can be influenced by the biological, psychological and the sociological theories of ageing.

### **Theories Relating to Why Caregivers Abuse Elderly People**

Throughout the literature, many authors have provided theories on the aetiology of caregiver abuse of elderly people, and its origin. Pedrick-Cornell and Gelles (1982), Myers and Shelton (1987) and Godkin, Wolf, & Pillemer (1989), suggest that much of the theory which has been applied to elder abuse has been developed from other forms of interfamilial abuse, such as child abuse and domestic violence. Other authors have suggested varying theories outlining why caregivers abuse elderly people, while some researchers have linked several characteristics together, to form one theory.

According to Anetzberger (1987), the early theories of caregiver abuse toward elderly people suggested that there are five main theoretical explanations regarding its causation. One of these theories relates to the victim of abuse and the remaining four

relate to the perpetrator of the abuse. The theories relating to the abuser are "abuse socialisation, pathology, stress, and social isolation" (Anetzberger, 1987, p.8). The one, which focuses on the victim, is the theory on vulnerability. Giordano and Giordano (1984) however, have indicated that while there are several hypotheses which relate to why abuse occurs, they have reduced it to seven stressors. They suggest that each of the stressors is not independent of each other, and that they overlap in many instances, as abuse "is triggered by the interplay of several factors" (Giordano and Giordano, 1984, p.234). Haviland and O'Brien (1989) support these views by suggesting that the causes of elder abuse are multifactorial, while Bentley (1999) also supports the view that the causes are varied, suggesting they range from stress and substance abuse, through to family conflict, vulnerability and dependency.

The seven stressors identified by Giordano and Giordano (1984) are: "family dynamics; dependence because of impairments; personality traits of the abuser; filial crisis; internal stress; external stress; and negative attitudes toward the elderly" (p.234).

Several other authors, including O'Malley et al. (1983), Long (1987), Myers and Shelton (1987), Godkin et al. (1989), Haviland and O'Brien (1989), Tomita (1990), and Benton and Marshall (1991) have also cited some or all of these stressors as being important in identifying theories as to why caregivers abuse elderly people. These theories and stressors, and other theories such as the exchange theory, symbolic interactionism, and the environmental press theory, will now be discussed, to provide an overview of the area.

## **Family Dynamics / Abuse Socialisation**

This theory suggests that members of a family become aware of violence at an early age, either through being beaten as a child, or through observing violence of other family members. It is therefore a learnt behaviour, and one that is carried out through life. According to Steinmetz (in Giordano & Giordano, 1984) "one in 400 children who are reared nonviolently attack their parents later on, compared to one out of two children who are mistreated violently by their parents" (p.234).

This theory is supported by Haviland and O'Brien (1989) who suggest that if there has been a history of marital conflict between one's parents, where violence has been the response to stressful situations, then this characteristic (violence) may be displayed by children during times of stress. One of these stressful times may be when a child is caring for an elderly parent. Godkin et al. (1989) suggest that this type of abuse can be called a "cycle of violence" theory (p.209). Several authors including Freeman (1979), Anetzberger (1987), Long (1987), and Delunas (1990), indicate that the theory is an important determinant of the origin of caregiver stress, and suggest that if an individual has been abused as a child then there is a strong chance that they will abuse their children. Additionally, these children may then go on to abuse their elderly parents.

Studies conducted by Rathbone-McCuan (1978) and Lau and Kosberg (1979 in Anetzberger 1987) both provided results that indicated support for the notion that conflict can occur as a result of either intra or inter generational violence. This can be related to the aetiology of caregiver abuse of elderly people. Tomita (1990) labels this



as the social learning theory. Therefore, if a history of family violence is evident, it could continue into elder abuse as some family members age.

### **Personality Traits of the Abuser / Pathology Related Abuse**

The personality traits or pathological traits of the abuser have also been identified as a reason for caregiver abuse occurring. These traits may range from conditions such as "development disability, mental illness, substance abuse or defective personality" (Anetzberger, 1987, p.10). Once a caregiver is subjected to one or more of these stressors, one may develop a lower tolerance for frustration, and conversely the stress may in fact increase the abuser's "tolerance for abuse infliction by giving abuse special meaning and value for itself" (Anetzberger, 1987, p.10).

Essentially, this theory suggests that some caregivers are abusive because of their particular personality, or due to a character disorder. While Haviland and O'Brien (1989) suggest that "caregivers who are cognitively impaired themselves may abuse or neglect the care recipient," the theory still needs more support (p.13). Generally research has not been able to support or refute this theory, however, it is a consideration which must be taken into account, when discussing reasons for elder abuse (Giordano et al., 1984). Despite this, several authors, such as O'Malley Everitt & Champion (1983), Long (1987), Myers and Shelton (1987), Godkin et al. (1989), Tomita (1990) and Benton and Marshall (1991) suggested that this is an area of major theoretical consideration, when discussing the aetiology of caregiver abuse of elderly people.

## **Stress**

This theory suggests that abuse of elderly people can occur due to the build up in the stress of the carer. The stress can take two major forms, those being either internal stress or external stress. The internal stress relates to pressures of caring for an elderly person, and it's sometimes associated burden and strain. External stress relates to environmental relationships, which may have an effect on the caregiver (Anetzberger, 1987).

Most existing research indicates that whether a caregiver is stressed or not relates to a number of specific factors. These include factors such as "the frequency and distress of an elder's behaviours; competing tasks performed; type of caregiver tasks performed; functional status of the elder; dangerous or odd behaviour or lack of cooperation by the elder; insufficient time or money; or some combination of specific factors" (Anetzberger, 1987, p.12).

### **Internal Stress / Environmental Press Theory**

Abuse can occur by a family member who has the additional stress of looking after a parent. Often an adult child may have finished raising children, only to have the additional problem of now having to look after an elderly parent. Often this requirement is left to one child within the family, which further adds to the pressure (Giordano & Giordano 1984). Accompanied with this may be the caregiver's feelings of isolation, frustration and non-appreciation, which also may induce stress and abuse (Haviland

and O'Brien, 1989). In addition, it is thought that behavioural problems of the recipients of care, such as wandering, incontinence, and verbal belligerence, may cause the caregiver stress, which ultimately may lead to abuse (Haviland and O'Brien, 1989).

Situations where the elderly person comes to live with the family when children are still living at home, can add further pressure to one's natural routine, and can cause stress and ultimately abuse (Giordano et al., 1984). Steinmetz (in Kimsey et al., 1981) suggests that "parenting a parent" can cause frustration to a middle-aged child's financial and emotional goals. Haviland and O'Brien (1989) suggest that these stressors can represent environmental press. This concept is based on the stressors in one's environment becoming too strong, and making it difficult for an individual to cope with them in a competent manner, resulting in abuse and neglect.

Tomita (1990) refers to this theory as the situational model. At its core is the concept that increased stress on the abuser will lead to he or she abusing the elderly person whom is in his/her care. The "sandwich generation", as described by Tomita, is a result of the ageing of the population and the low birth rates, which have culminated in many middle aged individuals being responsible for the care of their elderly family and relatives. Often this can be the catalyst for abuse by the unprepared person, as many stressful situations can develop (Tomita, 1990).

Consequently, some caregivers feel that they have a right to blame elderly people for their behaviour, and that the elderly person, for whom they are caring, may in fact be the catalyst of their problems. The problems may relate to several areas, none the least being unemployment or financial difficulties. Therefore the "elderly person is

perceived to be the source of the mistreating person's frustration and of his or her diminished status" (Tomita, 1990, p.172). This theory is also supported by Myers and Shelton (1987) and Long (1987) who suggest that it is an important theoretical consideration when discussing the aetiology of caregiver abuse of elderly people.

### **External Stress**

Problems such as low financial income, employment level and age of abusers, can all relate to the abuse of elderly people. If the carer is not in an appropriate situation to provide for an elderly person because of one or more of the above-mentioned reasons, stress and abuse may eventuate. It can also occur if the carer is a substance user, who is having difficulty supporting an addiction as well as family (Giordano et al., 1984). O'Malley (1983), Godkin et al. (1989) and Delunas (1990) support the theory, suggesting that external stressors are likely to serve as a precipitator of elder abuse.

### **Social Isolation**

Social isolation is thought to have an important effect on elder abuse. If individuals are isolated they have to face crises alone, and can limit their ability to obtain assistance when required. In addition, isolation further inhibits outsiders from noticing cases of abuse, and ensuring that adequate interventions are put in place (Anetzberger, 1987). Consequently, it also reduces the chance of gatekeepers being involved in the process, which can therefore lead to less accountability of what actually happens in one's home. The theory is also supported by Godkin et al. (1989) who suggested that it

is difficult to identify if isolation is in fact an antecedent or precedent factor of an abusive situation.

Some families may prefer to be isolated from their neighbours and other members of the public to avoid detection of the abuse, which may have already occurred. Godkin et al. (1989) also suggested that research has demonstrated that "the way in which social supports mitigate family life stresses supports the notion that isolation may precede acts of abuse and neglect" (p.210). Therefore with regular interactions with the public, abusive situations may in fact be reduced, as individuals undertaking the caregiver role, may fear being detected as an abuser of elderly people (Godkin et al., 1989).

### **Vulnerability / Impairment and Dependence**

Vulnerability of elderly people can also be seen as a cause of elder abuse. This theory suggests that because some elderly people are dependent on others (caregivers), it can increase the stress-related dependency. It may also create the situation where the elderly person, due to the dependency upon the caregiver, is not willing to be removed from an abusive situation (Anetzberger, 1987).

Delunas (1990) suggested that elderly people who have some mental or physical impairment, may be placed in a situation of dependence, which could make them vulnerable to being abused. In association with this, there is the concept of learned helplessness (Seligman 1975). This theory suggests that as elderly people "become increasingly dependent they have no control over their lives and can do nothing to change their situation" (Giordano et al., 1984, p.234). Other areas of dependence

include financial and emotional stress on the caregiver, which in turn may cause her or him increased stress (Haviland and O'Brien).

### **Exchange Theory**

The vulnerability of elderly people can also be related to the notion of exchange theory (Anetzberger, 1987). This theory suggests that "as the elderly become dependent and impaired, an imbalance in the exchange of positive reinforcements occurs in their relationships with caregivers" (Godkin et al., 1989, p.209). There is the potential for the costs of caregiving to outweigh the benefits received, which could then induce anger and violence (Godkin et al., 1989).

Social exchange theory suggests that people want to maximise the rewards that are due to them, and to minimise their losses or punishment. Essentially, the caregiver wants to ensure that the cost of caring for an elderly person, in all aspects including time and finance, is offset by the rewards they receive. Tomita (1990) suggests that "the imbalance of goods creates a situation in which one person is more powerful than the other" (p.172) In some situations, elderly people are not financially affluent, and some may require a high level of service provision. In such situations if they are unable to adequately reciprocate the caregiver with rewards, it may contribute to a situation where the caregiver abuses the elderly person.

## **Filial Crisis**

This theory is related to the conflict, which occurs between a child, and parent during adolescence. "According to this hypothesis, a developmental task of adult children is to go beyond the stage of adolescent rebellion toward emancipation from their parents" (Giordano et al., 1984, p.234).

However, on occasions, the conflict, which arose during the parent-child stage, is carried through into later life. Myers and Shelton (1987) stated that due to a "variety of unresolved past conflicts and lifelong histories of inadequate relationships," the filial crisis can be seen as a theoretical grounding for the emergence of an abusive situation (p.377).

## **Symbolic Interactionism**

Symbolic interactionism (Mead 1934) involves a process that occurs between two people, and includes three phases consisting of the cognitive, expressive and evaluative processes (Tomita, 1990). Within the first phase, individuals "assign meanings to the encounter with the other person, and these meanings are based on prior encounters, belief systems, and current perceived roles" (Tomita, 1990, 173).

Often the role, which each person assigns to the other person, is based on the expectations one would have, if they were in the same situation (Tomita, 1990).

During the expressive phase, each person role-plays, demonstrating the imputed role they have been assigned by the other person. The next section of the theory, the

evaluation process, "consists of negotiations between the individuals, who sometimes alter their behaviours and expectations of others in response to their own assessment of the situation" (Tomita, 1990, p.173). Essentially, abuse may arise from one person behaving in a manner that the other person does not expect. Therefore they demonstrate role asynchrony, instead of role synchrony (Tomita, 1990).

Pedrick-Cornell and Gelles (1982) and Tomita (1990) suggested that some caution should be associated with the theories of elder abuse. Pedrick-Cornell and Gelles (1982) base their reservations around the notion that there is still no universal and clear definition of what does and does not constitute abuse of elderly people. Consequently, what may be defined as being abuse under the guidelines of one theory, may not be seen as being abuse under another theory, subsequently making it difficult to arrive at one conclusive definition.

Tomita (1990) based her view on the fact that no one theory in isolation, can be seen as sufficiently explaining all of the aspects that are associated with elder abuse. Therefore, one should not try to explain the reason as to why a caregiver abuses an elderly person, from within the rubric of one theory only.

### **Negative Attitudes Toward the Elderly**

Giordano and Giordano (1984) and Myers and Shelton (1987) have suggested that negative stereotypes towards elderly people may support the notion that elder abuse is an acceptable societal action. Kimsey Tarbox & Bragg has further suggested that a "general prejudice toward the aged population seems to have been translated into



abuse of the aged" (p.466). Barrett (1999) supported the above authors' views, suggesting that this perpetuates the myth of older people having little to offer society, and that the out of mind, out of sight approach is one of "assuaging any guilt we may feel about not attending to their needs" (p.30).

There is no universal agreement about one particular theory of what actually causes a caregiver to abuse an elderly person. However, the literature provides a range of theories from which one or more causes can be identified. As is consistently the case with elder abuse, one must continue to build and add to the theories that have been developed, in an endeavour to further develop a stronger theoretical understanding of the literature.

### **Definitional Problems With Elder Abuse**

It has been stated by Pedrick-Cornell and Gelles (1982) that a major barrier restricting progress towards a suitable information base on abuse within families "has been the problem of developing a satisfactory and acceptable definition of violence and abuse" (p.13). Bennett and Kingston (1993) have also stated that "the main controversy which has caused research and conceptual difficulties remains the definition of elder abuse and neglect" (p.10). There are numerous definitions of what constitutes elder abuse within the literature, and this in itself makes it difficult to generalise the results of one study across to another, as what may be seen as abuse in one situation, may not be seen as abusive in another. The following Table (1) highlights some of the variances in the definition of elder abuse, which have been used in a number of studies.

Table 1 Definitions of Elder Abuse

Source	Definition
Block & Sinnott (1979)	Physical abuse; Psychological abuse; Material abuse; Medical abuse.
O'Malley, Segars, & Perez (1979)	Abuse: The wilful infliction of physical pain, injury, or debilitating mental anguish; unreasonable confinement; or deprivation by a caretaker of services which are necessary to maintain mental and physical health
Douglass, Hickey, & Noele (1980)	Passive neglect; Active neglect; Verbal or emotional abuse; Physical abuse
Lau & Kosberg (1979)	Physical abuse; Psychological abuse; Material abuse; Violation of rights
Wolf & Pillemer (1984)	Physical abuse; Psychological abuse; Material abuse; Active neglect; Passive neglect
O'Malley, Everitt (1984)	Neglect: Abuse

(Source: adapted from Fulmer, 1991, p.28).

To summarise the above table, it can be seen that the elements one considers to be a part of a general definition of elder abuse vary from one author to another. While the area of physical abuse is evident in each study, the precise definition of what constitutes physical abuse still is inconsistent.

There is also some debate levelled at the use of the term neglect as a separate issue to elder abuse, or conversely, if it should be seen as an overall part of a definition of elder abuse. Pillemer and Finkelhor (1988) undertook a review of the past literature in an endeavour to identify a workable definition of elder abuse. They found that while abuse was included in many studies and state laws in the United States, it is still seen

as being a controversial term. The area of neglect has been criticised by some researchers, based on the fact that the results of neglect are more related to the failure of society to provide for its elderly people, as opposed to relatives or family members being the cause of neglect (Callahan, 1982; Crystal 1986; Salend et al. 1984, in Pillemer and Finkelhor, 1988). However, "there is general agreement that the failure of a clearly designated caregiver to meet the needs of an elder constitutes neglect" (Pillemer and Finkelhor 1988, p.53).

Based on this reasoning, the area of neglect is predominantly associated within the area of abuse, and most current studies include definitional characteristics that include areas of both abuse and neglect.

Phillips and Rempusheski (1986) suggest that within the rubric of health care providers' definitions of elder abuse and neglect, there are four notable themes. The first of these consists of defining elder abuse, based on the acts of the abuser. For example, acts of commission were generally termed abuse, while acts of omission were termed neglect. The second differentiation relates to the severity of the outcomes for the abused individual. Abuse was based on being related to immediate danger, while neglect was associated with less dangerous situations. The authors concluded that the third theme is based around the intentionality of the acts by the abuser to the abusee. Essentially, people identify abuse as being intentional, and neglect as being non-intentional. The fourth theme within the definitional rubric actually suggests that both abuse and neglect are very closely related, and that it would be difficult to provide clear definitions to distinguish one as opposed to the other. Phillips and Rempusheski (1986) suggest that "these four themes, then, form the conceptual underpinnings of the

decisions that these care providers made about who is and who is not an abused elder" ( p.135). While they did not necessarily use a formal definition of what constitutes abuse, they would define the outcome of an abusive situation, based on how they viewed the circumstances. Similarly, Douglass and Hickey (1983) believed that "the actions or inactions of the caregiver formed the basis of the definitions" (p.124). They used their definitions as a basis for the preventing abuse or neglectful situations from occurring.

Much discussion had gone into the definition of elder abuse, and what should and should not be included in a universal definition. Callahan (1988) initially felt that it makes little or no difference in regards to what a definition is comprised of, as long as elderly people are given the opportunity to live in the community without being abused. However Callahan (1988) further suggested that definitions are important, and served as useful tools in addressing the problem of elder abuse. They inevitably find their way into legislation, from which resources can be allocated and generally are the guide upon which human service professionals base whether they should intervene in an abusive situation or not (Callahan, 1988). Biggs Phillipson & Kingston (1995) also concluded that definitions are important, as they can provide people with a clearer comprehension of what the issue involves, definitions can articulate differences between the problem in question and other areas of concern, and they can guide experts and permit intervention.

Callahan (1988) outlined a problem with different definitions is that "a self-fulfilling prophecy may be created" (p.454). Therefore, some professionals may change their attitudes to what may have been an accident before or a mental health problem, to

now calling it abuse, for example, "when alcoholism was called a crime, people went to jail. When it was called a disease, people went to drying out facilities" (Callahan, 1988, p.454). The important element to consider is how the definition is developed, and what it is trying to achieve. One has to consider what actions should be called 'elder abuse', and what belongs to another area. Dunn (1995) suggested that until there is some "unanimity about the construction of the problem, there is a danger of the legitimization of some reported causes" of elder abuse (p.22).

Many authors such as Giordano and Giordano (1984), Haviland et al. (1989), British Association of Social Workers (1990), Gately et al. (1990), and Hailstones (1992), agree that the primary categories within elder abuse centre around physical abuse, physical neglect, psychological abuse, psychological neglect, material abuse or exploitation and violation of personal rights or exploitation. There is still much conjecture however, regarding the specific definitions within each of these categories, which is causing uncertainty within the area. A uniform operational definition of elder abuse would assist practitioners and researchers in the proper identification and classification of abuse and in the reporting of such data (Galbraith 1986).

The elderly person is the only one who can determine the limits of behaviour that are acceptable to him or her and give permission for intervention. Although society can develop general descriptions of behaviour that it considers unacceptable, only the elderly person can decide if those definitions apply in his or her individual case. In a sense, the elderly person can render a definition of abuse or neglect meaningless. If nothing can be done to ameliorate a situation because the elderly person refuses to acknowledge the existence of abuse or neglect, then there is little to be gained by

identifying cases in this manner. This imposes a very practical limit on the utility of definitions of abuse and neglect. Any definitions must facilitate the elderly person's acceptance of intervention; otherwise, they will be counter-productive (Fulmer and O'Malley, 1987).

### **Types of Interventions Available**

Often the decision as to what and when to apply an intervention is one of the most difficult decisions confronting a service provider. Not only is it difficult to identify the causal and risk factors associated with abuse, but also the legal considerations further add to the complexity. Furthermore, there is the balance between allowing the elderly person to remain independent and make one's own decision, and sometimes conversely, the need for service providers to make a decision to protect an elderly person from further harm (Canadian Medical Task Force on the Periodic Health Examination, 1994).

The interventions, which are used to assist in the amelioration of elder abuse, are specifically related to the knowledge which the person who is assisting the process, has of available resources. If professionals have a good knowledge of available resources and interventions, then they are more likely to provide the most suitable and least restrictive intervention for the elderly abused person. However, if they have limited knowledge of available interventions, then what is offered may not be suitable to the abused person, and they may choose to continue to be abused, as opposed to seeking help through the intervention offered, as outlined above by Fulmer and O'Malley (1987).

The Canadian Medical Task Force on the Periodic Health examination (1994) suggested that generally there are three intervention models that are used. They consist of the spousal - abuse; advocacy; and adult protection models. The spousal - abuse model removes the victim from the situation until a resolution can be found. The advocacy model promotes the use of a neutral person to assist the victim to utilise and find appropriate community services. The adult protection model is concerned with the violation of rights of elderly people, and has a focus on areas such as mandatory reporting (Canadian Task Force on the Periodic Health Examination, 1994).

These interventions have been models supported by Haviland and O'Brien (1989) who stated that interventions for the abused individual may include referral to a community agency, such as a home health care agency. Other individuals may require respite care and day care programs, or a completely new living arrangement. Other types of interventions include counselling and hospitalisation. On occasions, the "use of a home health aide" may be useful (Haviland and O'Brien, 1989, p.17).

For the abuser, interventions may include legal action, protective orders, and some other forms of guardianship. In circumstances of unintentional abuse, where the abuser may not be of sound health or mind, some form of treatment may be required (Haviland and O'Brien, 1989). Quinn and Tomita (in Haviland and O'Brien 1989 p.18) suggest that these types of interventions may include "education and resource linkage."

In all situations, it is important that the individual who has been abused, feels comfortable and relaxed about the types of interventions, which are to be introduced. As suggested by Bennett and Kingston (1993, p.48), "every effort should be made with competent elders to pursue a response based on choice, autonomy, and empowerment." They further suggest that with non-competent elders, there is a need for a global assessment of the situation, and possible case-management and legal interventions (Bennett and Kingston, 1993). Biggs et al. further stated that "the overriding goal of intervention will be to work with the characteristics of particular kinds of social relationships and social networks, strengthening the available resources which may be used to ensure protection of vulnerable adults" (1995, p.104).

### **Characteristics of Elderly People Who Are Most Likely to be Abused**

In a study conducted by Powell and Berg (1987) of 60 cases extracted from an Adult Protective Services Division in Texas, they identified several characteristics of elderly victims of abuse. Their major findings, which they indicated were similar to those of other researchers (Block and Sinnott 1979; Lau and Kosberg, 1979; O'Malley et al. 1979 in Powell and Berg) found that the likely victims of elder abuse, are those individuals who are 75 years of age or more, and are female (Powell and Berg, 1987). Kosberg (1988) supported this finding, adding further, that the elderly victim may be dependent upon others for care, as well as being a problem drinker. In a recent study in the USA (National Elder Abuse Incidence Study, 1999) their results further support the findings of Powell and Berg. The 1999 study outlined that female elders are abused more often than males, and that people aged over 80 are abused at a rate of two or three times their proportion of the elderly population.



Kosberg (1988) explained that women more are susceptible to abusive behaviour because they are less likely to resist, and are more vulnerable to sexual molestation. A person, who is a problem drinker, can also be more open to abuse, because of an inability to care for him or herself. Being dependent on others also reduces an individual's autonomy and can lead to victimisation (Kosberg 1988).

Holtzman and Bomberg (1991) while supporting the views of Powell and Berg (1987), further expanded their definition of the high risk characteristics associated with vulnerable elderly people, to include those who are loyal to caregivers, stoics, impaired, and those who may have a past history of abuse. Rathbone-McCuan (1980); Gelles (1982); Pedrick-Cornell and Douglass (1983); Galbraith and Zdorkowski (1984); Holland et al. (1987); Long (1987); Myers and Shelton (1987); and Haviland and O'Brien (1989) agree that generally, elderly people who could be identified as being vulnerable and at high risk of abuse, have the abovementioned stereotypical characteristics. Some of these authors suggest however, that additional characteristics of high-risk abused individuals were that they are also white and/or of middle class origin (Holland et al., 1987; Myers and Shelton 1987; Long 1987).

Pillemer and Finkelhor (1988) undertook a study in Boston of 2020 community - dwelling elderly individuals, with a focus on physical violence, verbal aggression, and neglect. Interestingly, the results suggest that the level of abuse and neglect experienced by the sample "were no higher for older (over 75) than for younger (65-74) elderly, and not significantly different for those of any religious, economic or educational background" (p.54). Additionally, the results indicated that minority groups

of whites were no more vulnerable than any others to abuse, and that men were as equally abused as females (Pillemer and Finkelhor, 1988). Significantly however, the study suggests that those likely to be more vulnerable to abuse were those in poor health, and/or those who were living with others such as a spouse, and with a minimum of one other person. The study also suggests that individuals who are likely to be neglected, generally have no one to whom they can turn for assistance and support (Pillemer and Finkelhor, 1988). The results of this study therefore, are not congruent with those of earlier studies. They do not align themselves with the earlier stereotypical characteristics provided by many authors, on vulnerable elderly people who may be considered as being at risk of being abused. Gold and Gwyther (1989) in supporting the results obtained by Pillemer and Finkelhor, suggested that the earlier research and stereotypes identified about high-risk elderly people may be too simplistic and inaccurate. Callahan (1988) supported the notion of broad based service delivery and strategies for elderly people, as opposed to specific service delivery to address the area of elder abuse, suggested that "evidence is that the typical victim is not so typical" (p.456). He cites a research study conducted in Arizona, which describes the victim as atypical of earlier stereotypical definitions of vulnerable, at risk elderly people (Callahan, 1988). Wolf and McCarthy (1991 in Ammerman & Hersen) further criticise early studies into the area of elder abuse on the basis of "using small, unrepresentative samples, relying on retrospective case records, omitting control groups, and lumping together the various types of maltreatment" (p.358-359).

The results of this earlier research have lead to tighter methodologies, and increasingly complex concepts of what constitutes the characteristics of elderly people at risk. Wolf and McCarthy (1991 in Ammerman & Hersen) provide profiles of individuals, based on

their type of abuse. From this information, three distinct profiles emerged. Firstly, for those who have been subjected to physical and psychological abuse, they were identified as having emotional problems, but they were also characterised as living fairly independently in relation to their general activities and daily living. Secondly, individuals who have been neglected were defined as being very old, and having cognitive and functional impairments, while also having little social support. Finally, in cases of material abuse (financial), the victims were defined as having restricted social networks, and as being often unmarried. From this perspective, when focusing on the type of abuse which has occurred, the profile of the victim can change (Wolf and McCarthy, 1991 in Ammerman & Hersen).

Johnson (1991) agreed that there has been much conjecture regarding the characteristics which are important in identifying at risk elderly people. However, she provides an overview of the jurisdictions used in the United States of America, using two demographic variables, age and functional status of the victim to compare the differences among the states. Johnson (1991) outlined that two thirds (33%) of the jurisdictions do not separate older adults from within their mandates, but only define 18 years of age as a demarcation for separating the criterion regarding the type of abuse (such as child abuse). The other states use 55, 60, and 65 years as the numerical age for defining people as being associated with elder abuse. Additionally, within the U.S., three quarters (39) of the jurisdictions make disability a prerequisite in the identification of elder abuse, while one quarter (12) do not see this as an important criterion, when addressing the area of elder abuse (Johnson, 1991). The significance of this discussion is that the majority of jurisdictions within the U.S.A. use both the age and the functional status of individuals, as characteristics of determining elder abuse.

There are high levels of disparity associated with the specific criterion for defining an elderly person who is at risk of being abused. As with many research areas within the elder abuse rubric, there is no one clear universal definition. Hudson (in Schlesinger and Schlesinger 1988) suggests that elder abuse crosses the span of all "social, ethnic, socio-economic, and education strata. Hence, given the heterogeneity of the population, profiles of abused and abuser have limited utility" (p.18).

The literature also has extensive views on the characteristics that are likely to be associated with people whom abuse elderly people, as outlined below.

### **Characteristics of Individuals Who Abuse Elderly People**

Pritchard (1992) concluded that the typical definition of the abuser of an elderly person is that of a female who is middle aged, and generally the offspring of the individual who has been abused. Holland et al. (1987) supported this definition, depicting the abuser as often generally being the daughter of the victim, and as also having being abused as a child. However in research which she conducted in Sheffield, Pritchard (1992) identified the majority of the abusers as being male, and ranging in age from 11 through to 89 years of age. Within the study, which identified 70 abusers of elderly people, 39 (60%) of the abusers lived with their victim. Although not all of the victims and abusers were related by blood, the majority were, with 16 of the abusers being one's husband, and 15 being their son, while nine of the 70 abusers were daughters of the victim. Interestingly, the majority of the abusers were either retired from work (29), or unemployed (21). Powell and Berg (1987) in their review of 60 cases of elder

abuse, also found that the abuser was most likely to be the son of the victim (37.1%), with the daughter less likely to be the abuser (13.3%). They also found that the victim primarily resided in their own home (80%) and that in 27 of those 48 cases, that the perpetrator of the abuse actually lived with the victim. In the National Elder Abuse Incidence Study undertaken in the United States (1999) it was found that in almost 90% of cases of abuse, the perpetrator was a family member, and approximately two thirds of the perpetrators were known to be either adult children of the victims, or a spouse.

Fulmer and O'Malley (1987) also indicated that the most likely abuser is a male son of the victim, with the next most prevalent being a daughter. The third most prominent type of abuser is that of a male spouse, who is undertaking a caretaker role. Fulmer and O'Malley (1987) suggested that cause was related to psychopathy theory, which focused on the characteristics of the abuser, and his or her traits or disorders, can cause the individual to become abusive. These characteristics of an abuser may range from substance addiction, and financial concerns, through to marital problems. It is expected that an abuser would undoubtedly be under a great deal of stress, either from undertaking the caretaking role, and or from his / her own characteristics. However, this does not condone the abusive action occurring (Fulmer and O'Malley, 1987). Long (1987) supported the views of Fulmer and O'Malley, by suggesting that the majority of abusers have stress related concerns, such as alcoholism, medical problems, financial concerns, and/or drug addiction stresses.

and McCarthy (1991 in Ammerman & Hersen) in providing an overview of the previous two decades of research into elder abuse, describe how earlier research

studies had not been rigorous enough to be of immense benefit, by not providing universal definitions of perpetrators of elder abuse. Research in the mid to late 1980s however, concentrated on specific areas of abuse. The end result of this were definitions of the characteristics of perpetrators based on the type of abuse they inflicted on the elderly person.

Within the areas of physical and psychological abuse, the perpetrators were defined as having a history related to alcoholism, and / or mental illness. In addition, they were described as being in a situation of financial dependency, with the victim being the source of the finances. In situations of neglect, the perpetrators found that the elderly person was a cause of stress to them. In relation to material abuse (financial exploitation), it has been indicated that substance abuse characteristics were identified with the perpetrators, along with the obvious problem of having financial deficiencies. Therefore, the elderly person became an easy target for exploitation ( and McCarthy, 1991 in Ammerman & Hersen). While there are different characteristics of the abuser for the various types of abuse inflicted on a victim, most of them related to the psychopathological areas of the abuser.

Pillemer and Finkelhor (1988) conducted a study that had a target population of over 2000 elderly individuals who were living in communities in Boston, USA. While they discussed the concept of elder abuse as being a stereotypical derivative of generational inversion, where the once cared for child now has the responsibility of caring for their parents, their research findings did not support this view. Rather, they suggest that the perpetrator of elder abuse is more likely to be a spouse. Their research finding indicated that 58% of the abusers were in fact spouses, 24% were

children of the victim. They concluded that the dynamics of an abusive situation are most likely to be related to whom the victim is living with, as opposed to the relationship between the victim and the abuser. Statistically, many more elderly people live with their spouse, as opposed to their children, and the Pillemer and Finkelhor study (1988) supported this view. Their results outlined that abuse occurred at a rate of 41 incidents per 1000 people who resided in a spousal situation, as opposed to 44 incidences per 1000 elderly people who lived with just their children. They argued however, that the stereotypical view of elder abuse being a child and parent situation is somewhat myopic, and that the focus should be expanded to include spouse-related situations. This view is also supported by Adams (1993, p.6) who suggested that perpetrators of abuse can include "spouses, family members and carers" who are known to the elderly person, and Kurrle (1992) while supporting Adams also adds that the abuser usually lives with the victim.

In her study into the relationships between the health characteristics of elderly people who reside in the community, and the type of abuse experienced by elderly people, Round (1992) identified similar characteristics to those highlighted by other researchers. These included that in almost all cases, the abuser was a relative of the victim, with the largest group of abusers being children (35.6%). This finding however, is opposite to that outlined above by Pillemer and Finkelhor. In the total of 29 abusers who were identified, interestingly, there were 15 men and 14 women who were the perpetrators of the abuse. One of the most significant findings from the study however, was that over 82.2% of the abusers, had no form of support such as respite, formal support groups, or family assistance, while they were in the caretaking role (Rounds, 1992).

It appears that the stereotypical characteristics of an abuser, based on his/her stresses, and the relationship between the abuser and the victim, are still unclear. This further adds to the area of elder abuse being somewhat clouded, with definite characteristics of both abusers and abusive situations being difficult to identify.

However, Pritchard (1993) suggested that it is not unusual that the abuser is the person who has a problem, and not the elderly person. Therefore it is important that "any work or intervention that is undertaken with a case of elder abuse should include the victim and the abuser" (Pritchard, 1993, p.31). Despite the concepts which address the likely characteristics of individuals who abuse elderly people

It is quite likely that some abusers are essentially kind, caring people who are 'pushed over the edge' in a moment of despair, frustration, or fear, such as reacting to a person with dementia who has become combative (Haviland and O'Brien, 1989, p.13).

### **Problems Associated With Caregivers**

One of the problems of elder abuse is that often it is not always possible to separate who is the victim and who is the perpetrator. The elderly person may intentionally upset the child/ caregiver, who then abuses. In such circumstances, both are victims of abuse, and also abusers. On some occasions "the overwrought, exhausted, and stressed adult child who does use psychological, verbal, physical, or medical means to maintain control, often does so with the best intentions." (Steinmetz, 1988, p.180)



Schultz and Schultz (1990) found that family members generally have a special responsibility towards their elderly kin. This assistance is offered to elderly family members, regardless of where they are living. Schultz and Schultz conservatively estimate that up to half a million Australians, aged 60 years and over, while living outside of institutional care, are dependent on family members, friends, and community services "to cope with the normal pressures and needs of daily living" (1990, p.86).

Caregivers often are not well informed of the role they are expected to play, and of the issues which are associated with elderly people, such as their psychological, physiological and emotional needs. This can lead to increased levels of stress for them. Some caregivers reported that their role in looking after an elderly parent was both physically and emotionally tiring, and left little time for them to meet their own needs and interests (Schultz and Schultz, 1990). Toseland & Rossiter (1989) suggested that caregivers can become overwhelmed by the situation because the demands placed on them outweigh their coping resources. Loss of sleep, added to the physical and mental burdens, can cause increased stress for the caregiver. In some situations the role of the caregiver even limits one's social life, and places more stress on an individual, as one finds it difficult to remove oneself from the situation (Schultz and Schultz, 1989). Often caregivers and some professionals are not aware of what help is available for caregivers of elderly people. The type and suitability of the interventions for both the elderly person and the abuser therefore need to be outlined.

Wolf (1998) indicated that the type of illness which the elderly person who is in need of care has can affect the relationship between the caregiver and the recipient of care.

Wolf (1998) outlined that a trigger for abuse may not necessarily be the level of

cognitive impairment of the person needing assistance, but more so the disruptive behaviours which they exhibit.

Often caregivers and some professionals are not aware of what help is available for caregivers of elderly people. The type and suitability of the interventions for both the elderly person and the abuser therefore need to be discussed.

### **Mandatory Reporting**

The aspect of mandatory reporting of cases of elder abuse has raised some conjecture among service professionals. By 1988, every State in the US except two had passed laws that required the mandatory reporting of cases of elder abuse. Certain groups such as doctors, pharmacists and social workers in the U.S. are now required by law to report any suspected cases of abuse. The United States was the only country in the world, up until 1991, that had legislation requiring the mandatory reporting of elder abuse. Through the introduction of mandatory reporting, a 300% increase in reporting of incidence of abuse was obtained (Hailstones, 1992). However, Goudie and Alcott, (in Eastman, 1994) concluded that the introduction of mandatory reporting in parts of the USA have not reduced the incidence of elder abuse.

Hailstones (1992) felt that the major benefits of mandatory reporting are that most cases of abuse against elderly people are brought to the public's attention, and that this helps to make people aware of the problem and to place it on social agendas. Other benefits outlined by Hailstones (1992) are that through bringing the problem to

the attention of the public and government, more resources may be allocated to the amelioration of the problem, and clearer procedures will begin to emerge.

The effects of mandatory reporting are not all beneficial however, and Hailstones (1992) concluded that the negative aspects outweigh the benefits. Some of these negative effects include that it prevents elderly people from making their own decisions, especially about abuse. "It removes their control over their life and endangers their autonomy, dignity and self-esteem" (Hailstones 1992, p.33). Other concerns are that current interventions are not acceptable, and this may cause inappropriate institutionalisation to be used until other actions can be initiated, and that the "problem is not in finding the cases but in doing something about the issue when identified" (Hailstones, 1992, p.33). Data collected in the USA indicates that after mandatory reporting laws were introduced, (and of the cases which have been diagnosed and interventions offered), "50% of the victims were placed in institutional settings. A further 25% received various home supports and another 25% declined any assistance at all" (Goudie and Alcott, in Eastman, 1994, p.236).

One of the underlying problems with the use of mandatory reporting is the difficulty associated with defining elder abuse. Professionals may not be sure what encompasses abuse, and therefore what abusive actions may need to be reported, against those that are not classified as being abusive, and therefore inappropriate to report. Kosberg (1988) concluded that while mandatory reporting may help to raise the awareness of elder abuse within a community, it does not however, "give guidelines for detecting mistreatment in elders, therefore placing the diagnosis of abuse and neglect in the hands of the health care professional" ( p.25).

## **Reasons Why Abuse is Not Reported by Elderly People**

It has been suggested that some elder abuse may be hidden because the older person may prefer to remain in the abusive situation, or does "not know that there may be other alternatives." (Pritchard, 1993, p.29) Some elderly people feel that it may be better to put up with abuse, rather than having to face the indignity of being rendered incompetent, as at times, the aged have been described as having a "so-called chronic brain syndrome" (Kimsey et al., 1981, p.466). This then makes their claims of being abused appear less valid and reliable, and often they are ignored. Some elderly people also have impairments, which restrict them from reporting actual cases of abuse (such as senile dementia or confusion). Other elderly people are reluctant to report abuse by family and or relatives, as they may feel that it is a reflection on them. They are also embarrassed to admit that their son or daughter, or a close relative is abusing them (Kosberg, 1988).

Older persons who are dependent upon others for their care are unlikely to report them, as they may fear reprisal. They also are uncertain of their own future, with regard to who will look after them, and the thought of having to move into institutional care often deters them from reporting cases of abuse. As such, some elderly people feel that they must give excessive loyalty to an abusive caregiver. Additionally, some abuse may occur due to overcrowding of houses, but the elder will not report it due to fear of having to move out of the house, and into institutional living (Kosberg, 1988).

Some elderly people have been past abusers of their children, and they feel that should they report their children for mistreating them, that they will in turn be reported for mistreating their children. On some occasions the only visits an elderly person may receive, are from those who abuse them, and therefore they fear isolation should they report being abused. On other occasions, elderly people may think that the abuse to which they are subject, is just caregiver inexperience, and not deliberate. Additionally, in some cases, the elderly person may be economically reliant on their abuser, and feel that they are not in a position to report the abuser (Kosberg, 1988).

### **Reasons Why Abuse is Not Reported by Professionals**

Elder abuse is often not seen by people outside of the family home, due to the 'family sacrosanct'. Interference to family life by outsiders, be they friends or professionals, is not tolerated. Often the family conspires to ensure that what happens within the home, stays with the members of that household, and therefore often abuse is hidden from the scrutiny of outsiders (Kosberg, 1988).

Elder abuse may also be undetected because of the failure of professionals to identify the problem or to be aware that abuse may have occurred. Even if professionals are aware of the problem, they may fail to report it or to act to intervene and stop it from occurring (Kosberg, 1988). It has been suggested by Haviland and O'Brien (1989) that often professionals, through their lack of understanding that abuse of elderly people actually occurs, may give a misdiagnosis of the problem. While often much of the abuse may be subtle and difficult to detect, this lack of awareness further adds to the reasons as to why abuse is not reported.

Health professionals may often feel that families give elderly people a lot of loving and caring, which is attached to the supporting role they provide. This assumption, while in many cases is true, also "has prevented practitioners from examining those situations that are actually potentially abusive" (Haviland and O'Brien, 1989, p.15).

When practitioners have built up a long-standing relationship with both the victim of abuse and the family, this further places an unwillingness on the practitioner to identify cases of abuse and neglect. Haviland and O'Brien (1989) suggested that "a lack of knowledge of appropriate and effective interventions, and a lack of protocols for systematic assessment and detection further prohibit practitioners from addressing abuse" (p.15). It is important therefore to outline why abuse occurs, so that intervention and effective detection strategies can be developed.

### **General Practitioners**

Pittaway and Westhues (1993) concluded that health and social service agencies can play a pivotal role in uncovering cases of abuse, as "people seek out professional intervention as a result of abuse and neglect" (p.78). Daniels et al. (1989) suggest that general practitioners "are among the first professionals who come into contact with cases of elder mistreatment, yet they are rarely the first to identify it" (p.324). The reasons for this may be that often general practitioners are not informed about abuse, neglect and exploitation of elderly people (Daniels et al., 1989). Rybash, Roodin & Hoyer (1995) also stated that GPs are reluctant to report elder abuse because they have a lack of awareness, "lack of sufficient training, minimal knowledge of the life

situations of their patients, and ageist attitudes" (p.389). In addition, is the perception that medical students receive minimal amounts of gerontological studies through their University training. O'Leary (1996) cites Butler (1980) as estimating that between 10% and 30% of mental disorders which elderly people have, are misdiagnosed by doctors as being untreatable. "The relevant physician assumes that such impairment is to be accepted and with advancing age makes no special effort to rule out reversible disorders" (O'Leary 1996, p.39).

Swagerty, Takahashi and Evans (1999) stated that as GPs may be the only "person outside the family / caregiver role who regularly see the older adult" they are in an ideal situation to detect abuse (p.2). However, for several reasons, GPs may miss cases of abuse, despite their accessibility to elderly persons outside the family home. The reasons for missed cases of abuse include little training in the area; negative attitudes towards elderly people; little information in the medical literature about the area; disbelief that it occurs; reluctant and fear of confronting the offender; and not to break the patient / doctor confidentiality (Swagerty et al., 1999).

At the 1997 World Congress of Gerontology there were some discussions about elder abuse. In overviews presented by Bennett (UK) and Patterson (Canada) of studies which they had undertaken respectively in their countries, over 50% of GPs indicated that they were aware of elder abuse cases. Interestingly, a large majority of the respondents to these studies requested further education and training in the area of elder abuse.

Glover & Woollacott (1992) indicated that GPs consulted "85% of the population at least once in 1989" (p.261). Figures extracted from the Australian Bureau of Statistics National Health Survey (1989-90) highlighted that 2,999,200 out of 5,071,800 people interviewed, went to a GP which represents over 17.2% of the total Australian population.

Dickens, Browning, Jellie, & Thomas (1993, p.1-2), stated that "the older age group are more frequent users of primary health care services than younger age groups." The following figures would support this, as Glover (1992) indicated that the people aged 65 years and over on average had nearly nine (8.9) visits to a GP per year. This is significantly higher than the overall figure for all ages, which was nearly five (4.9) visits per year (Glover, 1992, p.281). More specifically however, people aged 65 and above had a total of 644,600 visits to a GP as opposed to 68,800 visits to a dentist, and 224,800 visits to other health professionals (Australian Bureau of Statistics National Health Survey 1989-90, catalogue No 4376.0, p.4). These figures further strengthen the reason for focusing on general practitioners as the target population for the study. They highlight the fact that doctors' services are the most used health services. Therefore, elderly people see general practitioners more than other health professionals, as well as these workers being more likely to be in contact with elderly people who have been abused.

Through the support of general practitioners, combined with their status and power in society, the issue of elder abuse may gain further momentum. This may lead to increased research, improved reporting procedures, policy development, increased funding, and the development of suitable and increased interventions to be used to



ameliorate the problem. However if general practitioners do not recognise elder abuse, they may be less likely to see it as a major social concern. If this is the case, it would be advantageous to identify why general practitioners do not recognise the problem, as both the current overseas literature and human service professionals, have shown that abuse of elderly people is occurring.

Pratt, Koval & Lloyd (1983) outlined that general practitioners may be able to provide "valuable personal, legal, and medical" support to elderly abused people (p.148). However, general practitioners understanding of the area of elder abuse "and of community resources available to the elderly and their families is a critical determinant of the effectiveness of their interventions" (Pratt et al., 1983, p.148). It is therefore important to identify what level of knowledge general practitioners have in these areas, and what they see as their role. Should general practitioners feel that legal and personal support is not part of their role, then this will have to be addressed by other human service professionals. Additionally, if general practitioners indicate that these areas fall within the rubric of their job, but however do not recognise elder abuse, then this too may need addressing.

## CHAPTER 3

### Methodology

#### Introduction

This chapter presents an overview of the approaches undertaken for the data gathering and data analysis stages of this study. Many arguments can be found throughout the literature to support either the sole use of a qualitative or quantitative research method, while other arguments support a combination of the two methods. Browning et al. (in Minichiello et al., 1992) suggested that the major difference between a qualitative and quantitative methodology, "is what counts as important data and the way in which the research phenomenon is identified for inquiry" (p.186). The area of elder abuse has not yet been widely explored in Australia, and consequently it is relatively unknown in Western Australia, particularly when compared to America. Therefore, to gather in-depth information and to explore the area, primarily a qualitative approach was undertaken. While parts of these data have been gathered through a mailed questionnaire, which is generally aligned to a quantitative approach more so than a qualitative one, the questionnaire has also provided for respondents to answer questions by writing in comments.

By using a mailed questionnaire and a small number of face-to-face interviews with GPs, a wider and in-depth view of the area was obtained. To gain further insight into the area through key informants who were identified as being the people who have knowledge of elder abuse, it was beneficial to use the face-to-face interview process.

Through these predominantly qualitative data gathering approaches, the researcher was able to gather a broader and in-depth exploratory view of elder abuse, both from the perspective of general practitioners and experts in Western Australia.

### **Qualitative Research**

The area of elder abuse is not a new phenomenon within countries such as the United States of America and Great Britain. Subsequently, much of the current research and literature, which is available, emanates from these countries. Australia has not researched the area to the same extent as the United States, because in part, elder abuse is not yet seen as a significant social problem of similar proportions to that of America. While cases of abuse have been identified within Australia, overall the extent, nature, causes, required interventions, and the types of abuse which are occurring in Australia towards elderly people are not clearly documented. A qualitative approach allows for rich and in-depth information to be obtained from which a broader understanding of the area can be obtained. As outlined by Strauss and Corbin (1990, p.19) "qualitative methods can be used to uncover and understand what lies behind any phenomenon about which little is yet known."

Qualitative researchers support the view that:

Particular emphasis is placed on studying and documenting what people know, express and reflect about their subjective experiences and how people give meaning to their situations (Browning et al., in Minichiello et al., 1992, p.186).

This is important with area of elder abuse as there is much conjecture regarding elements such as its definition; the most appropriate interventions to use; the major causes of abuse; and among many other areas, the most common characteristics of the perpetrator and abused person. Each of these areas has been discussed extensively in the overseas literature, and currently there is no one universal answer. Furthermore theories of ageing have been widely discussed within the literature, and many of the theorists have discussed why and how people age, but again, currently there is no one universal or dominant theory which adequately and comprehensively can be used to explain the ageing process.

Essentially, the areas of ageing and elder abuse do not have a dominant theory, which explains their perspective. As mentioned previously, this trend is not unusual, as there tends to be pluralism and diversity of theory across the whole area of gerontology. From using a qualitative methodology for the study, information can be developed from the respondents, which can be used for obtaining a better understanding of elder abuse issues.

It is important that data specific to Western Australia be developed, so that more research in the area of elder abuse can be undertaken, and additionally, so that local people have a more informed overview of the situation in Western Australia. For this to happen, a qualitative methodology was used, and the target populations were limited to the Perth metropolitan area.

**Sample Overview - Source of Samples - Numbers for Sample**

This study had three distinct data gathering areas. They consisted of a mailed out questionnaire to 100 general practitioners, a face-to-face interview with 11 key informants who have specific knowledge of elder abuse, and then five follow up face-to-face interviews with GPs who were initially involved in the mailed questionnaire.

Table 2

Data Gathering Processes

Technique Use To Gather Data	Number
Mailed out Questionnaire	100 sent
Face-to-Face Key Informant Interviews	11 undertaken
Follow Up Face To Face Interviews With Doctors	5 undertaken

The 100 general practitioners were selected from the Western Australian Government Gazette - List of Medical Practitioners. Only those doctors who had their address listed as being within the metropolitan area of Western Australia were selected. If a selection was made which was not suitable because of a residential address (such as someone living in a rural location), then the next available selection was used. The doctors listed in the Gazette had been in practice for a varying number of years, and had received their qualifications from various institutions both within and outside of Australia. Those doctors who had either been granted temporary registration or regional registrations for one year were not included in the study. Additionally, those doctors listed in the Gazette as having a postgraduate or teaching registration also were omitted. The reason for omitting these individuals was that it was not clear as to when their one-year

of registration commenced. Consequently, it was unclear if those listed as being involved in postgraduate or teaching positions were still involved in such roles. One of the problems with the list from which the selections were made, was that it was unclear if those selected were in general practice, or were specialising in another form of medicine. Additionally, it was also not clear if those selected were still currently practising medicine, despite still being listed as registered. This therefore led to some doctors being selected and receiving questionnaires, who inadvertently were not suitable for the study.

The key informant interviews were conducted after the written questionnaires were returned and analysed. The target population for these interviews consisted of human service professionals, who were either involved directly with the 'hands on' care of seniors, or were involved in policy or related areas for seniors. Initially, participants who were selected were known to the researcher through their professional status, although the researcher knew none of them personally. The project was outlined to them through a letter, and a follow up phone call was made to ask them if they would be involved in the study. This strategy has been referred to as a 'purposeful' sampling technique. As discussed by Patton this concept involves selecting "information-rich cases for in-depth study" (1990, p.182). Therefore the actual number and size of the sample depends more on the study purpose, and the quality of information obtained.

Another method used included the use of a 'snowball' strategy in conjunction with the purposeful sampling approach. In essence this allowed the researcher to identify "cases from people who know people who know which cases are information-rich, that is, good examples for study, [and] good interview subjects" (Patton, 1990, p.182). At

the completion of each interview, the respondents were asked if they knew of anyone who had a good knowledge of the area, who they could recommend being involved in the interviews.

While it is acknowledged that these methods do not utilise randomised techniques, and thus can be criticised as having some sampling bias, it was a qualitative methodological approach, which the literature indicated as the most effective method for data gathering in this section of the study. As Patton (1990) suggested the sample size for qualitative inquiry largely depends on what the researcher would like to know, "the purpose of the inquiry, what's at stake, what will be useful, what will have credibility, and what can be done with available time and resources" (p.184). The rich information that was obtained from this method, using a gambit of different Human Service professions, proved to be very extensive. Thus, it allowed for in-depth information about elder abuse and doctors to be obtained from experts in the field, as opposed to undertaking a randomised sample of people who either may or may not have had knowledge of elder abuse.

The final facet of the data-gathering component consisted of interviewing doctors in a face-to-face interview. These individuals were self-selected from the written mail out questionnaire, and five doctors agreed to be involved in these interviews. One question in the initial questionnaire invited the doctors to be involved in a follow-up face-to-face questionnaire. Those responding in the affirmative were then interviewed. This technique again aligns itself with the purposeful sampling technique. It was used in part, to accompany the mailed questionnaire, which while being capable of gathering information from a larger sample size, was somewhat limited in the depth of the

information it gathered. The face-to-face interviews allowed for more qualitative, in-depth and rich information to be gathered. They also provided the opportunity for the researcher to undertake 'member checks' of data gathered in the mailed questionnaire.

### **Age and Gender Criteria**

There were no criteria placed on either the age or gender of any of the respondents within each of the data gathering areas. No attempt was made to obtain an equal number of male or female responses, or data from people either of varying or similar chronological ages.

The mailed questionnaire to the GPs was randomised, and allowed for natural selection of ages and gender. The face-to-face GP interviews were self-selected, and the key informant interviews were based on individual knowledge and experience of elder abuse, using a 'snowball effect' for selection. The important consideration was to obtain 'rich quality' information, as opposed to limiting data sources for the study to specific ages or gender.

A delineating age was required in response to a definition of a senior, and in relation to an individual who had been abused. This was set at a minimum of 60 years of age. There currently is no universal definition of what either chronologically or physiologically constitutes being elderly. The Office of Seniors' Interests (OSI) uses this age for entry into its services. Additionally, the Office of the Family, an organisation that deals with cases of domestic violence, does not accept cases of elder abuse



(people 60+). They refer these cases to the OSI, or work in conjunction with them. Consequently, it was felt that 60 years of age could then be defined as a distinction between what is classified as 'domestic violence' and that which has been defined within some services in Western Australia, as 'elder abuse'.

### **Questionnaires / Schedule Design**

Due to the small amount of research that has been undertaken in the area of elder abuse and neglect in Australia, the researcher primarily developed the questionnaire. Literature which informed this process included Fulmer and Wetle (1986); Wolf and Pilmer (1988); Daniels et al. (1989); Haviland and O'Brien (1989); Delunas (1990); Clark - Daniels et al. (1990); and Holtzman and Bomberg, (1991). Of these research projects, Holtzman and Bomberg's project entitled "A national survey of dentists' awareness of elder abuse and neglect" was the most useful. Some of the concepts and questions from that study were then adapted for the questionnaire used for the doctors in this present research.

The schedule for the key informant interviews, and the schedule for the face-to-face interviews for the doctors, were developed by the researcher, based on the literature. No specific research projects outlined in the literature were used as a focus area for developing either of these schedules.

## Question Design

The question design for the mailed questionnaire was a mixture of knowledge questions, background and demographic questions, experience and behaviour questions, and opinion and value questions. Background demographic questions, are concerned with "identifying the characteristics of the person being interviewed" (Patton, 1990, p.292). Questions one through to seven were related to this area.

Experience/behaviour questions are related to what "a person does or has done"

(Patton, 1990, p.291). They are concerned with extrapolating information regarding what actions, activities, behaviours and experiences an individual has undertaken.

Questions 11 and 16 were related to this area. The opinion and value questions "are aimed at understanding the cognitive and interpretive processes of people" (Patton, 1990, p.291). Essentially they give the interviewer some insight into what the

respondent thinks about an issue. Patton (1990) suggested that this style of question can give information about "people's goals, intentions, desires, and values" (p.291).

Questions 12 - 14 and 18 - 22 address these areas. Knowledge questions refer to factual information, or as Patton describes:

The assumption is that certain things are considered to be known - these things are not opinions and they are not feelings; rather they are things that one knows, the facts of the case (1990, p.292).

The questions that relate to this are nine, 10, 15 and 17. Overall, the questionnaire was designed to provide a mixture of responses to the area of elder abuse from the doctors. All of the questions have been designed to avoid being "double barrelled", and

to ensure that they are not biased. They were designed to be clear, so that the interviewee could understand each question.

Both the key informants' schedule and the doctors' face-to-face schedule were semi-structured, and were therefore open to changes within each interview as required. However, attention was paid to the sequencing of the questions, to ensure that the respondent was comfortable with the interview, and that the more difficult questions were left to the middle and end of the interview. This allowed the respondent to relax and speak about issues in full, without feeling under threat within the interview process. The questions addressed some of the areas outlined above in the mailed questionnaire.

## **Pilot**

The mailed questionnaire was piloted on 10 doctors. A total of nine responses were received, with eight being completed in a written format, and one via verbal feedback. The doctors were known to the researcher (and or his family), and therefore were not randomly selected. The questionnaires were hand delivered to the doctors with a return envelope, and when completed, they were then picked up from the doctors and returned to the researcher. Ten doctors were chosen for the pilot sample, as this represented a figure of 10% of the 100 doctors randomly sampled for the overall study.

The feedback from the pilot study proved invaluable, and caused the remodelling of some of the questions. It was generally stated that open-ended questions would take the doctors too long to complete, and this would therefore reduce the overall return

rate. Based on this feedback, some of the questions were redesigned. Predominantly the actual question remained the same or very similar, but options for the respondent to choose from, to replace the open-ended answer were included. This subsequently reduced the amount of time required to complete the questionnaire, as some of the questions then only required a tick or number to be placed in the appropriate box, as opposed to a more detailed written reply. This changed the format of the methodology for the study, from being totally qualitative, to using a 'closed' questionnaire. However scope was left for the inclusion of additional responses by the respondents, if they desired, therefore not totally closing off all questions.

One doctor in the pilot study suggested that a reward should be placed in with the questionnaires, in an endeavour to increase the return rate. It was suggested that a 'scratch and match' lotteries ticket or a pen be included in with the questionnaire. It was decided that the former should be included, and therefore a lottery ticket was placed in each envelope with each questionnaire.

Feedback from the questionnaire was also received from two academic personnel who were not related to the study in any form, and also from a senior person within a large human service organisation. In the main, their feedback suggested that the questionnaire should be 'closed off', so that coding of the questions could be done for the processing stage of the data, and also to ensure that the questionnaire was not too long and time consuming.

After receiving the pilot questionnaires back, questions one through to seven remained the same. In the pilot study, question eight asked for a definition of elder abuse. This

question was removed, and replaced with an overall definition of elder abuse/neglect from which the respondents could be guided for their responses. This had the advantage of ensuring that each of the answers could then be grouped together, by allowing the researcher to 'compare apples with apples.' Essentially, each response was then guided by a definitional set of boundaries, which clearly stipulated elder abuse and neglect, as opposed to each respondent giving a different answer, which would then make it difficult to compare the responses with each other.

Changes were made to the questionnaire based on suggestions made from feedback on the pilot questionnaire. Questions 11, 12, 14, 15, 16, 17, 20, 23 and 24 in the final questionnaire were the same as that presented in the pilot study. The final questionnaire was reduced to a total of 24 questions, as opposed to the 27 questions in the pilot study. It is important to note, that because of the removal of some questions from the pilot study, the question numbers in each questionnaire (those being the pilot and the final) did not correspond.

Neither of the schedules for the key informants or the doctors' face-to-face interviews was piloted. While the questions for each schedule were developed by the researcher, because the interviews were not just limited to the questions on the schedule, it allowed for flexibility in the interviews and for people to talk about ideas and thoughts which were broader than those listed on the schedules. Additionally, the schedules allowed the researcher to seek immediate clarity on responses given by those interviewed, and also to refocus the respondent if they did not clearly understand the question being asked.

## **Instruments Used for Data Collection**

The mailed questionnaire was chosen for its practicality and resource advantages for the interviews with the doctors, as opposed to the other methods, such as the telephone interview or face-to-face interview. Due to the time it would take to interview 100 doctors in a face-to-face interview, this method was deemed to be impractical by the researcher. Further complications included that the doctors were scattered throughout the Perth metropolitan area, which would have further increased the time required to undertake face-to-face interviews on a wider scale. As the researcher was also working full time in conjunction with undertaking this study, time was at a premium. Furthermore, as it was also necessary for the questionnaire to reach a larger volume of people, the most practical method of doing this within the constraints mentioned was through the mailed questionnaire.

Of equal consideration was the fact that doctors are busy people. Information fed back through the pilot questionnaires, clearly indicated that GPs would be less likely to become involved in an extended face-to-face interview or a written open-ended questionnaire, which are both time consuming, and that the GPs would be more likely to complete a closed questionnaire. While mail questionnaires do have a low cost associated with them both in terms of data collection and processing, they are also able to reach a widely dispersed group of people. They also have the capacity to ask many questions in a short period of time. Due to GPs being the target sources of this section, there were no issues regarding literacy and the ability of the respondents to be able to complete the questionnaire.

Despite the fact that the mailed questionnaire is time effective and cheap, it too has some limitations. The major criticism of this approach to data gathering, is that it "is essentially inflexible, there is no opportunity to probe for further information, to clarify an ambiguous answer, or help a respondent to understand the meaning of a question" (ABS 1984, p.8 in Wright, 1988, p.43). Other disadvantages include a low response rate that creates bias, no chance for respondents to seek clarity on questions and a lack of opportunity for the researcher to check on incomplete questions. Patton (1990) further criticised this approach by adding that the limitation of such a data gathering technique is that the "respondents must fit their experiences and feelings into the researcher's categories" (p.289). This may then limit the possible responses given to each question. To reduce the impact of this tendency, the questionnaire was designed with the option of the respondent being able to add to the lists of possible responses.

It has been acknowledged that the personal interview is an effective instrument for data gathering. It allows for greater depth and probing by both the interviewer and the interviewee, and for this reason, it was chosen as the preferred instrument for the face-to-face interviews with the doctors and with the key informants, although it too has some limitations. Rossi and Freeman (1989) suggested that some of these limitations included misinterpretation, the expensive involved in reaching a widely dispersed population, and that it is time consuming both in undertaking the interview and analysing the data.

Patton (1990) however suggests that the major benefit of such an approach is that it allows the interviewer to fill in the gaps that may be obvious in the data by asking

relevant questions. Additionally, "the outline increases the comprehensiveness of the data and makes data collection somewhat systematic for each respondent" (Patton, 1990, p.289). However Patton (1990) too, outlines limitations with the use of the face-to-face interview. These include the possible omission of relevant topics, and the potential for inconsistency in the wording of questions and their sequences, that may inadvertently result in the responses from different people varying, thus reducing their comparability. To reduce this problem, schedules for both face-to-face interviews (key informants and doctors) were developed, and the questions were asked from this format, in a consistent and pre-determined sequence, although this was only treated as a guide, and further questions were asked during interviews.

This is relevant to both the face-to-face interview process, and the mailed out questionnaire. However, due to the limited scale of this project and financial considerations, it would have been difficult for this researcher to undertake extensive fieldwork observational data gathering. It may also cause ethical concerns, particularly in relation to doctor / patient relationships, and also with confidentiality issues with some of the key informants.

### **Collection of the Data**

Each mailed questionnaire was coded with a number, to identify which of the doctors had responded to the questionnaire, and to help with identification for the follow up letter. Each questionnaire had a covering letter outlining the purpose of the study. In addition to the lottery ticket, which was included to increase the response rate, each envelope was individually typed using a label, and every covering letter was personally



addressed to the doctor. Enclosed with each questionnaire was a self-addressed envelope, with a reply paid address and a sticker in the top corner of the envelope stating that no postage was required. The doctors were given a two-week period to respond to the questionnaire.

At the end of this period, those doctors who had either not responded to the questionnaire, or had not contacted the researcher were then sent a follow up letter. Some 54 follow up letters were mailed, again with the envelope of each being type in each doctor's name and address, and the letter being personally addressed and typed. The doctors were given a further two weeks to respond to the questionnaire. A total of six (6) further responses were received, which provided a total response rate of 32%.

With the key informants' interviews, the researcher wrote a letter inviting them to become involved, and then made a follow up phone call. A date, time and location were then set with the key informant for the interview to be held. An overview of the study area, while given in the initial letter, was also discussed over the phone with the key informant, so that they were able to think about the interview prior to it being held.

A similar method to that used for the key informant interviews was used for the doctors' face-to-face interviews. However, due to the fact that they had already responded to the mailed out questionnaire, it was not as important to outline the study in detail in the letter.

## Data Analysis

The responses from the mailed questionnaires were analysed by adding the number of responses given to each question, against the response given. These are presented in the data through frequency tables and in written discussions. Responses given to the open ended-questions were also presented in the analysis, often in a verbatim format. If more than one doctor wrote the same general response, then they were either summarised, or one response was presented to provide the reader with an outline.

The data from the face-to-face doctor interviews and the key informant interviews were transcribed verbatim from the taped recordings. These two sections of data were then analysed separately. The data were assessed by looking for consistent regularities from each response made, therefore the data were analysed using a cross-case analysis. As outlined by Patton:

If a standardised open-ended interview is used, it is fairly easy to do cross case or cross-interview analysis for each question in the interview. With an interview guide approach, answers from different people can be grouped by topics from the guide, but the relevant data won't be found in the same place in each interview. The interview guide actually constitutes a descriptive analytical framework for analysis (1990, p.376).

From this analysis, patterns emerged in the data from which themes were developed. The themes were a combination of indigenous concepts, which Patton describes as

the "elucidation of a key phrase or terms used" (1990, p.390) in the data, and sensitising concepts, which are "concepts that the analyst brings to the data" (p.391).

To ensure that relevant data from different questions were included in the analysis, recurring data were highlighted, and notes made in the margins of the transcripts, to ensure that the analysis was comprehensive. To assist the reader to understand how the themes emerged, and to allow for generalisation by the reader, direct data have been included in the analysis. As suggested by Patton "by presenting respondents in their own words and reporting the actual data that were the basis of interpretation, [it] permits readers to make their own analysis and interpretation" (1990, p.392).

### **Credibility**

The data analysis has been outlined above to assist with the credibility of the study. Additionally, to ensure that the findings are accurate and representative of the data obtained, quotes from the respondents have been included throughout the analysis chapter. This also allows the reader to identify how the researcher developed the emergent themes from the data.

Patton (1990, p.372) suggests that there are no:

"Straightforward tests for reliability and validity. In short, there are no absolute rules except to do the very best with your full intellect to fairly represent the data and communicate what the data reveal given the purpose of the study."

Throughout the analysis of the data, there have been efforts made to look for rival or competing themes and explanations to the themes developed. These techniques have been undertaken, to demonstrate to the reader that the researcher was not "driven" by one perspective, or that he held predetermined views while analysing the data.

To further increase the reliability and validity of the study, various sources of information were sought. These included 11 individual key informants, feedback from doctors, and literature on the topic area. Additionally, varying methods of data collection were used, including face-to-face interviews, mailed questionnaires and numerous sources of literature.

In relation to sample the sample size for this study, Browning, Kendig and Minichiello suggested that:

"The process for selecting cases must allow for some degree of flexibility and openness to enable the investigator to make the most of data which arise from fieldwork. This suggests that sampling is cumulative and dependent upon categorise which have been justified as relevant" (in Minichiello et al, p.188-189).

This study is exploratory in nature, and has been designed to look at the area of elder abuse from the perspective of key informants and GPs. It is not expected to be generalisable to other studies, but focuses on providing an insight to the area. Given the minimal research undertaken in Australia relating to elder abuse, and some of the inherent problems associated with the area such as definitional limitations, the study

has been based on an exploratory approach. Both the data collected and the sample size have allowed the researcher to achieve this outcome.

To assist with 'triangulation' a purposeful sample was chosen for the key informant interviews. As suggested by Rossi and Freeman (1989) qualitative approaches are able to obtain rich information on the area under study, as this was achieved through the purposeful sample approach. Additionally, through using three means of data collection, multiple perspectives on the topic areas were obtained. Through the face-to-face follow up interviews with the doctors, member checks were also made, which allowed the researcher to ensure that the interpretation of the responses in the mailed questionnaire, were in fact what the doctors had indicated. As outlined by Loesch and Wheeler (1982) triangulation is obtained when three separate but related pieces of information are considered for analysis.

## **Summary**

This chapter has endeavoured to give the reader an opportunity to trace the steps and decisions made by the researcher during the study. The results of this study are not intended to be generalisable, but may inform or allow the reader to make personal generalisations to other studies or similar areas. The information provided in this chapter should assist this process, while also assisting the reader to make judgements regarding the validity and credibility of the study.

## **CHAPTER 4**

### **Data Analysis**

#### **General Practitioners' Perceptions of Elder Abuse - Responses to the Mailed Questionnaire**

##### **Introduction**

This chapter focuses on the GPs' perceptions of elder abuse. The purpose of this section of data collection was to gather a general overview of GPs awareness and views of the area of elder abuse and neglect. One hundred questionnaires were sent out, to which there was a 26% response rate. A follow up letter was sent to the non-respondents from the initial mail out, which generated a further six returned questionnaires. This gave a 32% response rate to this section of the study. While the response rate was low, it was only originally intended to obtain 30 responses, because it was anticipated that it would be a long drawn out process to try to obtain more. While overall it was a low response rate, it met the original target of 30 as intended by the researcher. It is acknowledged that these results may affect the validity of this section of the study, however the results of this study were not intended to be generalised across the broader GP population.

##### **Characteristics of GPs**

Of the 32 respondents in the survey, 23 (72%) were male and nine (28%) were female (refer to table 3). The majority of the respondents (24) were between the ages of 31 and 50. There were two respondents who were under the age of 31 as outlined in Table 4.

Table 3

Gender of participants

Gender	Number of Responses
Male	23
Female	9
Total	32

Table 4

Age of participants

Age	Number of Responses
23-30	2
31-40	15
41-50	9
51-60	4
61+	2
Total	32

Information outlining years in practice was important as it provided a gauge of the respondents' level of experience. This could not be obtained solely through having information on age, however, as an individual may have been a mature age student, or

may have also left the profession for a period of time. Additionally, the information provided a gauge in regards to the length of time since they had left university, which is important in terms of training in the area of elder abuse. Table 5 indicates that the majority of respondents (34%) have been in practice for between six-ten years.

Table 5  
Number of years that respondents have been in practice

<u>Number of Years</u>	<u>Number of Responses</u>
1 - 5	4
6 - 10	11
11 - 15	4
16 - 20	5
21 - 25	2
26 - 30	4
31 or more	2
Total	32

The majority of respondents (23) undertook their medical training in Australia. The remainder undertook their training in the United Kingdom (4); Ireland (3); Italy (1); and Singapore (1). The origins of training are listed in Table 6.

Table 6  
Country of medical training

<u>Country</u>	<u>Number of Responses</u>
Australia	23
United Kingdom	4
Singapore	1
Ireland	3
Italy	1
Total	32



Table 7 presents the type of practice, which GPs worked in. Twenty-three were in multiple and eight were in solo practice.

Table 7

Type of practice in which the general practitioners worked

Type of Practice	Number of Responses
Solo practice	8
Multiple practice	23
Other	1
Total	32

The majority of respondents (18) worked in practices that had communities of 9000 people or more, as can be seen in Table 8.

Table 8

Size of the communities in which the doctors practice

Size of the Communities	Number of Responses
1000 and under	1
1001-3000	4
3001-6000	7
6001-9000	1
9001 +	18
Not answered	1
Total	32

GPs were asked to estimate how many of their patients were over the age of 60. The majority (22) responded that they had less than 25% of their patients over this age.

### **Summary of Characteristics of GPs**

Most respondents in this section of the study were male (72 %), and 26 of the respondents were between the ages of 31 and 50. A relatively high number (11) of the GPs had been in practice for six to 10 years with 23 having undertaken their medical training in Australia. Twenty-three respondents were in a multiple practice, and 18 had a practice with in excess of 9000 people attached. A total of 22 respondents indicated that one quarter or less of their patients were 60 years of age or older.

This information provides a valuable basis for the following section of data. It outlines the level of experience that the GPs have, as well as the size of their practices, with the majority indicating that they have over 9000 people. They therefore have an increased chance of coming into contact with an elderly person who may have been abused, although indications are that less than one quarter of their patients are 60 years of age, and a high percentage work in a multiple practice.

A large majority of the respondents indicated that they undertook their university studies within Australia, which assists with identifying the level of training which Australian universities have given to the area of elder abuse. This can be further explored, when one considers the age levels of the respondents and their years of practice, which provides a sample of the level of training which practitioners have had in the area, not only prior to graduating, but also since graduating.

## **Elder Abuse and GPs**

The remainders of the questions in the survey were directly related to the area of elder abuse. To ensure some uniformity of responses, and to allow for data to be compared, it was important that a common definition of elder abuse and neglect was used. For the purpose of this study, the following definition was provided on the questionnaire. The reason for providing a clear definition in this segment was so that all respondents were working within the same conceptual boundaries, and therefore the responses from each individual could then be compared to each other.

The definition provided was:

Elder abuse / neglect is the wilful infliction of physical pain, injury, or debilitating mental anguish, unreasonable confinement, or deprivation by a caregiver of services that are necessary to maintain mental and physical health for someone over 60 years of age (O'Malley et al., 1983).

## **Frequency of Elder Abuse and Neglect**

When GPs were asked the question "How often they perceived abuse or neglect occurring when they witnessed physical injury" four responded usually; eight occasionally; 19 rarely; and one never. These results are stated in Table 9.

Table 9

Frequency with which doctors considered the possibility of elder abuse for patients 60 years of age and over

<u>Number of Times</u>	<u>Number of Responses</u>
Usually	4
Occasionally	8
Rarely	19
Never	1
Total	32

The above data show that the majority of GPs rarely consider injury being caused by abuse, with the next highest response being that they ‘occasionally consider it’ as a possibility. This information indicates that elder abuse is not always carefully thought about as a cause of injury when elderly people have a medical consultation, although one doctor indicated that usually he applied ‘the same ideas as non-accidental injury in children’.

**Suspected Elder Abuse**

In answer to the question on the number of cases that GPs suspected in the previous 12 months, 18 recorded a nil response, while 14 mentioned between one and five cases. These frequencies are listed in Table 10.

Table 10

The number of suspected elder abuse / neglect cases which doctors have treated in the past 12 months

<u>Number of Cases</u>	<u>Number of Responses</u>
0	18
1 - 5	14
6 - 10	0
11 - 15	0
16 - 20	0
Over 20	0
Total	32

Although the number of cases suspected through this sample was relatively small, it does provide a clear indication that elder abuse is evident within the community.

### **Type of Abuse**

The 14 respondents in Table 10 above, who had suspected situations of abuse, were asked to specify the types of abuse they had witnessed. The responses showed that physical aspects of abuse and neglect (combined) were the most prominent, along with psychological abuse and neglect, which was also noticeably high. Collectively, they constituted almost two thirds of the recorded cases treated by GPs in the past 12 months as listed in Table 11.

Table 11

Types of abuse doctors have treated in the past year

Types of Abuse	Number of Responses
Physical abuse	4
Physical neglect	9
Material abuse	2
Financial abuse	4
Psychological abuse/neglect	7
Exploitation	2
Number of responses	28

**Suspicious of Elder Abuse**

The respondents were asked to indicate if there were ever any times that they strongly suspected a patient as being abused, but had not spoken to the patient about this. Of the responses given, four indicated that this was the case, and 28 suggested that it had not occurred. Of the four who indicated that it had happened, three supported their responses with the following remarks. One doctor suggested that abuse had happened because the elderly person was institutionalised and not being cared for by his relatives. A second doctor responded by saying that the issue of abuse was not pursued 'due to the patient's mental status'. The third doctor provided the following statement::

I suspected wife-beating husband - [they] are in a closely supervised situation and [these] patients see me regularly, and [the] problem seems to have resolved itself - [I] alluded to problem and got a very quick denial! [The] problem stopped after that.

Although it is a small number of responses, these four doctors outlined above have indicated that they did not address the issue directly, although they were aware that abuse was occurring. What is not clear however, are the length of time over which the abuse had been occurring, and the extent of the abuse. However, when considered with

the results in Table 12 below, it is apparent that on the majority of occasions in which abuse has occurred, doctors have spoken to the patient about the issue.

Table 12

Occasions when doctors have strongly suspected elder abuse / neglect but have not spoken to the patient

Are There Occasions When This Has Happened?	Number of Responses
Yes	4
No	28
Total	32

**Identification of Abuse**

The doctors were asked to indicate if they felt that there was anything that may restrict them from identifying a case of elder abuse. Some 23 doctors reported that they felt there were restrictions on the identification of abuse, while nine indicated that there were no restrictions. The results are listed in Table 13 below.

Table 13

Constraints on a doctor in identifying a case of elder abuse / neglect

Response Given	Number of Responses
Yes	23
No	9
Total	32

Responses given for the restrictions included that patients were not forthcoming, or perhaps not mentally capable of informing their doctor due to dementia or delirium. Other reasons included social pressure, and the patient not being able to tell their doctor about the problem due to physical limitations and also for fear of neglect or reprisal.

GPs were also concerned about the likelihood of offending carers where the suspicion was not correctly founded. Other limitations identified by the doctors included having a lack of history regarding the patient, dealing with denial from the patient that abuse occurred, and concealment by the carer. Many of these responses are consistent with those presented in the literature. However one interesting restriction not mentioned, was a lack of knowledge of the area of elder abuse and neglect by the doctors, or the finding that they lacked experience in identifying cases.

### **Restrictions on Interventions**

Respondents were asked to indicate from a given list, which circumstances may restrict a doctor from intervening in a case of elder abuse. The most prominent circumstance identified was the uncertainty of the cause of the problem (19), which is consistent with the responses given above. Other feedback included legal concerns, cultural differences and lack of personal training in the area as stated in Table 14.



Table 14

Circumstances which may restrict a doctor from intervening in a case of elder abuse / neglect

Type of Circumstances	Number of Responses	Percent	Rank
Uncertainty of the cause of the problem	19	27.0	1
Lack of personal training in elder abuse / neglect	13	18.6	2
Cultural differences	12	17.1	3
Legal concerns	10	14.3	4
Lack of appropriate interventions	8	11.5	5
Time consuming	6	8.5	6
Objection from patient	1	1.5	7
Uncertainty of diagnosis and difficulty of proof	1	1.5	7
Total number of responses	70	100%	

If GPs are not certain about the cause of the problem, then there is the potential that cases are not being adequately identified. This could be addressed through increased training within the area, so elder abuse can be properly identified, and appropriate interventions can also be applied as required.

**Mandatory Reporting**

There were no clear indications within the data that the reporting of elder abuse cases should be mandatory. The three options proposed consisted of, “Should be”; “Should Not Be”; and “Don’t Mind”. Twelve respondents indicated that it should be mandatory, 13 felt that it should not be, and seven were in the “Don’t Mind” category. This is similar to responses outlined in the literature, which do not clearly support one view more than another does. The responses are detailed in Table 15.

Table 15

Mandatory reporting of cases of elder abuse / neglect

Type of Response	Number of Responses
Should be mandatory	12
Should not be mandatory	13
Don't mind	7
Total	32

One respondent who supported mandatory reporting suggested that it might act as a deterrent, stating that:

Any abuse causing ill health to an individual should be dealt with. It is the only way to explore possible cases which can be proven or disproved; and it should be mandatory so as to remove the legal constraint while also encouraging an official response to the problem.

Other respondents suggested vulnerable people must be protected regardless of their ages, and that mandatory reporting could improve the awareness of the problem both within the community and governmental arenas.

Those who rejected mandatory notification provided the following comments. One suggested that abuse might be able to be dealt with in the family home system. Another suggestion was that reporting the cases should not be mandatory unless the situation were life threatening, while one doctor indicated that with mandatory reporting, the diagnosis rate would fall and the diagnosis would be 'masked' as something else.

**Interpretation of Abuse**

The GPs were asked whether their professional association provided a clear-cut definition of elder abuse and neglect. Three doctors indicated that there was such a definition, 14 suggested that there was not, and 15 did not know. While there is clearly some indecisiveness in this area, interestingly, nearly half of the respondents did not know if any definitions existed or not, (as can be seen in Table 16). This may have a relationship to the difficulties some doctors referred to in the identification of suspected cases of abuse.

Table 16

Professional association definitions of abuse

Are Clear Cut Definitions of Elder Abuse / Neglect Given by Your Profession?	Number of Responses
Yes	3
No	14
Don't know	15
Total	32

Literature focussing on elder abuse has identified poor definitional consistency as a significant problem associated with the area in general. This limitation is also apparent from the GPs surveyed within this study, and would further inhibit their ability to assess the problem accurately.

**Difficulties With Assessment**

Doctors were asked whether there were any difficulties associated with accurately assessing whether an elderly person had been injured as a result of abuse or neglect. As outlined in Table 17, 26 doctors reported that there were problems with this type of assessment, while six felt that there were no problems.

Table 17

Assessing an injury

<hr/>	
Difficulties Assessing an Injury	Number of Responses
Yes	26
No	6
Total	32
<hr/>	

Several GPs took the opportunity to further articulate their answers which ranged from dementia and denial, through to elderly people being more likely to bruise and suffer from lacerations. This was seen to have a direct relationship to GPs ability to identify the problem and provide accurate assessments and interventions.

**Relationship of Medical Education to Abuse**

The doctors were asked if they were given training in the area of elder abuse during their university studies. A strong majority (30) recalled that they were given no training, while two doctors indicated they received training. One doctor commented that no one ever-mentioned elder abuse, nor was it a recognised entity when he undertook his university training. The responses are detailed in Table 18.

Table 18

University studies and training in the elder abuse / neglect

<u>Training At University</u>	<u>Number of Responses</u>
Yes	2
No	30
Total	32

The data strongly suggest that the are of elder abuse has not been a prominent and consistent component of academic training for GPs.

**Likely Causes of Abuse and Neglect**

From a given list, the doctors were asked what they thought were the most likely causes of abuse and neglect, and to list the three priority causes. Six doctors felt that the abuser with a substance addiction was a major cause, while another six indicated that inadequate interventions available for the abuser to utilise, was a major cause.

Using an aggregate system, where the first preference is given three points, the second is given two, and third preference is given one point, the following Table was developed.

The most likely causes of elder abuse and neglect were identified as the abuser having a substance addiction, followed by abuser having financial concerns, and thirdly a lack of adequate interventions for the abuser to utilise. Other prominent causes included marital problems, learned behaviour from childhood, and the abuser having dementia. Table 19

below presented these results. These concerns are also prominently discussed through the literature, and are seen as some of the likely reasons why elder abuse occurs.

Table 19

Most likely causes of elder abuse / neglect

Causes	Preferences				Rank
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	Agg	
*Abuser has a substance addiction	6	6	4	34	1
*Abuser has financial concerns	5	5	7	32	2
*Inadequate interventions available for abuser to use	6	4	1	27	3
*Marital problems	3	4	5	22	4
*Learned behaviour from childhood	2	3	5	17	5
*Abuser has dementia	2	2	3	13	6
*Abuser frustration/anger and permanent disorder	1		3		7
*Possible abuse due to relative or carer's tiredness after years of caring under difficult circumstances	1		3		7
*Behaviour of the elderly may be intolerable and cause the carer to reach breaking point		1	2		10
*Lack of knowledge		1	1		11
*Lack of support and respite services available for elders and their abuser		1	3		7

(n=26)

**Vulnerability to Abuse**

The doctors were asked to rank the likely characteristics of someone who was vulnerable to elder abuse. Number one was seen as their first priority, through to number three, which was seen as the third most important characteristic.

In these doctors' perceptions the most prominent characteristic associated with an elderly person vulnerable to abuse was dementia. This response was ranked number one by 19 doctors. Again using the aggregate system, where the first priority is given three points through to the third priority which is given one point, it is clear that dementia is the most important characteristic identified by the doctors. Although not listed in Table 20, within the questionnaire, there were also other categories, such as financially secure, being single; and being married. However, no respondents felt these were significant considerations.

Table 20

The most common characteristics of an elderly person vulnerable to abuse

Characteristics	Preferences			
	1st	2 <sup>nd</sup>	3 <sup>rd</sup>	Ag/t
Dementia	19	1	5	66
Physical problems	1	15	6	41
Poor communication	3	4	8	28
Substance abuser	3	3	2	17
Limited finances	1	2	4	13
(n=28)				

**Witnessing Abuse**

When asked if doctors would be likely to see more elderly individuals who have been abused than any other helping profession, 23 doctors indicated that this would be the case, while nine felt that this would not be the case. Of interest, one doctor suggested that often abuse goes unnoticed because the problem does not present during consultation. The results are shown in Table 21 below.

Table 21  
Perceived likelihood of doctors seeing more abused individuals than other professions.

Likelihood Of Seeing More Abused Persons	Number of Responses
Yes	23
No	9
Total	32

Given that a majority of respondents (23) indicated that GPs were more likely to see an individual who had been abused more so than other helping professions, the role which they see themselves undertaking during consultation was important to identify.

**Preferred Roles in Relationship to Abuse**

GPs were asked to indicate which of the roles outlined below, they felt a doctor could play in the area of elder abuse. Table 22 highlighted that the two most prominent roles identified were treatment of physical and mental illness, and referrals to other agencies. The third most important role identified was that of counselling.



Table 22

Roles that doctors can play

<u>Type of Role</u>	<u>Number of Responses</u>
Assistance with treatment of physical and mental illness	28
Referrals to other agencies	28
Counselling	23
Legal intervention	4
Financial advice	2
Advice	1
(n=32)	
* multiple responses	

GPS are well qualified to meet the physical treatment areas of patients, however without a clear understanding of the area and an ability to identify abuse; referrals to other agencies may be somewhat limited. Despite this, it is still a strong and effective role that GPs can provide to abused patients, and therefore an effective intervention to use.

**Desirable Interventions**

Doctors were asked to suggest which interventions would be the most useful for their profession to use. Again they were asked to rank the interventions in order of importance, with one being the highest priority. The most important intervention was seen to be a referral to another agency, with the next most important intervention being the use of respite care and counselling. In total, there were 27 responses to this question, and the results are listed in Table 23 below.

Table 23

Useful interventions for doctors to use in the area of elder abuse / neglect

Type of Intervention	Preference			
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	Agg
Referral to community agency	9	7	6	47
Respite care	7	8	7	44
Counselling	7	6	5	38
In home health aide	2	4	4	14
Hospitalisation	1	2	4	11

(n=27)

**Discussion**

The above section of data addresses the awareness and views of GPs in regard to elder abuse and neglect. This discussion section will relate the results to literature written in this area, and provide a conclusion.

The results of this chapter identified some interesting findings. Of the 32 doctors involved in the survey, 24 received their training within Australia. However, 30 of the 32 doctors indicated that they received no training in the area of elder abuse during their university studies. Further it is more apparent that those doctors who participated in this study, graduating from an overseas university, also received no training in elder abuse and neglect.

The findings from this study, that GPs do not receive training specific to the area of elder abuse and neglect, supports the opinions of Daniels et al. (1989, p.322). They suggested that doctors are rarely the first to identify cases of elder mistreatment, because they are

not informed about abuse, neglect and exploitation of elderly people. Brewer and Jones (1989, p.1221) indicated that the first step "in preventing elder abuse and neglect is to increase the levels of awareness and knowledge" among physicians. Kurrle (1993) also argued that training in the area of elder abuse and neglect is important. She suggested that the best form of intervention is prevention, but "specific education and training for all health care professionals working with the elderly will be necessary for this to occur" (Kurrle, 1993, p.9).

The lack of awareness about the area of abuse and neglect by the doctors who responded to this study, is further highlighted from the results of Table 9. Some 19 respondents indicated that they rarely consider the issue of elder abuse, when an elderly person who has signs of physical injury enters their surgery. This would support the view that there is an apparent lack of training and awareness within the area.

Conversely however, and despite the view of Kosberg (1988) who suggested that even if professionals are aware of the problem, often they fail to report it or to act to intervene and stop it from occurring, however this would not appear to be the situation with this study. Only four doctors out of 14 who indicated that they had treated cases of elder abuse recently, outlined that they did not address the issue when they suspected that it was occurring. What this does indicate however, is that elder abuse is occurring without detection.

Dementia and altered mental state either in the carer or the elderly person were prominently identified as causes of elder abuse. Table 20 in particular, demonstrated that doctors felt dementia was the most common characteristic of an elderly person's

vulnerability to elder abuse. Therefore, an association with elder abuse and dementia could be suggested, and with the rising incidence of dementia, it is possible that the cases of elder abuse could also increase.

This view is supported by Cahill and Sharpio (1993), who noted that if the number of elderly people with dementia in Australia rises as predicted, then "it seems likely that behavioural problems associated with the disease will manifest with increasing frequency" (p.10). Therefore, not only is there concern about the prevalence of dementia, but also the fact that it has direct relevance to the area of elder abuse and neglect, with respect to both the elderly person who may be abused, and also the elderly caregiver.

According to the respondents, dementia can also impact on a GP's ability to identify cases of abuse and neglect through a patient's inability to provide clear case histories. However, Cahill and Sharpio (1993, p.14) suggested that "service professionals should be made more aware of the potential for violence in dementia caring arrangements" and also that "educational programs need to be developed, which aim to assist primary caregivers..." (p.13).

Mandatory reporting of elder abuse is another important issue to emerge from these results. Within the literature there are varying opinions with regard to whether reporting cases of abuse and neglect should be mandatory. The responses obtained from doctors in this study are as ambiguous as the literature. There were no clear trends within the results, as 12 respondents suggested there should be mandatory reporting, while 13 felt that it should not be mandatory, and seven didn't mind. Hailstones (1992) stated that the major benefits of mandatory reporting are that most cases of abuse against elderly

people are brought to public attention. Such reporting helps to make people aware of the problem and to place it on social agendas. Hailstones (1992) further suggested that through this public exposure, resources could be allocated for the amelioration of the problem, and clearer procedures about dealing with the issue could be developed.

Kosberg's (1988) views were similar to those of Hailstones (1992), as he suggested that mandatory reporting might help to raise the awareness of elder abuse within a community. However, mandatory reporting according to Kosberg (1988) does not provide "guidelines for detecting mistreatment in elders, therefore placing the diagnosis of abuse and neglect on the hands of the health care professional" ( p.25).

While acknowledging the benefits of mandatory reporting, Hailstones (1992) is of the view that the negative aspects outweigh the benefits. Some of these concerns include the unacceptable nature of existing interventions. She noted that the "problem is not in finding the cases but in doing something about the issue when identified" (p.33). This view was also supported by some of the doctors, where it was indicated that inadequate interventions were seen as a disincentive to intervene in a case of abuse. While the area of mandatory reporting may need further debate, the results of this study, are congruent with the current literature.

A majority of the responding general practitioners indicated there were difficulties associated with accurately assessing whether an injury to an elderly person resulted from abuse, or if in fact it occurred as a result of an accident or another cause. Despite this, almost half of the respondents indicated that they favoured the mandatory reporting of abuse. This might suggest that doctors could report cases of abuse if it became

mandatory, without having a clear assessment of the cause of the injury. Additionally, cases may either go unreported, or alternatively, cases may be reported which have been wrongly diagnosed. This could impact on several areas, including the doctor - patient relationship; the professionalism of the reporting doctor; and the agency to which the abuse is reported. If mandatory reporting were to be introduced, effective training for GPs would need to be undertaken.

This view is supported by McCallum (1993), who suggested that the identification of abuse should have two primary foci, those being to "prevent abuse where it truly occurs; and to avoid incorrect assessment of abuse" by professionals (p.3). Therefore, it is important that if mandatory reporting is ever introduced and GPs are involved in it's reporting, that they have the necessary skills, knowledge and awareness to undertake the task.

Several causes of elder abuse were identified in the doctors' responses in this study. The primary causes stated was that the abuser had a substance addiction, the abuser having financial concerns, and inadequate intervention available for the abuser to use. While the literature does not clearly identify any one element as the major cause of elder abuse, all three of the causes cited by the doctors were discussed by varying authors. O'Malley (1983), Godkin (1989) and Delunas (1990) supported the view that external stressors such as financial problems and substance abuse can be a likely cause of elder abuse. Toseland (1989) and Schultz and Schultz (1990) suggested that the demands placed on caregivers can outweigh the resources they have, and this can lead to caregiver stress, especially if satisfactory interventions are not available. GPs must therefore become more

aware of elderly people in caregiving situations, and ensure that they have the necessary skills and support required to maintain their role as a caregiver.

When asked to outline circumstances that may restrict a GP from intervening in a case of abuse, doctors indicated that uncertainty about the cause of the problem was the biggest restriction. Importantly, the second highest restriction was identified as a lack of personal training in the area of elder abuse and neglect. Lack of training and a lack of clear guidelines about elder abuse and neglect were areas that were both identified in the results. This may account for a low overall knowledge of the area by GPs. As well as relate to GPs having a poor understanding of the cause of the problem when patients enter their surgeries.

Nearly all of the doctors indicated that to their knowledge their professional body gave no clear-cut definitions of elder abuse, or that they did not know if their professional body provided any. Without clear guidelines doctors may not know what constitutes abuse and neglect and what does not. This would not only impact on their ability to diagnose cases, but also on their level of awareness.

When doctors were asked what they would suggest as the most useful interventions, the majority clearly indicated that referral to a community agency would be the most favoured intervention, followed by counselling and respite care. These responses suggest that doctors favour using external interventions, outside of their own skills, to deal with an issue of elder abuse, and that they would mainly deal with medical problems only. This was further supported by responses to question 21 where the doctors indicated the major role that their profession could play in the area of elder abuse and neglect would be

assistance with the treatment of physical and mental illness, and referrals to other agencies. Clearly they did not see their role as one of directly dealing with the cause of the problem, but more with addressing the medical component only.

Over two thirds of the respondents (23) indicated that general practitioners would be likely to see more individuals who have been abused or neglected than any other helping profession. This response was interesting when considered with their lack of training and their inclination to refer abuse cases to external agencies.

Within this study, the majority of doctors rarely, or occasionally, consider the possibility of elder abuse when elderly people with signs of physical injury presented at their surgery. Combined with this is the fact that the majority of respondents were unaware of any definitions being provided by their professional association and they had little university training in the area of elder abuse and neglect. However, in their opinion, they are likely to see more abused and neglected elderly individuals than any other helping profession.

## **Conclusion**

The general practitioners that participated in this study have a low awareness of the issues associated with elder abuse and neglect. Their lack of training in this area may be a contributing factor.

The results of this section of the study are supported by the literature, and reinforces the findings of previous studies. The medical profession needs to increase its focus on the area, and address many of the issues outlined such as clear definitions of 'abuse',



improved techniques for identifying abuse, and clear outlines of useful interventions to support general practitioners. All of these aspects would improve the quality of life of many elderly people, while also assisting doctors to identify and respond to cases of abuse. Additionally, an issue of importance is the impact that dementia may have on the incidence of elder abuse and neglect, not only from the abuser and abusee aspect, but also its impact on GPs' ability to diagnose a case.

The survey data indicate that abuse exists. The respondents suggested that they are the most likely profession to see individuals who have been abused, more so than any other profession, so therefore it is important that they have the required support and skills to deal with the area of concern. It is valuable to identify that GPs see their role as one of referral, after dealing with the 'medical' problems of the patient, and that referral is an intervention which they feel is useful for them to use. Therefore, it is necessary that GPs and other human service professionals build up a strong rapport, so that collectively they can deal with cases of elder abuse.

## **CHAPTER 5**

### **Data Analysis**

#### **Responses to Key Informants' Interviews**

This chapter will present the findings from the key informant interviews. The purpose of these data is to obtain relevant information about elder abuse from the key informants, and to gather information with regard to GPs and elder abuse. The following data have been obtained from the responses of 11 key informants from 10 interviews. Interviews seven and eight were concurrently, with the two respondents answering the questions independently. The key informants consisted of individuals who have experience working in the area of aged care, and who come from a wide range of backgrounds with varying experiences. Due to confidentiality, it is not possible to define the background of the key informants, or to be specific about their current or past occupations, as this information could make them identifiable. Therefore, pseudo names have been assigned to each respondent. A schedule was used to guide the interview process, however the questions asked were not limited to this list, and thus allowed for a rich and varied amount of data to be gathered.

The data was analysed by comparing the responses. Similarities identified in the data were grouped together to form themes and sub-themes, which emerged from the interviews. Often the questions asked from the schedule were a nucleus for identifying the group's themes that emerged from the data. As outlined by Patton (1990) content analysis "is the process of identifying, coding, and categorizing the primary patterns in the data" (p.381). Patton further suggested that "the purpose of classifying qualitative

data for content analysis is to facilitate the search for patterns and themes within a particular setting or across cases" (p.384).

The themes have then been used as headings throughout this chapter. A total of nine major themes have emerged, as well as some sub-themes. The major themes consist of definition; existence; identification; prominent abuse; causes of abuse; interventions; general practitioners; mandatory reporting and characteristics. A short discussion will conclude each heading, and an overall conclusion has been provided at the end of the chapter.

## **Definition**

One emergent theme from the data was 'definition'. What became evident was the inconsistency of a definition that could be drawn from the data. There appears to be a great deal of confusion about elder abuse, and what elements should be included in a definition. The key informants indicated that the term can be ambiguous in meaning, and that the composition of a definition could be limited by various factors, such as an individual's place of employment. For example, Sarah, a key informant suggested that "probably a lot of individuals wouldn't have what they see as elder abuse clearly defined in their mind, but a lot would, it depends on where they work."

Claudia suggested that she really didn't have a clear definition. She felt "there is lots of talk on what people perceive as their definition, but a clear definition [understood by everyone], no."

When asked about a definition of elder abuse, some respondents had difficulty clearly articulating one, as they felt that what may be considered elder abuse by one person, may not be seen as the same thing by another. Dominique felt that "it's been talked about casually in the last perhaps three months but no, we've just queried the word 'elderly abuse'. You know, what is abuse? We've never really got a definition of our own." Gai had similar views, asking, "What is abuse? What is neglect? And does your meaning make sense to me and vice versa."

## **Discussion**

There are a lot of arbitrary judgements which have to be made by a professional in deciding whether a situation is or is not abusive, and this can lead to cases being either missed, or the likelihood of false cases being included as being abusive and neglectful.

From the responses received within this study, it is clear that there is still wide conjecture about defining elder abuse, even by people who have knowledge of the area. In the literature, several authors such as Callahan (1988) did not feel that a definition is of great significance, while others (Galbraith, 1986) would argue that it had merit. Callahan (1988) outlined that one problem with definitions is that "a self-fulfilling prophecy may be created" (p.454). Therefore, some professionals may change their attitudes from what may have been an accident before or a mental health problem, to now classifying it as abuse. An element that needs to be considered, is how the definition is developed, and what it is trying to achieve. One has to consider what actions should be called elder abuse, and what belongs to another area. Galbraith

(1986) however, has an opposing view and felt that "a uniform operational definition of elder abuse would assist practitioners and researchers in the proper identification and classification of abuse and on the reporting of such data" (p.13).

The data gathered in this study supports the views of the general literature, that indicate that a universal definition of elder abuse is difficult to achieve. Definitions can be specific to an individual's place of employment, and differ from one individual to another, based on their own theories relating to the ageing process. This can then have an effect on the significance of the problem, and the type of cases that are seen to be either abusive or non-abusive.

## **Existence**

An important theme, which developed from the data, related to the existence of elder abuse. Three sub-themes, which supported this major theme, consisted of duration of existence; evidence and significance.

### **Sub-Theme One: Duration of Existence**

The data gathered indicated that elder abuse has existed for some time, and although the area has not been overly publicised, it clearly occurs but is under reported. Some respondents indicated that they were aware of cases of elder abuse as far back as the late 1970s and early 1980s, while others indicated that they were not aware of the problem until the early 1990s. While these responses are detailed below, what has become evident is that elder abuse exists in metropolitan Western Australia.

Sarah suggested that she initially was aware of a case in the "70s or 80s." Verity also stated that she had a long period of awareness of the elder abuse. "I worked in nursing homes, it would have to been in [the] nursing [homes] you know, 15 years ago I suppose." Other respondents however, indicated they became aware of cases of abuse around five to 10 years ago. Shelley stated "I had some psycho-geriatrics, that was perhaps the first time, so that was six to seven years ago". Dan indicated he had been aware of elder abuse "for about five years." Conversely, Rachel indicated that she had only become aware of cases more recently. "I mean I can only comment in so far as I have been working in this office and I would have to say, I've got allegations of abuse in 1992." Another respondent, Jade, was made aware of issues through "... an incident of abuse, chemical abuse of the residents, so that would have been about three years ago."

From the data it is evident that abuse and neglect of elderly people has been observed for at least 15 years in Perth. However some key informants had only noticed it occurring recently, which may indicate that the area has been, and to some extent, is still not fully recognised. Alternatively, it is possible that due to poor definitions as to what is and is not elder abuse, what may have been identified by some individuals as elder abuse 15 years ago, may still not be seen by some people today, as being elder abuse at all.

## **Sub-Theme Two: Evidence**

A theme developed from the data was the importance of "evidence". The data in this study provided evidence that elder abuse exists in Perth, as respondents were asked if they had been involved in cases in the past 12 months. Some respondents indicated that they have seen a relatively small number of cases, while others indicated seeing several hundred in the past 12 months.

The following responses highlight this point, with some key informants suggesting that they had seen ten or less cases in the past year. Jacquelyn stated that "within the last 12 months [I would have seen] probably just a few cases of abuse." Sarah outlined she had seen around "seven, eight, in that time, something like that I think", while Shelley felt she had seen "probably around I think around 10." Other respondents however, clearly indicated that they had seen significantly more cases of elder abuse. Verity suggested she had come across "hundreds, my boss has had to be advocate for hundreds of different situations", while Claudia also had seen a large number of cases, stating that "I've probably come across a couple of hundred. It depends on the degree of elder abuse."

The area of elder abuse has become more conspicuous over the past few years in Australia, due in part to more media coverage. However, it appears that there are differing opinions as to the rate of its prevalence, with some authors within the literature suggesting that it is a major problem, while others indicate that it is not a significant issue. This inconsistent view is supported by the data in this study, where its rate of prevalence appears to vary.

### **Sub-Theme Three: Significance**

One interesting sub-theme that developed from the data is related to whether elder abuse is a significant concern. The key informants in this study indicated that elder abuse was an issue within their profession, and therefore it had some significance. The level of significance which elder abuse has however varied amongst the respondents, and further adds to the uncertainty about the extent of the problem.

Jacquelyn indicated that she had not seen a lot of cases:

For this agency it's been an area that was identified some 18 months ago as a potential area that needed consideration. Mind you there are very few cases, but we are aware there was a problem.

Alternatively, another respondent, Rachel, indicated that the area was of major importance, and that there were a lot of cases which occurred. She suggested that it was a "hugely, hugely relevant and unfortunately [she had seen] quite a lot." This view was supported in part by Sarah, who indicated that the area is only just being seen as significant. "I think elder abuse is now where child abuse was some years ago. It's only just, I think, being recognised as being a primary problem."

As mentioned previously, one of the major problems with identifying the significance of the issue, relates to its definition. Other areas which may impact on the reasons for major differences in the significance of elder abuse could be associated with a respondents' awareness of the problem, their ability to address the issue, and their knowledge of useful and appropriate interventions.



## Discussion

From the data presented by the key informants, it is evident that elder abuse exists within the city of Perth, and that in some instances, it has been occurring for in excess of 15 years. Generally though, the area of elder abuse and neglect has been perceived as a relatively new area of concern, despite being evident for some time. This is supported by Kingsley and Johnson (1993) who suggest that while elder abuse is not a new problem, "it is a problem which has only recently been acknowledged by society generally and by those who work with older people" (p.20). Unlike other family social issue areas such as child abuse and domestic violence, which have been more prolonged in terms of their existence, there is a general feel that elder abuse is a new issue, and one that has not occurred in great numbers over the years. Kurrle (1995) supported this view, suggesting that "elder abuse is not a new phenomenon, however until recently it has gone largely unrecognised in Australia, as it is one of the last forms of familial violence to come to public attention" (p.173).

Kurrle (1995) further suggested that "there have been no prevalence studies in Australia" (p.173), the data in this study indicate that respondents have seen varying numbers of cases of elder abuse, ranging from less than 10, through to a couple of hundred cases.

It appears that prior to definite information being obtained on the extent of the problem, there is a need for the development of a universally accepted and understood

definition of elder abuse. This would further assist with the substantiation of its existence, and help in further providing an indication as to its significance.

## **Identification**

The ability to accurately identify cases of elder abuse developed as a major theme within the data. Two sub-themes emerged in support of this major theme, those being, initial contact and restrictions. The first sub-theme focussed on who would be the most likely profession to initially come into contact with elderly abused individuals. The second sub-theme discussed some of the possible restrictions associated with identifying cases of elder abuse.

### **Sub-Theme One: Initial Contact**

An issue that emerged from the data focussed around which profession is most likely to come into initial contact with elderly people who have been abused and therefore, what profession is most likely to be in a position to initially identify elder abuse. The key informants provided varying opinions with regard to the emergent sub-theme of 'initial contact'. Some respondents indicated that social workers would be likely to come into contact with elderly abused people, while others indicated either GPs or community care workers would be the initial point of contact.

Dan outlined "well I guess social workers would be, [however] certainly the people that see the abuse would be those that go into the homes." Rachel also supported this view. "In the area of elders, it is probably social workers generally who are in a position

to be concerned about it [elder abuse] and to locate evidence that might support any concerns that they have."

However, other respondents indicated that GPs were the most likely profession to come into contact with elderly abused people. Claudia felt that "in the community GPs would normally be the first line of contact". Jade also suggested GPs would have initial contact, "... both in the community and even in the setting such as residential living."

Other respondents stated that the most likely individuals to see elderly people who had been abused would not necessarily be a profession at all, but individuals who went into people's homes, and had some involvement within the house and communities. This perspective is summed up by the following data. As outlined by Sarah, "I think community workers, volunteers, home help agency workers would probably see as much as say visiting community workers, HACC agency coordinators, nurses, social workers."

The views of Daniels et al. (1989) stated that physicians are amongst the first people to come into contact with abused elderly people, and this has been supported by some respondents. However, two other prominent areas include Social Workers, and home care and support workers. It is important that people within these groupings are aware of the problem of elder abuse, so they know what they are looking for, and to minimise poor identification of cases of abuse. One method of overcoming this could be through training on the issue.

## **Sub-Theme Two: Restrictions**

Restrictions on the GPs' ability to diagnose cases of elder abuse accurately emerged as a theme within the data. Additionally, restrictions on the key informants' ability to intervene in a case of elder abuse also emerged, and together they developed the sub-theme 'restrictions'.

The primary restrictions suggested by the key informants for GPs not identifying abuse and neglect, was that GPs did not know what to do, and not having enough time to act. Other reasons outlined included that GPs do not acknowledge elder abuse as a problem, and that they did not have a strong working relationship with other professionals in the area.

Gai felt that "one of the problems is that it's not talked about, it's not acknowledged as an issue [elder abuse], and I don't know what doctors get in the way of training."

Jacquelyn supported this view suggesting that she thought, "the only thing that would rectify a doctor would be believing that it [elder abuse] happens," while Rachel also felt that "they (GPs) just don't know what to do." Respondents also indicated that not having enough time was a major consideration for GPs non-intervention in a case of elder abuse, as can be seen in this comment from Shelley. "Well, the time factor is an obviously one."

From these research data, it is difficult to clearly ascertain if the key informants felt that GPs could accurately diagnose elder abuse. Some respondents indicated that GPs could not do it, citing that elderly people may cover up the fact that abuse occurred.

Others indicated that GPs can and do accurately diagnose abuse and neglect of elderly people.

Dan felt that "... if you've got a very careful carer that can lie convincingly I don't think the doctor would ever think it was anything else, because Alzheimer's people do fall over and they lose their balance." Emma, who suggested that GPs could not accurately diagnose elder abuse, supported this view. "I think the reason for that is the abused person will go to the doctor to have the problem sorted out but the problem will be presented as, 'I had a fall'." Conversely however, Claudia suggested that GPs accurately diagnose elder abuse. "I have doctors that ring me up and tell me what is happening and I go out and look at it."

When the key informants were asked what might have restricted them from intervening in a case of elder abuse, the following data were provided.

Rachel felt that "the person themselves, in cases of self-neglect, refusing to go to the doctor can cause huge problems." While Emma suggested "time to do the counselling, and I guess, initially a lack of knowledge " restricted her from becoming involved. Gai felt that her restrictions related to:

People not willing to admit that abuse occurred, because they didn't know what to do, lack of knowledge of what to do about it, the difficulties of what to do about it and they cover for people, what happens to them if they intervene? There are no safeguards, there are no guidelines, you are kind of grasping at straws and lack of training and educational resources in how to intervene. I think they are all restrictions.

Gai further suggested that:

I mean one of them is often the unwillingness of people to feel a responsibility... It's too hard, like there is no help out there, no supports, and no back up. So we err on the side of not acting, rather than making a mistake, which is very understandable, I think that's sort of an impediment.

## Discussion

One of the key areas of elder abuse is the need for identification of cases. However, if the problem is being hidden, then detection is difficult to uncover. Issues could be further complicated through the fact that the elderly abused person is in a dependency situation, where he or she is reliant on the perpetrator for something, and therefore is prepared to put up with the abuse.

Previously this study has indicated that GPs may be an initial point of contact for elderly people, and one of the primary roles for GPs is seen as detection. If the problem has been hidden however, then it may be extremely difficult to detect. It is probable that Social Workers, GPs and Home Care Workers will need extra training to identify cases of elder abuse, so they can refer people on to appropriate professional care. These were the groups identified by the key informants, as the most likely people who may have initial contact with elderly abused people.

The key informants suggested that the major restrictions for GPs intervening in a case of elder abuse were their lack of time, and not knowing what to do with identified cases of abuse. For GPs to play a major role in this area, they need increased knowledge of the issues involving elder abuse, and skills in detecting cases. They also need to have a resourceful knowledge of available interventions and services available to deal with the issue of elder abuse. As outlined by Pratt et al. (1983) general practitioners'

understanding of "community resources available to the elderly and their families is a critical determinant of the effectiveness of their interventions" (p.148).

GPs having sufficient time to adequately provide a consultation to elderly people is also a concern that has been highlighted in the literature. Kurrle (in Hickson 1991) suggested, "old people often need a 25- or 45 minute session, and doctors are reluctant to grant that" (p.71). Time is necessary not only to detect that abuse has occurred, but also to provide suitable counselling and intervention. Kurrle suggested however, that GPs may not provide adequate time in a consultation for elderly people, as "they don't see it as cost effective" (Kurrle in Hickson, 1991, p.71).

Interestingly, the key informants also indicated that time was a restriction that they felt impeded them from intervening in a case of elder abuse. Others restrictions, which included awareness, knowledge and also skills to adequately intervene, were seen to be limitations which constrained professionals from all areas, and not just GPs. There would appear therefore, to be a need for awareness and training sessions to be conducted across the broader human service field.

### **Prominent Abuse**

From the responses gathered, two prominent areas of abuse were identified. They consisted of financial, and psychological / emotional abuse. While it was argued that some types of abuse are more traceable than others, and therefore more prominent in terms of actual occurrence, these two areas were seen as being pronounced, as outlined in the following data from Emma.

I think the one that is the most prominent is emotional abuse, and I think we don't recognise that. Often the person that is being abused doesn't recognise this abuse. I mean constant put downs, being told that you are a silly old coot, being called a fossil, ... it doesn't grab the limelight the same as somebody who's got a broken arm or [has] been beaten up. It is just as insidious and it sets up the whole stereotyping of 'I'm useless, and if this person says it therefore I am.

Gai also felt that psychological abuse was prominent, and focussed on insolation as an important element of this form of abuse. "I would think probably psychological abuse, and that can [include] being socially isolated, not allowed out of the house, or not taken anywhere."

A common thread regarding financial abuse amongst the respondents was that it is traceable, which can make it detectable and prominent, while other forms of abuse may not as easily identifiable. Rachel felt that:

Financial abuse would certainly be the easiest to find. I would say very closely followed by emotional abuse or psychological abuse, because you can't measure it and that's all hearsay. Financial abuse you can get the bank statements and trace the information relatively easily, although it is still quite hard to detect. But I'd say psychological abuse would be pretty close, but you can't measure it. It is somebody else's judgement that this person is being abused.

Sarah suggested however, "that it would be too difficult to clearly articulate a prominent type of abuse, as more research would be required before an accurate answer could be given."

## **Discussion**

Both financial and psychological abuse were prominent throughout the literature as being areas that affect elderly people. Many theories outline why these two types of



abuse occur, ranging from inter-family relationships and dynamics, through to financial dependency between the abused and the abuser.

Social exchange theory suggests that people want to maximise the rewards that are due to them, and to minimise their losses or punishment. Essentially, the caregiver wants to ensure that the cost of caring for an elderly person, in all aspects including time and financial is offset by the rewards they receive. Tomita (1990) suggested that "the imbalance of 'goods' creates a situation in which one person is more powerful than the other" (p.172). In some situations, elderly people are not financially affluent. In these circumstances, if they are unable to adequately reciprocate the caregiver with rewards, it may create a situation where the caregiver abuses the elderly person (Tomita 1990).

Interestingly, the two areas of abuse are varied insomuch that one is tangible and traceable (financial abuse), while the other is largely intangible. From the data gathered in this study, indications are that the two aforementioned areas of abuse would be useful categories to address when trying to ameliorate the area of elder abuse, and when providing training to professionals working in the area.

### **Causes of Abuse**

The data gathered suggests that the two primary causes of elder abuse are a lack of education of professionals about the area of elder abuse, and caregiver stress. These two sub-themes, lack of education about elder abuse and caregiver stress combined to form the major theme of 'causes of abuse'. Interestingly, they are varied insomuch that

one is focussed on the professional, and the other is focussed on the untrained and over burdened caregiver. However, they also are related in that they both focus on the area of education and elder abuse.

### **Sub-Theme One: Caregiver Stress**

The key informants indicated that caregivers did not have enough support and may be unskilled when undertaking the task of being a carer. When asked why abuse occurred, Shelley suggested "carer stress in the main. ... incontinence is another one that you'll find, ...it produces a lot of stress in the home." This view was also supported by Dan who suggested that "... the double incontinence and the lack of services to assist that person..." can cause elder abuse through increased caregiver stress. Rachel supported these views, indicating that "I would have to say, that it appears to be in situations where you have someone with very high care needs and you have someone who is unqualified to deal with those care needs..."

The literature supported the concept that caregiver stress is a major cause of elder abuse. As outlined by Haviland and O'Brien (1989), it is possible that some perpetrators of abuse may be caring people "who are 'pushed over the edge' in a moment of despair, frustration, or fear, such as reacting to a person with dementia who has become combative" (p.13).

## **Sub-Theme Two: Lack of Education About Elder Abuse**

An area of concern that became evident throughout the data, was the need for further education about elder abuse. There was strong agreement within the responses given that specific training within human services in the area of gerontology was needed. Not only is further education required for GPs, but also for social workers, and other professionals in the human service field. Jacquelyn suggested:

I think it's crucial, particularly as we are entering that period where we are going to see that demographic shift. I think it's been an area that for too long that has been the poor relation in medicine, that there's not only a need for specialist Gerontology in medicine but also in the other helping professions.

When asked if there was a need for training on elder abuse in the Human Services areas, Emma responded:

...absolutely, and not just for GPs, but nurses, OTs and social workers. I believe the subject of elder abuse needs more than one lecture, which is what is currently happening. It is an issue all on its own that needs considerable time.

Claudia responded by suggesting that she felt "it should be a speciality. I don't know if it is at the moment, but yes I think, it's going to be an ever increasing need."

Conversely however, when asked if training should be provided in the area of elder abuse, Sarah indicated that "...it is at various places. Various universities have gerontology courses, not only for health workers. I mean obviously everyone thinks there should be more, but they are there."

Rose felt however, that training and education was not the only answer to solving issue related to elder abuse. "You can have all the training in the world and if they [people] are not prepared to listen and act on it, well it doesn't happen."

The key informants indicated that poor education and training about elder abuse was a primary cause of abuse occurring. Claudia felt that "medical and nursing training lacks in the area of specific skill training for people working in the area of gerontology." This was also supported by Rose who suggested "I would say lack of education and acceptance [of elder abuse]" were major reasons why elder abuse occurs.

## **Discussion**

From the data gathered, it is apparent that the area of stressed carers is a major cause of abuse and neglect towards elderly people. A theory relating to stress suggests that it can take two major forms, being either 'internal' stress or 'external' stress. The internal stress relates to pressures of caring for an elderly person, and it's sometimes associated burden and strain. External stress relates to environmental relationships, which may have an effect on the caregiver (Anetzberger, 1987).

Research indicates that whether a caregiver is stressed or not relates to a number of specific factors. These include:

Frequency and distress of elder behaviours; competing tasks performed; type of caregiver tasks performed; functional status of elder; dangerous or odd

behaviour or lack of cooperation by the elder; insufficient time or money; some combination or specific factors (Anetzberger, 1987, p.12).

Additionally, what has become important to consider is that both the untrained caregiver and the professional need further education regarding the area of elder abuse. The key informants indicated that lack of caregiver's skills and adequate support could compound the problem of caregiver stress. Interestingly, it was also suggested that there is a lack of education and training for professionals who are working in the area. There is a possibility that because professionals are not adequately trained about elder abuse, they are further compounding the problem for caregivers, as the professionals are not able to adequately support and train caregivers in their role as a carer.

## **Interventions**

A theme to emerge from the data was interventions. The types of interventions, which the key informants used varied markedly, as did their knowledge of the different types available. Some respondents indicated that they have used the Public Guardian as an intervention, while others have utilised Police and other service areas. Some respondents indicated that the level of intervention used is related to the type and extent of the abuse.

Other interventions suggested by the key informants included using an Enduring Power of Attorney; Guardianship and Administration; Older Persons Rights Advocacy

program; Age Care Assessment Teams; Jesus People and the Good Samaritans. The following data from Shelley is representative of the general responses.

The first thing we do when we see someone, is identify whether there is a high need, the person is high care need, in the home and what their supports are. ... so really it's a matter of getting as many people into that home, as you possibly can. But once again that can increase the stress as well, having your privacy invaded by Meals on Wheels, home help, carer coming in, someone coming to shower, someone coming in to do medication. So I mean that can be equally stressful.

## **Discussion**

Many of the interventions were referred to in the data above are similar to those that where outlined in the literature. Haviland and O'Brien (1989) suggest that interventions for the abused individual may include referral to a community agency, such as a home health care agency, while other individuals may require respite care and day care programs, or a completely new living arrangement. Other types of interventions included counselling and hospitalisation.

The traceable acts, such as financial abuse appear to be dealt with through formal interventions including the Public Guardian and Enduring Power of Attorney. In some cases, it is clear that interventions include referral to other agencies, such as Age Care Assessment Teams. The key informants indicated that often the type of interventions used to ameliorate a case of abuse of elderly people, could be related to the severity of the abuse. Other things, which need to be considered include the rights and responses of the elderly person involved, and the types of interventions, which are available for professionals to introduce.

## **General Practitioners**

The area of general practitioners developed in the data as a major theme. The two sub-themes associated with the major theme relate to the involvement of GPs, and the role of GPs in regard to elder abuse.

### **Sub-Theme One: GPs Involvement**

The key informants were asked if they had known of cases of elder abuse where GPs have been involved. The majority of the responses were negative, which is similar to criticisms in the literature of GPs and their involvement in elder abuse. However, one respondent indicated a positive response, having have good rapport with a local GP but felt that this was more of a 'one off' situation as opposed to a common practice. However, the respondents were generally critical of GPs involvement in elder abuse as outlined in the following responses.

Shelley was of the view that GPs don't "actually pick up on the abuse, they pick up on neglect, but they don't seem to really pick up on the abuse." Gai suggested that "most of what I have heard ... unfortunately has been quite critical of GPs." Dan was of the opinion that "unfortunately not a lot of GPs know that much about dementia..." While Rachel outlined that she "hadn't had any [cases of elder abuse] that I think were referred from a GP."

Jade offered the following feedback with regards to her knowledge of GPs involvement in elder abuse:

The only one that I know of, was that this person was being abused because of the particular person's nutrient intake, the lady was virtually starving to death. The GPs intervention was how dare the ...[department] get involved.

Emma however, while not being overly positive with regards to GPs involvement in the area of elder abuse, did have excellent rapport with her local GP. "We're very lucky here in that I've got a GP who works with many of my seniors... but I would suggest that he is an exception rather than the rule, and I have found that to be the case."

It is apparent that GPs' involvement in elder abuse has not been viewed as positively by the key informants. While it has been suggested that GPs have a role to play in the detection of abuse, the key informants have indicated that currently this is not occurring.

### **Sub-Theme Two: Role of GPs**

The role of a GP emerged from the data as an important sub- theme. The key informants indicated that identification of abuse would be a major role and responsibility for GPs. Reasons for this included that GPs may be the first person to see a victim of elder abuse, and that they may have the trust and confidence of an elderly person. Another role of the GP that emerged from the data was to refer the elderly person on either to other service areas, or to other professionals.

Gai indicated that detection would be an important role, as GPs "are often the first port of call for lots of people seeking help and I also think that a lot of older people have an enormous respect for doctors." Shelley, who indicated that she "would like to see them



[GPs] having more of a role in actually picking it [elder abuse] up, earlier," supported Gai's view. Shelley also went further however, suggesting that the role of GPs "is being able to identify [elder abuse] earlier on, and make the referrals..."

Gai indicated that:

They [GPs] also are people who have access, more access than any other group, ... in terms of a family, [which may include] both the abuser and the abused. ...[Therefore they are able to get] support services in where they may not have been before.

The primary roles that the key informants indicated GPs should undertake in the area of elder abuse were detection and referral, including organising support services. For this to occur, it is important that GPs are aware of elder abuse and its associated issues.

## **Discussion**

Sections of the literature on elder abuse and neglect focuses on general practitioners not being aware of the issue, and not identifying cases. Some authors have been critical of GPs based on these areas, given that in some instances they may be the initial points of contact for elderly people who have been abused. The data indicates that professionals who are working with the aged, and who have knowledge of elder abuse, are critical of GPs' involvement in this area. Daniels et al. (1989, p.324) suggested that GPs "are among the first professionals who come into contact with cases of elder mistreatment, yet they are rarely the first to identify it." Much of this could be related to GPs not being adequately informed about the area, not believing that it occurs, and not being adequately trained to deal with the issue. Additionally,

there is also a lack of clarity regarding roles and expectations of GPs and other professionals involved in elder abuse.

However, the key informants' data also indicates that GPs have an important role in the identification of abuse to elderly people. With GPs being one of the initial contact points for elderly abused people, and through the trust which has been built up between the elderly person and the GP, the respondents indicated that GPs have a major role to play in identifying cases of abuse. The respondents did not indicate that GPs should deal with the cases of abuse, other than treating medical problems, but that they should refer cases of elder mistreatment onto other professionals.

Therefore the key informants identified that the role of GPs should be one of detection and referral. For this to occur, GPs must have the awareness and skills to identify that abuse is occurring, and they must be cognisant of the support services and referral placements available to deal with such cases.

### **Mandatory Reporting**

The area of mandatory reporting was a theme that strongly emerged from the data. When asked about their views on this issue, the respondents had varying responses similar to what has been outlined in the literature. Some were in favour of mandatory reporting, while others were against the idea. Additionally there was no clear consensus with regards to which cases should be reported.

Jade, who is in favour of mandatory reporting, stated "I think personally that it [mandatory reporting] should be done every time." Claudia, also supported mandatory reporting, felt "it's a responsibility, particularly of a health professional or anyone who comes into contact with them [abused elderly people]." Shelley indicated that:

I personally believe that certainly in cases of people with dementia there should be mandatory reporting. I feel it is rather like dealing with a minor in that instance, because the person does not have the mental capacity to advocate for themselves.

Some respondents weighed the situation up, and did not either favour or disagree with mandatory reporting. Gai indicated she didn't "really have strong views either way. I can see some benefits but I can also see that it could yet be another impediment to people intervening and taking action." Rachel was also non-committal to mandatory reporting, suggesting "that's really, really, really hard. I think there's pros and cons."

Other respondents did not agree with mandatory reporting: Sarah stated that she "was not for it at this point. I think a lot more has to be very clearly established before we even think about it. I think there is a risk of misreporting for all sorts of reasons." Jacquelyn also indicated that she felt "there's some problems with it (mandatory reporting). There are some issues because people can make reports and spend all their time making the reports while not a lot happens on the ground."

The respondents had different views about who should be notified of elder abuse and neglect. One view was that it should be reported to GPs, while another was to establish small teams of experts to deal with the problem. Rachel felt it was a role for GPs suggesting that "well again GPs have a big role don't they..." Dan felt that "you should report the abuse to the doctor first of all to get it fixed up and then, it has got to

be the Department of Community Services". Jacquelyn however had an opposing view, suggesting that it should be dealt with from within already established services. "It doesn't need a new infrastructure... What it does need is a bit of `nous', commonsense and a bit of co-operation."

## Discussion

Mandatory reporting is an issue on which the literature is divided. Some experts are in favour while others are opposed, so there are no general consensus as to whether it should be introduced or not. Those in favour suggest that it will reduce the number of cases of abuse, while those opposed suggest that it may cause cases to be misdiagnosed and wrongly reported. They go further suggesting that elder abuse will continue to remain hidden and be covered up by elderly people.

It is clear that there is no consensus from respondents about whether reporting elder abuse should be mandatory, and if it is reported, who should be responsible for following it up. Kosberg (1988) suggested that while mandatory reporting may help to raise the awareness of elder abuse within a community, it does not however, "give guidelines for detecting mistreatment in elders, therefore placing the diagnosis of abuse and neglect in the hands of the health care professionals" (p.25). With the data gathered in this study clearly indicating that there are no consensus amongst professionals with regards to definitions, interventions, and roles of some professionals, it could be risky to introduce mandatory reporting without training, and clear procedures. Even then, it may not be a preferred option.

## **Characteristics**

The characteristics of elderly people who have been abused, and those of the caregiver who are likely to abuse, form the two sub-themes for the major theme of 'characteristics'. Both of these sub-theme areas have been outlined extensively in the literature, and varied views have been presented as to what are the most likely characteristics of a perpetrator of elder abuse and an abused elderly person.

### **Sub-Theme One: Characteristics of the Abused**

One of the key characteristics of an abused elderly person identified by the respondents was dependency. This has been linked to isolation and frustration of the caregiver. Other characteristics which have been identified include reduced mental capacity or dementia, which can make caring for someone difficult, particularly if the caregiver is not trained, and has little support as outlined under the major theme of 'causes of abuse' discussed earlier in this chapter. When asked about the characteristics of someone who is elderly and likely to be abused, the following responses were provided.

Gai suggested:

I guess most of all dependency. ...if they're dependent and don't have as much control over their own lives, and the way they live, then they are very vulnerable...

Emma was of the view that:

They are usually isolated, they are usually dependent on a carer, they are frequently suffering from an altered mental state, or a physical disability, that makes them vulnerable.

While Jacquelyn suggested:

Well my understanding, is that I think there is a relationship dependency. ... there aren't a lot of other people in the persons' lives so I think isolation and vulnerability are factors as well.

Rachel felt that "people are dependent on someone. People who are isolated in the community or who need people to give them support. People who aren't mobile."

Claudia outlined:

Well broadly speaking anyone with decreased cognitive capacity, because their behaviour is often unacceptable socially, just makes them more vulnerable to abuse, and also makes the public almost more accepting of the abuse.

As elder abuse can be a hidden area, the knowledge that somebody could be at risk, can assist professionals to build in safeguards to either prevent or assist with ameliorating situations. Based on the above data, professionals should be more aware of elderly people who may be in some form of a dependency relationship or situation, and people who have dementia.

## **Sub-Theme Two: Characteristics of Caregivers**

Similar to the characteristics of abused elderly people, the area of perpetrators characteristic developed as an important theme in the data. When asked about the characteristics of someone who is likely to abuse elderly people, the key informants

suggested several responses. They included caregiver stress, substance abuse, psychiatric problems and poor relationships between a family over many previous years.

Shelley indicated that the characteristics of an abuser might include:

Somebody with little supports... People who have pathological relationships with the patient themselves who may be like a daughter, it may be like a father - son, that aren't really good relationships to begin with.

Emma indicated that:

Perpetrators of elder abuse are often stressed carers... Another situation is hospitals that do not adequately discharge clients... There are the other variables such as substance abuse, and pathological background, and altered mental states...

Gai suggested that dependency was a major component. "Often it is their [caregivers] dependency... I think drug and alcohol abuse... and pathology, I think that a lot of people who have got psychiatric problems that aren't addressed."

Jacquelyn suggested that a characteristic of an abuser might be related to family history:

Well I think where you've got families where this thing is patterned psychopathology, that crosses generations and we know of families that have been through the welfare system that have actually been the perpetrators of abuse on their children for instance.

Many of the areas suggested by the key informants are outlined in the literature. Interestingly however, is the fact that respondents did not try to identify specific characteristics of the carer, such as age and gender. Much of the early literature focussed on this type of discussions.

## Discussion

This study clearly indicates that a likely characteristic of someone who is vulnerable to being abused would be in a dependency situation. The individual may be dependent for several reasons ranging from social isolation through to physical or mental impairment. In such situations, the elderly person may be dependant on a caregiver, and this same 'carer' may be abusing or neglecting the elderly person. The views of the key informants, are similar to those of Kosberg (1988) who suggested that one of the key characteristics of elderly people likely to be abused is dependency. Being dependent on another person, can reduce an individual's autonomy, and lead to hostility between a carer and a caregiver. Unlike some of the literature however, the respondents in this study did not define the characteristics based on an individual's age, gender or culture.

In relation to perpetrator characteristics, Wolf and McCarthy (1991 in Ammerman & Hersen) suggested that the elderly person can be a cause of stress for the caregiver through mental and physical deficiencies, that substance abuse by the perpetrator is related to elder abuse, and psycho-pathology can be related to elder abuse. From this study, it seems that no one characteristic of a perpetrator is more likely to be related to elder abuse than another. In many situations, it can be a combination of many of the above characteristics that cause an individual to abuse an elderly person. In some situations, it may be the carer who also is the recipient of abuse.



In some cases, abusive situations can be avoided or resolved if the characteristics of the perpetrator can be identified. The key informants have suggested that circumstances where the caregiver is under stress, has not been given adequate support, or is not trained to undertake the task of caring for another person could be potentially dangerous. In other cases, the caregiver may in fact be suffering from an altered state of mind or have some form of physical disability, which makes caring for another person difficult. The data from this study present a guide as to the likely characteristics of a person either vulnerable to being abused or someone who may be a perpetrator of elder abuse. If professionals become more aware of elderly people and caregivers that have these characteristics, some likely cases of abuse could be circumvented.

## **Conclusion**

The main purpose of this chapter was to gather relevant information from the key informants about elder abuse, and also to gather their views on GPs with regard to the area. The data suggested that elder abuse exists within Perth, and while there is some disagreement with regard to its significance, evidence has been provided from the key informants, that clearly indicates its existence. However there is still a need for further clarity with regard to some issues relating to elder abuse. These include the effectiveness of mandatory reporting, and the development of a clear and concise definition.

There was however general agreement with regard to the need for specific gerontology training on elder abuse in Human Services area. There was also general agreement on

what constitutes the major characteristics of a perpetrator of abuse, and the data were very clear with regard to dependency being the major characteristic of an elderly person's vulnerability to being abused.

In relation to doctors, some of the reasons given by the key informants for GPs not being involved in the area of elder abuse included shortage of time; lack of training; and a non-acceptance of elder abuse. The key informants indicated that GPs should have a primary role of detection, but that they should not necessarily be responsible for dealing with the problem once it had been identified. While some respondents indicated that GPs might be the first profession to see elderly people who have been abused, others suggested that Social Workers or para-professionals might be more likely to initially see abused elderly people. Many of the key informants however, were critical of the current involvement that GPs have in the area of elder abuse.

The data gathered from the key informants have been beneficial, not only in obtaining general information regarding elder abuse and neglect, but also from gathering information about GPs and their involvement in the area. What is apparent throughout this section of data is that there are elements of uncertainty and inconsistency with regards to elder abuse, despite the key informants having knowledge of the area. It is clear that more research and work needs to be undertaken in conjunction with awareness training in the area of elder abuse and neglect. The elements of uncertainty and inconsistency that were evident in these data are similar to those that can be identified in literature. This inconsistency however, helps to enhance healthy debate, and further assist with the refinement of important boundaries and guidelines, which need to be further developed for the area.

## **CHAPTER SIX**

### **Data Analysis**

#### **Responses to Doctors' Face-to-Face Questionnaires**

##### **Introduction**

This chapter provides an overview of the responses given by five doctors in follow-up face-to-face interviews. The doctors were self-selected through responding to the section from a previous postal questionnaire, where they indicated that they would be prepared to be involved in these interviews. The purpose of this data was to obtain in-depth information from GPs regarding elder abuse. The data gathering process for this section consisted of using a schedule of interview questions. The schedule was used primarily as a guide, and the questions were not limited to those contained within the schedule, which allowed for further in-depth data to be obtained.

Themes were developed from an analysis of the data. Through a comparison of the responses, similarities emerged which were then grouped together to form specific themes. Seven major themes developed from the data, as well as some sub-themes. The major themes, which emerged consisted of definition, societal problem, existence, the victim, training, referral, and consuming of resources. Each of these themes will be discussed separately, and an overall conclusion provided to sum up this chapter of data. To protect confidentiality, each of the doctors has been given a fictitious name.

## Definition

One of the themes to emerge from the data was the development of the need for a definition of elder abuse. Throughout the literature, there are numerous definitions and widely varying discussions on what should be included in an adequate definition. From these interviews elder abuse was defined as psychological, physical, emotional, financial, and legal abuse. Also emerging were acts of omission or neglect, such as elderly people having poor nutrition, and their personal needs not being met. These characteristics relate to having something withheld. O'Malley et al. (in Haviland et al., 1989, p.12) suggested that "abuse can be defined in terms of acts of commission, while acts of omission lead to neglect."

Doctor B defined elder abuse in these terms:

Not only is it the receiving of violence, but also poor nutrition because they haven't got the wherewithal to attempt the basic things like nutrition, [for] their nutritional needs and heating and stuff like that.

In another interview, the response was a combination of both the omission and commission aspects of abuse and neglect towards elderly people. Doctor E indicated that a wide definition is needed, as abuse can be:

Physical, can be emotional, and it encompasses not only people doing things to others, but also not doing so. Neglecting to provide adequate basic needs of clothing and food and water, but also emotional needs, ... and social interaction that most of us would regard as normal.

Both of the above descriptions contain elements of omission and commission as components of abuse. They do not however consider the financial and legal aspects that

may also contribute to elder abuse as noted in the literature. Nonetheless, Doctor A identified these aspects of elder abuse as outlined below.

It doesn't have to be actually being beaten it can be emotional abuse, or relatives controlling their money to such an extent that they haven't got access to it... So it is not only physical abuse it is anywhere they are taken advantage of because of a weakness or a lack of strength in any area that they may have.

Doctor D also mentioned age with regard to a definition, by saying, "you can take an arbitrary age... I don't think that it is too important". In general however, this group, in relation to defining elder abuse did not see age as a significant characteristic.

Self-injury was not identified as a part of the overall definition. Responses from the GPs however included comments that elder abuse could be from deliberate neglect of elderly people. This included elderly people not wanting interference and elderly people having options available to them to reduce the abusive situation but choosing not to do so.

## **Discussion**

It is difficult to succinctly draw together a clear definition of abuse from the above descriptions. However what is demonstrated is that abuse and neglect can vary from individual to individual. Generally from the data, abuse may consist of psychological, physical, and emotional abuse. However some doctors included financial and legal considerations within their definition. Interestingly, no respondent mentioned sexual abuse and age was not seen as a major concern, despite both these areas being included in some definitions outlined in the literature.

Pederick-Cornell and Gelles (1982, in Galbraith 1986, p.13) stated that:

Perhaps the most significant impediment in the development of an adequate knowledge base on intrafamily violence and abuse has been the problem of developing a satisfactory and acceptable definition of violence and abuse.

The interview responses supported this view, as it is clear that what constitutes abuse for one doctor, may not be seen as abuse by another.

The overall areas developed in the data as being components of abuse, such as psychological, physical, emotional, financial, and legal, are consistent with those considered by some authors within the literature. Many authors including Giordano and Giordano 1984; Haviland et al. 1989; British Association of Social Workers 1990; Gately et al. 1990; and Hailstones et al. 1992, agreed that the primary categories within elder abuse centre around physical abuse and neglect, psychological abuse and neglect, material abuse or exploitation, and violation of personal rights or exploitation. The evidence from the interviews tended to support these views.

### **Societal Problem**

Another theme evident in the data focussed on whether doctors felt that elder abuse was a societal problem. Prominent areas which developed in the data to support this perception were an ageing Australian population; a lack of respect for elderly people; cultural impact; and a focus on the level of family responsibility.

### **Sub-Theme One: Ageing Population**

With an increased number of elderly people, it is likely that elder abuse may also escalate. The ageing of the population is occurring for several reasons, including the provision of medical services, as outlined by Doctor E.

I think in society there is a reluctance to withhold medical treatment for people whereas you know maybe years ago people, with respect, if they were a bit dotty and they had a bad heart, you may not go all out to save them. Whereas now we do, people tend not to hold back anything.

With the onset of improved and arguably more equitable medical services, it is possible people will live to an older age. With increased numbers of elderly people, it is also likely that conditions such as dementia will increase, as was suggested by Doctor E.

By having an ageing population you are going to get more people with dementia. The fact that we keep people alive longer with medical technology, [means] you live longer. I remember some professor or someone telling us they have done studies and worked out that if everyone lived to the age of one hundred about eighty per cent or more would have Alzheimers.

The respondents, particularly in relation to carer stress saw dementia as a concern related to elder abuse.

Doctor B suggested that an ageing population would impact on the area of elder abuse because "we all get old in the end, ... I think people are more likely to suffer neglect and abuse at the other end of their lives from what I see." In an ageing population the increase of such violence could be expected to affect more people in the future.

Doctor C indicated that elder abuse was less prevalent than child abuse or domestic violence. Additionally, Doctor C also stated that "violence perpetuates more violence, [so] that the child develops the notion that violence is an acceptable part of normal behaviour." Therefore, according to Doctor C, it is likely that "they are violent later on in life to other people, and even their own children, and that sort of thing." With people living longer and therefore an ageing population increasing, this theory could have serious implications as to elder abuse being a societal problem. Studies conducted by Rathbone-McCuan (1978) and Lau and Kosberg (1979 in Anetzberger 1987) provide support for the notion that conflict can occur as a result of either intra or inter generational violence, and that this can then be related, in part, to the aetiology of caregiver abuse of elderly people.

#### **Sub-Theme Two: Lack of Respect / Cultural Significance**

Two other themes were evident in the interview data, a lack of respect for elderly people, and cultural differences in Australia compared to other nations. Generally it was felt that Australians did not have the same level of respect for their elderly people as do other cultures.

Doctor E suggested that there is a direct relationship between a lack of respect for elderly people and elder abuse. Doctor E indicated that the respect of elderly people in Australia was not as strong as in Asian communities. "You have got to respect your elders no matter what they do to you. But here, I find it not such a strong thing. So I think that contributes to it." Doctor E's view is one of Western society placing an emphasis on youth, and discarding the elderly. Doctor A, who indicated that lack of respect could impact on elder abuse being a societal concern, also supported this viewpoint.



The Asians tend to keep their elderly and look after them better. They feel that is their duty and they respect their wisdom and they have much more of a social conscience about looking after their elderly.

Doctor A further suggested that, "there are lots of different cultural things, I think Caucasians are a lot meaner to their elderly than perhaps say Asians are and Italians."

Such issues are relevant in the area of elder abuse, especially when one considers that the government would prefer to keep individuals out of institutions. This is supported by Saunders (1988) who observed that the goals and philosophy of the Home and Community Care program are based around facilitating elderly people who do not require acute medical care, to stay in their own homes and out of institutional care. This then can place pressure on a family member to become a caregiver, and abuse could occur.

### **Sub-Theme Three: Extended Family**

A break down of the extended family may contribute to some older people being placed in nursing homes. Loneliness and depression can affect elderly people, because they are socially isolated from their families, and this can contribute to emotional and psychological abuse. This view was evident in the data, as some of the doctors indicated that poor family relationships and lack of extended families added to elder abuse as a societal concern. Doctor A indicated that, "quite often a lot of the old people here are alone, there are no extended family systems. The family ties I think here are not as strong as in Malaysia / Singapore."

Doctor E indicated that the composition of the family in Australia has changed, bringing with it changes for elderly people, which can impact on elder abuse being an increasing problem. "From what I can ascertain from what I have seen, right from the fact that families are too busy, often women are working as well now, so there is no one around to look after the elderly." Doctor A supported the view that families should be responsible for elderly people. When asked if elder abuse was a societal issue, she responded, "I suppose it should be. Basically people and families have to be responsible for their own. The government seems to be taking over more and more."

## Discussion

It is apparent from the interview responses that elder abuse can be viewed in a wider context as a 'societal problem'. 'Societal' has been defined in the Universal Dictionary (1988, p.1443) as "of or pertaining to the structure, organisation, or functioning of society." Problem has been defined as "a question or situation that presents uncertainty, perplexity, or difficulty" (Ilison 1988, p.1227).

The sub-themes developed from the data all relate to the structure, organisation and functioning of society, therefore being 'societal'. Abuse and neglect fit into the definition of 'problem', as they present both uncertainty and difficulty. Consequently, as defined within the data, elder abuse can be seen to be a societal problem. What is not clear from the data however, is the perceived extent of the problem.

The literature documents Australia as having an expanding and ageing population.

According to Gately et al., from the years 1987 to 2031 the "total population is predicted

to increase to 22,500,000" people (Gately et al., 1990, p.18). During this same period, it is also anticipated that "the percentage of the population of pensionable age 60 plus is expected to rise by 180% from 2.1 million to 5.9 million" people (Gately et al., 1990, p.18). This represents a figure of over 20% of the total population. Furthermore, Minichiello, Browning and Aroni (in Minichiello et al., 1992 p.14) further suggest that "by the year 2031, the number of people 80 years of age and over will be 1.4 million." With an ageing population, there is a strong likelihood that elder abuse will increase in the future.

McCallum (1993, p.6) suggested that:

Abuse and neglect of older people occurs when individuals and families do not fulfil social obligations or when social obligations are structured against the interests of elders.

Therefore this suggests that the extended family may not be as supportive of elderly people as in the past, and the traditional caring role of women has changed, it further supports the perspective that elder abuse is a societal concern, as outlined by Jones et al:

For families, long term care in the home is becoming more difficult, especially when the primary caregiver is a woman who must also work to supplement the family income and take responsibility for her own children (in Minichiello et al., 1992 p.226/7).

Furthermore, Jones et al. (1992) also suggested that:

In Australia, as in many Western countries, conflicting family roles and cultural tradition may complicate both the adjustment of the older person to residential care and the psychological adjustment of younger family members who feel guilty because they are not able to fulfil their traditional role by caring for older relatives at home (p.239 in Minichiello et al.).

Thus it appears that Australia's culture is not one that is based on a commitment of being responsible for looking after elderly people within their own homes. It is possible that as the population grows older, more and more elderly people could be isolated from their families. This may then lead to depression, loneliness, and forms of neglect and social abuse.

The sub-themes are inter-related, and collectively support the major theme that elder abuse is a societal problem. The data suggest that an ageing population, that has minimal respect for elderly people, and culturally does not take responsibility for elderly people, all lend support to the notion that elder abuse is a societal problem.

## **Existence**

The most prominent theme, which emerged from the data in this section, is that of the identification of abuse. It became apparent that elder abuse exists, and that the types of cases that GPs had dealt with are varied. Outlined below are comments from Doctor A about her experiences of elder abuse and neglect.

There is another [person] who is ninety who lives on her own. ...she has the vilest temper, and the children who are in there seventies are often on the receiving end of it. So that's sort of like the reverse situation.

Doctor B relayed the following stories about financial abuse.

There was this instance where an elderly person was very distressed because they [sic] didn't have access to their [sic] money and their [sic] money was being tightly controlled by relatives.

I have come across two old people living together and they are both beating each other up. And that is a very difficult situation there is sort of alcohol involved and there is dementia involved and you know it becomes quite a difficult situation.

Doctor E experienced a situation where financial abuse and neglect were involved.

I had an elderly lady, she was over the age of 80, and her two daughters would come at different times and bring her to the doctors. ...I found one of the daughters was stealing from the mother and ripping her off and had arranged to have all sorts of assets transferred. ...it was really quite insidious, because the daughter that was doing this was the one which was actually providing most of the care for the mother, and must have felt that it was her entitlement.

Doctor B relayed the following story about self-neglect.

There were these two sisters living together, they were both about 90 and their place was just a tip. There was nothing in the fridge and the cats were weeing everywhere. ...that is the problem, a lot of people outlive their relatives, or their relatives are gone or lost.

## Discussion

From the data it is clear the GPs have had to deal with a number of abusive cases and that elder abuse exists as they outline with the comments above. What is not clear from the data however, is how extensive the problem has become. Importantly also, the respondents in this section of the study were self selected, which could indicate that they may be more likely to know of cases of abuse.

Some authors in the literature have criticised GPs for not identifying abuse and for doubting its existence. Thus, Hickson (1991) and Kurrle et al. (1991) suggest that there seems to be a denial by GPs that the problem of elder abuse actually exists.

Elder abuse has been seen by GPs as a societal problem. Combined with the type of cases in which GPs have been involved in, there is clear evidence that elder abuse exists, and there is no apparent denial from GPs of the problem's existence, as was suggested by Hickson and Kurrle. It is important to note however, that the responses to this study are not intended to be generalised to the wider population, and are only representative of the GPs who were involved. It is clear however that elder abuse exists, and that GPs in this study are not denying its existence.

## **The Victim**

Sub-themes developed from the data consisted of options such as asking the patients what they wanted the doctor to do; identifying how the problem happened so GPs could relate a degree of urgency to interventions; and counselling. All of these sub-themes joined together to form a major theme which concerned the 'victim'. Essentially, the data that have been gathered are trying to identify the victim in an elder abuse situation, and what the victim would like a GP to do.

### **Sub-Theme One: Options**

Some GPs indicated it was important to get the patients 'on side', and to outline they can provide assistance if the patient requires it and is willing to receive help. The GPs felt they

could only help patients if they wanted their help. To do this, many GPs indicated that they would have to ask the patient exactly what they wanted from them. Doctor C made the following comments:

What do they want me to do? I think that would be my initial approach... I think you need to get the person on side first, otherwise I found that you go racing in and then you get there and everything gets organised and then they turn around and say that 'there's nothing happening sorry, go away'.

Doctor A indicated that the type of interventions used often depended on the patient. "I personally, don't feel that she should be suffering this, and what does she see as her options. It really depends on what her response to that was."

Doctor C saw the practice of dealing with the problem without the patient's consent as a possible form of abuse in itself. "A lot of it depends on what she wants to do. If you kind of force them to do things that they don't want to do, then you are equally guilty of abuse."

From the data it emerged that GPs did not want to respond to the problem without the consent of the patient, and they would not see it as being useful to do so. If it were not clear as to what the patient wanted done about the abuse, then any intervention used by a GP may further victimise the patient who consequently could then be worse off.

### **Sub-Theme Two: Why it Happened**

A theme, which emerged from the data, was that doctors would like to know why the abuse occurred. Before they could address the problem, it was important that they

understood the aetiology of the problem. The basis for this was that they were not sure of who actually was the victim, and what should be done to ameliorate the problem. As outlined by Doctor D below, it is importantly to know how the incident of abuse started.

"What provoked this? I mean that maybe the carer just needs time out, maybe the person is demented and has got some unusual habits." Doctor D went further suggesting "you have got to find out the circumstances, everything is different." Another GP, Doctor E, indicated that "... [you need to] get a lot more history about how it happened, whether he was intoxicated at the time, what triggered the incident, who she lives with, who are her supports... drug related or whatever."

Doctor C suggested the following:

You would want to talk about why it happened, the circumstances under which it happened. Does she feel guilty... angry and quite sure that she is right and he is wrong. Or whether it has been so chronic that she feels that she is somehow guilty, the guilty party, she has provoked this, and she has done this and done that to provoke it.

The GPs wanted to know why the abuse happened, so that they could piece together appropriate amelioration processes. Putting interventions in place which either are not wanted by the abused person, or do not address the cause of the problem, may further inflame a volatile situation. Additionally, it could reduce the confidence, which a patient has in a GP, and adversely affect the doctor-patient relationship.



### **Sub-Theme Three: Counselling and Interventions**

Some respondents indicated there was a need for counselling to take place for both the victim and the perpetrator. The counselling was not necessarily needed to be undertaken by GPs as indicated in the following data, by Doctor A:

Ideally [there should be] counselling to try and resolve whatever the difficulty is. Because I haven't actually been in this sort of situation before, I would probably start with a social worker at the local hospital.

Doctor C suggested, "[I'd] get her back, you know counsel her. You can sometimes get them in to see the psychologists and things like that, and that is always useful."

### **Discussion**

Implicit in the data is that a doctor may not assist a patient without consent. For assistance to be given it is important that GPs know the cause of the problem, and when this has been identified, counselling can be utilised to assist.

A problem of elder abuse however, is that it is not always possible to distinguish the victim from the perpetrator. The elderly person may intentionally upset the caregiver, who then abuses. In such circumstances, both are victims of abuse, and also abusers. On some occasions, "the stressed adult child who does use psychological, verbal, physical, or medical means to maintain control, often does so with the best intentions" (Steinmetz, 1988, p.180).

This leads to the notion that it is important to know who is the "victim". As outlined by Steinmetz (1988), on occasions the victim is not just the person who has been abused, but in some circumstances, the carer has been provoked or is stressed, and can no longer deal with the situation. Some stressors increase the likelihood of elder abuse, and have been identified by Giordano and Giordano (1984, p.234) as, "family dynamics; dependence because of impairments; personality traits of the abuser; filial crisis; internal stress; external stress; and negative attitudes towards elderly people."

If one or more of these stressors are causal to the abuse occurring, it would be useful to know if the abused person wanted assistance, what type of assistance is required? How the abuse occurred? and to provide counselling and appropriate interventions. In some situations elderly people do not want assistance with abusive situations as they may fear isolation, being institutionalised, or they may be in a financially reliant situation with their carer. On other occasions, the abused person may feel guilty as he/she may be the cause of the problem, and in such circumstances, both the carer and the elderly person become victims. In these abovementioned situations, not only may the elderly person 'cover up' that abuse has occurred, but additionally they may also not give their consent for a GP to intervene.

## **Training**

A major theme that emerged from the data was the need for further training. All respondents indicated there was a need for training by GPs in aged care and specifically in elder abuse. Through the data, sub-themes which developed included undergraduate training; characteristics of populations, and training providers.

### **Sub-Theme One: Undergraduate Training**

Doctor E, who was comparatively younger than the other respondents, indicated that some geriatric training is optional at an undergraduate level. Should an undergraduate want to go into geriatric medicine during the final couple of years, one could "pick up which speciality you want to go into, so they would choose at that stage to want to train into geriatrics." Doctor D indicated that as an undergraduate and as part of the training he undertook, he spent several months in geriatric medicine, as well as other areas including palliative care, totalling around nine months of his training.

Doctor B indicated that they did not receive any undergraduate training relating to the problem of elder abuse. "I don't know if they are doing it now, they didn't when I was there. I think old people have a whole different metabolism, and so you do need to learn different stuff about them." Doctor A also supported this view: "I graduated about 20 years ago, and I can't remember any significant gerontology. No. It was all cut and chop and pills and stuff like that."

Doctor C suggested that "hospital based training is all geared, at least in my time towards acute stuff you know. When I was training... and I think it is still the case there is very little spoken of child abuse and elder abuse. Not that it doesn't happen but, people pretend that it doesn't."

From the data, it is apparent the majority of doctors who graduated in excess of 15 to 20 years ago, would not have had training in the area of geriatrics. Even those who have

graduated recently, have not had specific training in the area of elder abuse. Training in the area of geriatrics does not appear to be a pre-requisite for all undergraduate medical students, and has not been addressed at a post graduate level, unless doctors choose to take an interest in that area, or to specialise.

### **Sub-Theme Two: Characteristics of Populations**

The respondents indicated a major influence on the type of training that they undertook after graduating was dependent on the age and medical problems of the populations within their practices.

With regard to training after graduating, Doctor B suggested that "a lot of it is dictated by the patients that you are seeing, in younger areas obviously you do a lot of paediatrics." This view was supported by Doctor A, who indicated that she tended "to go on a sharp learning curve when I have got a patient that is worrying me." The other GPs indicated that training related to their patients' problems. Doctor C suggested that "you kind of hone in on what you actually deal with," while Doctor D outlined that "whatever you have got an interest in, which is usually whatever you happen to see in the area."

Several respondents indicated that due to a lack of time, it was easier to learn things on an 'as needed' basis. If a problem arose then it may require having further training in the area to address the problem, as outlined by Doctor A:

If there is something that I'm not sure about, I ring up and say look I've got a problem here. I tend to learn that way, with hands on things, because I find it difficult to find the time to sit down and read and absorb information in journals and stuff like that.

Doctor B supported this perspective suggesting "the problem is that in general practice, the glut of information is just unbelievable... you just can't accommodate it all in your head, let alone on your desk."

From the data, it is evident that the type of postgraduate training, that GPs undertake, depends on the characteristics of their patient population, and the amount of time, which they have to undertake training. The training would appear to be mostly reactive, in that GPs respond to immediate needs and problems as opposed to being proactive, where they are learning about dealing with issues prior to them becoming major concerns.

### **Sub-Theme Three: Provision of Training?**

From the data it appears that there is no coordinated approach to the type of training undertaken by GPs, and it is unclear as to who should provide the training for them. It was apparent in the data that the subject of elder abuse, while not currently being offered at an undergraduate level, should be taught in to students undertaking their medical studies.

When Doctor D was asked about training in the area of elder abuse, the reply was that "there is no structured degree or anything. I don't think you would get many people doing that sort of thing, most people would be too busy trying to earn a living."

Doctor B suggested that elder abuse could be a part of the undergraduate course. "I think it should be introduced at an undergraduate level. I think it should be taught as a mini subject within the general disciplines of general medicine." This view was supported

by Doctor A who suggested that, "for the people coming up it should be at the undergraduate level."

There was little consensus about who should provide and coordinate postgraduate training. GPs are required to undertake a certain amount of training, which is coordinated by the Royal College of General Practitioners. This role however, is only to ensure that training is undertaken, and not to provide or coordinate the type of training which is taken. The responses in the data varied about whom should provide gerontology training for GPs in the field.

Doctor C indicated that "the ACAT (Aged Care Assessment Team) would be good," with Doctor A suggesting that a course every couple of years would be adequate. "Whether a weekend of full on gerontology would give you the basics. ... perhaps that might be another way to go, every three or four years to have a seminar."

Doctor B indicated the following:

I think really where it should be coming through is from education series. It should be coming either from the College of General Practitioners, which it does from a certain extent, but it has not been very vigorous, and the other area probably it will come from in the future is from organisations which are called divisions of general practice, [where] they will probably start coordinating better teaching programs. Hopefully they will be drug company funded, but I think if the divisions can drive them, I think they will be better representative of what we need to learn.

The following data summarised the responses from the GPs. When asked about training in the area of elder abuse Doctor B replied, "... at a postgraduate level I think it is very important." He went further to suggest however, that one of the obvious problems with training is that "unfortunately general practice training is uncoordinated."

## **Discussion**

Training is a concern in regard to the area of elder abuse and GPs. While GPs have to undertake a certain amount of training each year to meet their vocational registration requirements, the type of courses that they undertake are up to the specific individual. In most situations the type of training, which is undertaken, is guided by the characteristics of a GPs patient population, or by specific individual cases which are of interest to the doctor.

The area of elder abuse and geriatric medicine is not an area that some respondents have been trained in, either prior to or after graduating. Therefore, for doctors to identify the problem of elder abuse, without training, raises the issue of whether they actually have the necessary skills. While GPs have identified and dealt with some cases of abuse, as outlined through this study, it is not apparent if they have missed cases or dealt with the problem adequately. With training, role definition and a coordinated approach, the treatment of elder abuse could be better managed.

## **Referral**

Referral was a theme that was generated from the data. All the GPs indicated they had a responsibility to identify abuse, however many responded that they were not able to address all the problems associated with it, and that they would require professional assistance to help them. As such, their role emerged from the data as one of referring patients to relevant professionals to deal with the area of elder abuse.

The sub-themes, which emerged from the data to support the theme of referral, were 'identification' and 'interventions'.

### **Sub-Theme One: Identification**

All of the respondents indicated that GPs have a responsibility to identify abuse and to deal with the symptoms. However this role is one of referring others to deal with the problem, after a GP had identified it.

When asked about their role in elder abuse, Doctor B offer the following:

To discover it basically. If you can discover it you have done well. Number two is you can often talk about it yourself but I think that it is not prone to be very effective because, we are not skilled at sorting that sort of stuff out. I think you need the back up of social workers, or you know departments, governments and teams and things like that.

This same doctor went further to suggest:

... that the whole thing is just too big and that is why I tend to more treearge things in a sense, and just refer them to someone who I think will probably know what to do and sort it out. I think as part of elder abuse I see my role more in finding it than in actually treating it.

Doctor A clearly indicated that identifying the problem was a major role. "I think that you have to identify it." Doctor D however indicated that doctors should not only be involved in the identification of elder abuse, but also in the amelioration of the cause. Doctor D went further to suggest however, that due to many impediments this may be difficult, and would require training as outlined below:



I think that we do have a responsibility to identify, and do something about it, not just the symptoms of it but the cause of it. But like I said, there are all these impediments to actually confronting the person or problem, face on, because there are always a lot of disincentives. So I suppose training is important in that area.

This same GP further indicated that while identification of elder abuse was important, it also needs to be accurate otherwise it can cause concerns. He indicated that:

I think you must be very careful of what you say. In the service industry you can get into a lot of trouble, it creates absolutely no financial gain. This is very mercenary, but I think that is something that I think is true. Why should you trouble yourself, and go to so much trouble, put yourself at risk, for next to nothing. So there are lots of disincentives to do that sort of thing. Sometimes, they [abused person] are not too bad, you turn a blind eye perhaps, it wouldn't surprise me if that happens. Or you say nothing until you are absolutely sure, which could be far down the track.

The role of identification of elder abuse by a GP, is congruent with the views of the data from the key informant interviews. The view expressed in the above quote however, indicates that while identification of elder abuse may be a role which some GPs are prepared to undertake, others are more cautious about its identification.

## **Sub-theme two: Interventions**

The GPs indicated that it is their responsibility to ensure that interventions are put in place, but they should not be involved in the actual provision of the interventions. Other agencies or specialists should be called upon to provide assistance. It highlights that GPs see their role as one of referring patients. Doctor D made the following comments:

Our role becomes more of one of detection, treating, yeah detection. You know what is appropriate, you refer on, and you get someone to confirm it is appropriate, and then things get done from there. You don't actually do it yourself, which is probably an advantage because, organisation of that sort of stuff takes up a lot of time. Ringing people, organising times, and taxis and

transport. That takes time, so that is unpaid work. So it is good in a sense that the Department of Geriatric Medicine had taken over all of this sort of function.

Doctor B also supported the referral role:

...you can organise respite in one of the frail aged hostels, and you can have respite for up to about six weeks. If it is a bit more difficult problem and you need a lot of intensive input then you have to get the geriatric service involved.

In general, these responses focus on the GPs referring patients for other interventions, once they have attended to the medical concerns of the patient.

## Discussion

The sub-themes, identification and interventions, support the major theme in that the main role that GPs have in the area of elder abuse is that of referral.

The GPs indicated they have a responsibility to identify abuse cases and to deal with them. However, as identified in earlier data, GPs may not be sure of what encompasses abuse, and therefore what abusive actions may need to be reported as opposed to those who are not abusive, and therefore not appropriate to report.

Despite this, Hailstones (1992) has suggested that the "problem is not in finding the cases but in doing something about the issue when identified" (p.33). This supports the view that GPs should then take on a referral role. There is still a need for training however, so that GPs have a wider knowledge of not only what abuse consists of, but also of what are appropriate interventions to take in the amelioration of cases.

It is evident from the data that these GPs feel they are not in a position to directly deal with many of the issues associated with elder abuse and neglect. Additionally, they did not feel that they have the training to adequately provide the assistance required. The GPs indicated that their role is one of identification, and therefore referral. It is important however, that GPs have a clear knowledge of available interventions, and that they take the time to clearly identify and meet the needs of the abused patient.

### **Consuming of Resources**

A theme which emerged, is consuming. The respondents outlined that elderly people will visit a doctor because they may feel lonely or isolated. Another area to develop from the data is elderly people taking more time in consultations, which can have financial implications for GPs. Therefore, consuming relates to elderly people requiring a lot of resources from GPs, as well as elderly people being time consuming for GPs. The sub-themes associated with the major theme of consuming resources are isolation, and length of consultation.

#### **Sub-Theme One: Isolation**

This data suggest that elderly people often are lonely, and as a result visit a doctor as a means of socialisation. While medically there may be no problems, elderly people may visit a GP to have some form of social interaction.

Doctor D suggested that:

Older people always have something to tell you, something to talk about, whatever that is, whatever minor things they may be. They appreciate that as a form of social therapy, if you like, and they are, a lot of them are lonely, just plain lonely, and want to talk about something.

While it is apparent that elderly people visit GPs for many reasons, social isolation is clearly one of them, and as such this may take up a considerable amount of consultation time of a GP.

### **Sub-Theme Two: Length of Consultation**

A sub-theme also emerged relating to the amount of time that is associated with older patients during consultations. Doctor E provided the following views suggesting that "a lot of them want to have a chat. I think, most of the time I would be lucky to get an elderly person out in less than 25 minutes. Usually a long consult as opposed to 10 minutes."

Doctor A suggested that "...they take more time. It takes time to explain things, and also there's sort of a balance between what you treat and what you don't and how far you go."

Elderly people were perceived to be slower, for various reasons. This impacts on the amount of time they take for a consultation, and has financial implications for GPs.

Despite this, the GPs indicated that they were prepared to spend time and lose money, to provide adequate consultations for the elderly patients, as stated by Doctor B:

I mean it is a hard problem because financially you sort of have got to see five an hour, but in reality it is hard to get through more than four an hour, particularly with older people, because they do have such a lot of complex problems some of them.

Doctor C concluded "I think a lot of us look after the elderly because we feel it is a service to them. I mean if you are looking to strictly make money, you don't make money out of it."

However Doctor E suggested that the Medicare system could be seen as a perpetrator of abuse, and a limitation to the provision of quality care to elderly people.

It discourages you from spending extra time with patients, and therefore it discourages you from giving high quality care, and it is only through the goodness of your heart that you give good quality care. Well you do it, but you know you are earning less money.

## **Discussion**

Some elderly people take longer for consultations, which has financial implications for GPs. Additionally, some elderly people may visit a GP for social interaction as they may feel isolated. These areas are consuming of GPs' resources, not only financially, but also in terms of time.

In the literature, many authors have criticised GPs for their approach to elderly patients, and the way in which they do not allow patients time to discuss their problems. Kurrle, suggested, "old people need a 25- or 45 minute session, and doctors are reluctant to grant that. For one thing, dare I say, they don't see it as cost effective" (in Hickson, 1991, p.71).

The criticisms outlined by Kurrle towards GPs, have not been supported by the results of this study. GPs are aware that the time required for elderly people to have a consultation in general, is more than that of younger people, and that by doing this they are losing

money. However the GPs in this study did not indicate that elderly patients require a 45-minute consultations as suggested by Kurrle. The time required for adequate consultation of elderly people however, may need further research.

The ability of GPs to adequately address the detection of elder abuse cases may depend on the amount of time which they are prepared to spend with their patients, and the type of environment which they provide within their surgery.

As suggested by Adelman et al.:

In settings with limited resources and specified physician productivity requirements, the time needed to adequately assess the elderly person may be hard to find and may make caring for the geriatric patient less desirable (1991, p.136).

While elderly patients are receiving more time in consultations, it is still not clear if this is enough time to actually identify cases of elder abuse. With increased awareness and training, GPs would be better equipped, and more proficient to deal with the problem.

Additionally, as evident in the data, one must question the scheduling of Medicare payments, and the time which is allowed for doctors to deal with issue such as elder abuse, which may necessitate longer consultation time.

## Conclusion

Within this chapter there were several sub-themes developed, which formed the nucleus of the seven major themes. Some of these major themes consisted of looking at definitions, as well as identifying if elder abuse is a societal problem. Other themes including looking at its existence, the identities of the victims, training, and referral. Another theme, which was developed, is that of resource consumption. Each of the abovementioned themes had elements, which can be inter-related with.

Through a clearer definition of what does and does not constitute abuse, doctors would be better skilled to identify cases. It is clear that elder abuse exists, and through training, GPs will be equipped to clearly identify the victims, and then provide adequate support and advice for them. Elder abuse may be time and resource consuming, but with increased skills and with well-defined role expectations, this could be minimised. Additionally, through adequate training GPs may be better equipped to identify the problem and to refer patients, to other professionals who can deal with some of the more entrenched issues involving elder abuse.

## CHAPTER SEVEN

### Conclusion & Recommendations

#### Introduction

This chapter presents a synthesis of the findings from the mailed questionnaire to GPs, the face-to-face interviews with key informants, and the follow up face-to-face interviews with doctors. While results from each of these different data techniques have previously been outlined in detail, this chapter will link elements from the three areas of research together, and present recommendations.

#### Training

Throughout the data, a theme, which constantly emerged, was that of 'training'. In the mailed questionnaires, 40% of the doctors indicated that one restriction they had in accurately identifying elder abuse, was a lack of training. Additionally, almost 94% (30) of the GPs indicated that they did not receive any training in relation to elder abuse during their university studies. This finding is supported in the literature by Perrotta et al. (1981, in Blakely et al., 1993, p.39) who suggested that "medical schools presented limited training opportunities to prepare future physicians to work with elderly people", further adding "medical students frequently lacked basic information about elders in our society."



Blakely et al. (1993) also supported this view suggesting that "it seems that many physicians lack the training, knowledge, and attitudes which are needed to respond effectively to cases of elder abuse and neglect" (p.40).

Additionally, data from the key informant interviews strongly supported the view that specific gerontology training was necessary for GPs, and the general human services' sector. As outlined in the data, one response which was representative of most key informants was "I think it's crucial, particularly as we are entering that period where we are going to see that demographic shift." This perspective was also supported in the data from the doctors' face-to-face interviews, with all respondents formulating the view that there is a need for specific training about elder abuse in the human services area. Data suggested that it needs to contain information on awareness raising about elder abuse, identification, interventions, and agencies that are able to assist with the amelioration of elder abuse.

The data also suggested that initially the key areas to focus the training on should be GPs, Social Workers, and Home Care Workers as they were identified as being the people most likely to have initial contact with an elderly abused person.

However the data from the face-to-face GP interviews suggested that most of the post graduate training undertaken by GPs was relative to the medical characteristics of their patient population. Therefore it is likely that GPs would only undertake training about elder abuse, if they were to see a number of cases within their own practice. Thus, it would be necessary that GPs' training be coordinated and proactive, as opposed to being

reactive and generally uncoordinated as currently it appears to be, especially if GPs are to increase their awareness of elder abuse.

### **Caregiver Training**

Within the key informants' data, lack of training was also seen as a major cause of why abuse occurs. While it was identified as being an impediment with regards to the level of input professionals have in the area, it has also been linked to caregiver stress. The data suggested that caregivers did not have enough training prior to and while undertaking the role of a carer, which caused them stress. This in turn might be attributed as a cause for them abusing elderly people whom they were looking after.

When considering all of the above, training is an important area that needs to be addressed. Not only can a lack of training affect a professional's ability to detect and deal with cases of abuse, it can also impact on the level of stress which is associated with caregiving, and therefore be an actual cause of elder abuse.

### **Mandatory Reporting**

The views of the respondents towards mandatory reporting were divided. The key informants had differing opinions, with some in favour of reporting cases of abuse, while others disagreed. Similarly, the responses from the mailed questionnaire were also indecisive, with 37.5% supporting mandatory reporting, 40.5% indicating that it should not be mandatory, and 22% suggesting that they did not mind either way.

The literature also is divided on the issue of mandatory notification of elder abuse. This subject needs further discussion, and possibly more research to completely explore the benefits and disadvantages. What must be taken into consideration, is that if mandatory reporting is introduced, there must be adequate services and enough skilled professionals to deal with the problem adequately. There is no benefit in reporting a case of elder abuse and then not being able to do anything once it has been reported.

### **Role of the Doctor**

While the data suggested that doctors can and should respond to "immediate" medical problems, what was overtly prominent was that a doctor's role was one of identification and referral. The key informant data strongly supported this view, and similar perspectives were also evident in the face-to-face GP interviews, where all of the respondents indicated that identification of elder abuse and referral to other agencies was a role that doctors should undertake when dealing with elder abuse. The data from the mailed out questionnaire were consistent with the above, in that a GP's role was one of treatment of physical and mental illness and referral to other agencies.

The key informant data however were clearly negative in terms of the current role undertaken by GPs, and their responses indicated that GPs generally do not identify or respond to elder abuse. Blakely et al. (1993, p.37) supported this view, suggesting that "it is more the exception than the rule that physicians play an active role in reporting elder abuse and neglect." This was also supported through the results from the mailed questionnaire, where 60% of GPs indicated that they rarely considered the possibility of elder abuse when a person of 60 years of age or older enters the surgery. This could

indicate that GPs might not identify cases of elder abuse as they rarely consider it as a possible cause of injury to elderly people.

### **Significant Problem**

The data from the key informants and the face-to-face GP interviews indicated that elder abuse is a societal problem. Much of the doctors' face-to-face data are based on factors such as Australia is becoming an ageing society; there is a lack of respect for the aged; the cultural impact; and the level of family responsibility, which in their view would all have an impact on the area of elder abuse and neglect.

Data from the key informants' interviews also indicated that elder abuse was a societal problem. However, again what was not clear, was the actual rate of occurrence insomuch that the each of the key informants indicated involvement in a varying number of cases, ranging from a few, through to a couple of hundred.

Therefore, what emerged from the data was the uncertainty of the level of elder abuse as a societal problem, and therefore there is a need for further research in this area. The data could be interpreted as suggesting that the area is significant, primarily because of the current and projected demographic changes to Australia's ageing population, and not necessarily because it is a problem which is occurring in increasing proportions.

Kurrl (1995, p.173) suggested however, that "there have been no prevalence studies in Australia." The reasons for this could include the difficulty associated with developing definitions, the possibility that elderly abused people may try to disguise or hide the fact

that abuse is occurring, and the lack of training and awareness of elder abuse, which is currently evident across the broader human services field. However, until further research is undertaken into the area, its actual prevalence will not be fully known.

Despite this, each of the three data gathering areas indicated that elder abuse exists.

Data from the key informants suggest that elder abuse was known within Perth from as far back as the early 1970s, and that in their view, the most prominent types of abuse are emotional / psychological abuse, and financial abuse.

## **Definition**

As mentioned previously, one attributing factor to the significance of elder abuse is the difficulty with ascertaining its current level as there is no universal definition which is adopted by all professionals and para-professions in the human service area. Without clear definitions, it is difficult to identify and measure elder abuse. Within the data, there was evidence that definitions of elder abuse were inconsistent, and that they varied appreciably across specific professional areas.

In the mailed out questionnaire to doctors, 43% (14) of the respondents indicated that no definition of elder abuse were presented through their profession, while 47% (15) indicated that they did not know if the medical profession had a definition of elder abuse.

In the data gathered from the key informants, it was evident that what may be identified as being abuse by one person, may be seen as being non-abusive by another. This highlighted the uncertainty associated with clearly defining elder abuse, particularly when

it is considered that the key informants were people who not only had some direct association with the aged area, but also had an awareness and knowledge of elder abuse.

The data from the face-to-face GP interviews were also inconclusive in terms of providing a definition of elder abuse. Some of the general components outlined in these data included psychological, physical, emotional, financial, and legal issues. However, although these areas were mentioned as components of elder abuse, no specific or clear definition of the area were agreed upon, further clouding the overall definition of elder abuse. Collingridge (1993) suggested that as a "social phenomenon currently exercising the minds of policy makers, researchers and practitioners, elder abuse is a political slogan in search of both definition and direction" (p.32).

Given the data, and the views of Collingridge (1993), it is necessary that a universally accepted definition of elder abuse is developed and adopted by professionals and para-professionals across all disciplines. This would assist with clearly identifying what is and is not elder abuse, and also assist with gathering information on the prevalence of the problem. As stated by Pedrick-Cornell and Gelles:

Perhaps the most significant impediment in the development of an adequate knowledge base on intrafamily violence and abuse has been the problem of developing a satisfactory and acceptable definition of violence and abuse (in Galbraith 1986, p.13).

## Restrictions

Over 71% (23) of the respondents in the mailed out questionnaire indicated there were restrictions associated with accurately identifying abuse in elderly people, with almost 60% indicating that 'being uncertain of the cause of the problem' was a primary reason for GPs not intervening. A 40% suggested that a lack of personal training in the area was another reason why they did not intervene.

The key informants supported the notion that there were restrictions on GPs being able to accurately identify elder abuse and neglect. In their view however, the reasons for GPs not identifying elder abuse were associated with doctors 'not knowing what to look for' and 'not spending enough time with elderly patients', to allow for issues such as elder abuse to arise in a consultation.

Interestingly, the key informants indicated that awareness, time, and knowledge, were also issue that restricted them from intervening in cases of elder abuse. This would further support the view that there is a need for further training to be undertaken within human services to address the issue of elder abuse.

This view is supported by Haviland and O'Brien (1989) who indicated that professionals, through their "lack of consideration that abuse of elderly people actually occurs, can often give a misdiagnosis of the problem" ( p.13). Misdiagnosis can then lead to inadequate or poor interventions being introduced.

## **Interventions**

The data indicated that the interventions for elder abuse used by the key informants varied. They included utilising the Public Guardian's Office, Power of Attorney, the Police, and services such as the Jesus People. In the mailed questionnaire, GPs indicated that the most useful interventions for them to use would be referral to a community agency, counselling, and respite care, while also assisting with the treatment of the elderly person. Kurrle (1993) supports the use of these intercessions, by suggesting that some of the more commonly used interventions should include crisis care, support services, respite, counselling, treatment of the abuser, alternative accommodation, and legal intervention. Many of these interventions as outlined by Kurrle, were used by both the key informants and the GPs, however, it is not clear from the data if they were used appropriately.

## **Characteristics**

Data from the key informant interviews suggested that elderly people who are in a dependent situation could be vulnerable to being abused. The data also indicated that being diagnosed as having dementia was another characteristic which could make someone susceptible to being abused. This view was also supported in the responses from the mailed questionnaire, with dementia being rated by GPs as the most common characteristic of an elderly person that may be vulnerable to being abused. In most situations, an elderly person with dementia, would then be dependent on a caregiver to look after him / her.



In part, the literature associates dependency with the Exchange Theory. Godkin et al. (1989) suggested that when an elderly person becomes dependent and impaired, then "an imbalance in the exchange of positive reinforcements occurs in their relationship with caregivers" (p.209). Other characteristics of someone vulnerable to abuse included deteriorating physical health. This can also lead an elderly person into a situation of dependency on a caregiver, which Delunas (1990) felt could make them vulnerable to being abused.

The GPs in the mailed out questionnaire responded that substance abuse might be the most likely characteristic of someone who is likely to abuse an elderly person. This view was supported by the key informants who suggested that both substance abuse and caregiver stress were major characteristics of perpetrators of elder abuse.

Characteristics of perpetrators such as substance abuse, psychiatric problems and financial concerns, have been referred by Anetzberger (1987) as the personality or pathological traits of the abuser.

Anetzberger (1987) further stated that caregiver stress can take two forms, those being from internal stresses and external stresses. External stress relates to environmental relationships which may affect the caregiver, while internal stresses relate to the pressures of caring for an elderly person, and it is sometimes associated with the burden and strain of doing this (Anetzberger, 1987). These stress areas can be caused through a multitude of elements, but particularly they include caring for an elderly person who has dementia and deteriorating physical health. A significant finding in a study undertaken by Round (1992) was that over 82% of the abusers in her study had no form of support such as respite, formal support groups, or family assistance, while they were in the care-taking

role. This study supports the findings of Rounds, as it identified that the stress associated with caring for an elderly person who has dementia and or deteriorating physical problems can add to caregiver stress. Stressed carers were identified in the data as a major cause of abuse to elderly people.

## **Identification**

In the mailed out questionnaire, over 70% (23) of the respondents indicated that doctors would be more likely to initially see an elderly person who had been abused before any other profession. Several key informants supported this view, while others outlined that either Social Workers or Home Care Workers would be more likely to see elderly abused people first. Interestingly however, as outlined earlier, nearly 91 % of the GPs in the mailed questionnaire either did not know, or were unsure if clear definitions of elder abuse were presented by their profession. Eighty one percent indicated that there were problems with accurately identifying cases of elder abuse, and over 62% either rarely or never considered elder abuse as a possibility of a cause of injury when a person 60 years of age or over entered their surgery.

Kurrie (1995) suggested that reasons for the non-recognition of elder abuse in Australia includes a "lack of awareness of the issues on the part of the medical profession and other health care workers" (p.173). The data from this study would support this view, and indicate that GPs need more awareness and training in regard to elder abuse.

Another criticism outlined in the key informants' data, relates to doctors not spending enough time with elderly people during consultations. However, the data from the GPs

face-to-face interviews suggested that this was not the case, as the doctors indicated that they were prepared to take time to spend with elderly patients if it was required. They acknowledged that it does impact on them financially, and that elderly people are more consuming of their time. The key informants however, indicated that doctors generally did not take the time during a consultation to allow an elderly person to disclose that abuse was occurring, and that this was a possible limitation as to why doctors did not detect its occurrence. This view is supported by Adelman (1991) who suggested that limited resources and specified productivity requirements could make caring for elderly people less desirable for doctors.

While doctors in the face-to-face questionnaire indicated that they are prepared to spend more time with elderly patients, they did not indicate if this would be enough time, in their opinion, to deal with the issue of elder abuse. Therefore, more debate is required over the length of consultation time allocated to GPs through the Medicare system, to identify if it is adequate for dealing with issues such as elder abuse. Furthermore, it should be acknowledged, that the respondents in the face-to-face interviews were self selected, and may have had a strong and genuine interest in providing services to the aged.

## **Summary**

The data from this study have identified some important information with regard to elder abuse and neglect in Perth. It has clearly indicated that elder abuse exists, and that some people have been aware of cases of abuse in Perth since the early 1970s.

The data from this study indicates that there is a level of uncertainty about some of the areas surrounding elder abuse, including its definition, the need for mandatory reporting, and its level of prevalence. This uncertainty however is also evident in the literature, and helps to create healthy debate and discussion about these areas, from which arguments and counter arguments can be presented, and clarity formed.

The role of a GP outlined in this study is one of detection and referral. What is required however, is an awareness and training program, that will assist GPs to undertake this role adequately, as elements of the data indicate that this currently is not the case. This training should also be extended to Social Workers and Home Care Workers, who were identified as other people who are likely to have initial contact with elderly people who have been abused.

Additionally, caregivers were identified as a group of people who also require training about their role of being a carer. Unqualified people undertaking this were seen to be at risk of being over stressed, and therefore vulnerable to becoming perpetrators of abuse, particularly if they also had a substance addiction, and or if they were in a dependency situation.

The data indicated that elderly people who had dementia, who were isolated, or were in a dependency situation, were more vulnerable to being abused. The most prominent types of abuse identified in the data included psychological / emotional abuse and financial abuse. The interventions used varied across the data, but were generally consistent with those outlined in the literature.

The data clearly indicates that training relating to elder abuse is a very important component within the human service field. However for this to occur, a clear definition of elder abuse, that is accepted by professionals and para-professionals needs to be developed.

## **Recommendations**

A clear and concise definition of elder abuse needs to be developed, which is understood and adopted by all professionals and para-professionals in Western Australia.

Based on this definition, further research that aims to identify the prevalence and rate of incidence of abuse within Western Australia should be undertaken.

An awareness raising campaign needs to be developed, which informs doctors and other professions about elder abuse. The campaign could include possible characteristics of individuals who are vulnerable to being abused, as well as characteristics of people who may be likely to perpetrate abuse. The campaign should not be commercial, but undertaken through directly targeting the relevant service areas, using a low-key approach while still getting the message across.

A coordinated approach to dealing with elder abuse should be developed, that includes the specific roles that can be undertaken by professionals and non-professionals. This should outline a GP's role as being the detection of cases of abuse, and referral to agencies that can assist with addressing individual cases. However, GPs should not have the sole responsibility for identifying abuse.

Training on elder abuse needs to be introduced into the studies undertaken by people in the human service field, particularly doctors, social workers and para-professionals who are working with elderly people. This training could either be at an undergraduate level or in a short course format outside the academic arena, to ensure that para-professionals also receiving training. It should include the following:

- \* Awareness that elder abuse exists
- \* Skills require to detect, deal with, and when necessary, refer cases to appropriate agencies
- \* Clear and exhaustive lists of interventions which could be used to address the problem
- \* The likely characteristics of people who are either vulnerable to being abused, or likely to be perpetrators of abuse.
- \* Investigation should be undertaken to identify who should provide and coordinate training in the area of elder abuse.

Training should be readily available to caregivers looking after elderly people. This training should include information on respite facilities, available counselling, looking after people with dementia and physical problems, places that can assist with substance abuse, and the general role of being a caregiver.

More research and debate is required into the area of mandatory reporting of elder abuse.

More research is require to establish if the amount of time which GPs spend with elderly patients is sufficient for them to identify cases of elder abuse, and if the allocated time from Medicare is adequate for GPs to identify elder abuse.

## CHAPTER EIGHT

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Dear Dr

The area of elder abuse / neglect (the abuse of elderly people) is an area which has been largely unexplored within Australia. To help ameliorate this problem, I am conducting a research project into the area, and would request your assistance. Elderly people visit a Doctor more than any other health service professional, and for this reason, your assistance with this study would be of immense value.

As was the case in the child abuse movement, where Doctors played such a prominent role, your skill and ideal community position, may assist with the detection and amelioration of elder abuse. This in turn, may then enhance the quality of life of many elderly people.

I am surveying a random sample of Doctors across Perth and therefore invite your participation. This study is not being funded by any organisation, and your participation is strictly voluntary. Please be assured there will be no publication of any identifiable or possible identifiable information which could lead to your identity being known, and any such information, will be held in the strictest of confidence.

I am conducting this research as part of my Master of Human Service program, at Edith Cowan University, Perth.

Any questions concerning this study can be directed to Paul Howrie, home Tel.

*Please find enclosed a 'Scratch and Match' lotteries ticket, which is a small token of appreciation for your participation in this study.*

PARTICIPATION CONSENT

I..... have read the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realising I may withdraw at any time.

I agree that research data gathered for this study may be published provided my name is not used.

Participant.....Date.....  
Investigator.....Date.....

Thank you for your consideration and assistance,

Paul Howrie

**PLEASE RETURN THIS QUESTIONNAIRE BY TUESDAY FEBRUARY 1ST 1994**



## ELDER ABUSE AND THE GENERAL PRACTITIONER

### INFORMATIONAL DATA

1. Sex: a) Male ☐  
b) Female ☐
2. Age: a) 23-30 ☐  
b) 31-40 ☐  
c) 41-50 ☐  
d) 51-60 ☐  
e) 61+ ☐
3. How many years have you been in practice?
  - a) 1-5 ☐
  - b) 6-10 ☐
  - c) 11-15 ☐
  - d) 16-20 ☐
  - e) 21-25 ☐
  - f) 26-30 ☐
  - g) 31 or more ☐
4. In what country did you receive your training?
  - a) Australia ☐
  - b) United Kingdom ☐
  - c) Canada ☐
  - d) New Zealand ☐
  - e) U.S.A. ☐
  - f) Other, please specify .....
5. Are you in
  - a) Solo practice? ☐
  - b) Multiple practice? ☐
  - c) Other? ☐
6. In what size community do you practice?
  - a) Less than 1000 ☐
  - b) 1001-3000 ☐
  - c) 3001-6000 ☐
  - d) 6001-9000 ☐
  - e) 9001 + ☐

7. Approximately what percentage of your patients are over 60 years of age?

- a) 1 - 25% ☐
- b) 26 - 50% ☐
- c) 51 - 75% ☐
- d) over 75% ☐

## ELDER ABUSE

For the purpose of this study, the following definition will be used. *"Elder abuse / neglect is the wilful infliction of physical pain, injury, or debilitating mental anguish, unreasonable confinement, or deprivation by a caregiver of services that are necessary to maintain mental and physical health"* for someone over 60 years of age. (O'Malley et al 1983)

8. When you see a person (60+) in your surgery, with signs of physical injury, how often do you consider the possibility of elder abuse / neglect?

- a) Usually ☐
- b) Occasionally ☐
- c) Rarely ☐
- d) Never ☐

9. How many cases of suspected elder abuse / neglect have you treated during the past 12 months?

- a) 0 ☐
- b) 1-5 ☐
- c) 6-10 ☐
- d) 11-15 ☐
- e) 16-20 ☐
- f) Over 20 ☐

10. What type(s) of abuse / neglect have you treated in the past year? (please tick)

- a) Physical abuse ☐
- b) Physical neglect ☐
- c) Material abuse ☐
- d) Financial abuse ☐
- e) Psychological abuse / neglect ☐
- f) Exploitation ☐
- g) Other, please specify ..... ☐

11. Are there occasions when you have strongly suspected elder abuse / neglect, but have not spoken to the patient about these suspicions?

- a) Yes ☐  
b) No ☐

If yes, please explain why.....

.....  
.....

12. In your opinion, is there anything which may restrict a doctor from identifying a case of elder abuse / neglect?

- a) Yes ☐  
b) No ☐

If yes, please outline what these restrictions are.

.....  
.....  
.....  
.....

13. In your opinion, would any of the following circumstances restrict a doctor from intervening in a case of elder abuse / neglect? (Please tick those which you feel are relevant)

- |  |                          |
|--|--------------------------|
| Legal concerns                                     | <input type="checkbox"/> |
| Time consuming                                     | <input type="checkbox"/> |
| Uncertainty of the cause of the problem            | <input type="checkbox"/> |
| Cultural differences                               | <input type="checkbox"/> |
| Lack of appropriate interventions                  | <input type="checkbox"/> |
| Lack of personal training in elder abuse / neglect | <input type="checkbox"/> |
| Others, please specify .....                       | <input type="checkbox"/> |

14. What is your opinion about the mandatory reporting of cases of elder abuse / neglect?

- a) Should BE mandatory ☐  
b) Should NOT be mandatory ☐  
c) DON'T mind ☐

Please briefly explain your response .....

15. Are clear-cut definitions of elder abuse / neglect given by your professional association?

- a) Yes ☐
- b) No ☐
- c) Don't know ☐

16. Are there any difficulties associated with accurately assessing, whether an injury has resulted from an elderly person (60+) being abused / neglected?

- a) Yes ☐
- b) No ☐

If yes, please explain briefly.....  
.....

17. During your University studies, were you given training in the area of elder abuse / neglect?

- a) Yes ☐
- b) No ☐

18. In your opinion, what would be the most likely causes of elder abuse / neglect? Please list your three most likely causes in order of priority, with 1 being the most likely.

- Abuser has a substance addiction ☐
- Abuser has financial concerns ☐
- Inadequate interventions available for abuser to use ☐
- Abuser has dementia ☐
- Marital problems ☐
- Learned behaviour from childhood ☐
- Other, please specify ..... ☐

19. In your opinion, what would be the most common characteristics of an elderly person vulnerable to abuse? Please list your first three preferences in order of priority, with number 1 being the first priority.

- Physical problems ☐
- Dementia ☐
- Limited finances ☐
- Poor communication ☐
- Substance abuser ☐
- Financially secure ☐
- Single ☐
- Married ☐
- Other, please specify ..... ☐

20. In your opinion, would doctors be likely to see more individuals who have been abused / neglected, than any other helping profession?

- a) Yes ☐
- b) No ☐

21. Which of the following do you see as being a role(s) that a doctor can play in the area of elder abuse / neglect? Please tick those which in your opinion should be undertaken by a doctor.

- Assistance with
- Treatment of physical and mental illness ☐
- Counselling ☐
- Referrals to other agencies ☐
- Legal intervention ☐
- Financial advice ☐
- Other, please specify ..... ☐

22. In cases of elder abuse / neglect, which interventions do you suggest would be the most useful for your profession to use? Please number the three which you feel are the most important, with number 1 being the most important.

- Referral to community agency ☐
- In home health aide ☐
- Hospitalisation ☐
- Counselling ☐
- Respite care ☐
- Other, please specify ..... ☐

23. Have you any further comments you would like to make?

.....  
.....  
.....  
.....  
.....

24. Would you be prepared to be involved in a follow-up face to face interview regarding the issue of elder abuse / neglect in the next few months?

- a) Yes                      ( )
- b) No                      ( )

If yes, please place your telephone number on the space  
provided .....

**THANK YOU FOR YOUR PARTICIPATION IN THIS STUDY**

PLEASE PLACE YOUR COMPLETED QUESTIONNAIRE IN THE SELF  
ADDRESSED ENVELOPE. NO STAMP IS REQUIRED.

### **SCHEDULE FOR KEY INFORMANT INTERVIEWS**

1. Could you outline a little about the profession you are in? Do you think elder abuse is an issue in your profession?
2. How many cases of elder abuse and neglect are you aware of within W.A?  
How many of these cases have you directly been involved in?  
Was A GP involved at any stage with any of these cases? If so, could you please outline there involvement?
3. In your opinion, what type of elder abuse / neglect is the most prominent in W.A.? What do you base these views on?
4. Which helping profession in your opinion, can have the biggest impact on the amelioration of elder abuse / neglect?
5. Which profession, in your opinion, is likely to come into the most contact with elderly people who have been abused / neglected?
6. Do you feel that doctors have a role (or roles) with regard to the areas of elder abuse / neglect? If yes, what is this role?
7. Can you tell me about your views on doctor's recognition of elder / abuse?
8. In your opinion, would doctors be inhibited in any way, from reporting a case of abuse / neglect? If yes, What may inhibit a doctor from reporting a suspected case of elder abuse / neglect?
9. Can you tell me of your feelings about the need for specialist training in the area of gerontology in the human service field? Do you feel that doctors require training in the area? Who should provide this training?
10. Do you feel that generally there is more or less societal awareness of the issues associated with the area of elder abuse / neglect, then with the area of:
  - a) Child abuse?
  - b) Domestic violence?
 Why?
11. In your experience, have doctors been able to accurately diagnose a patient as being a victim of elder abuse / neglect?
12. Can you please tell me of your views on mandatory reporting cases of elder abuse / neglect?
13. To whom should cases of elder abuse / neglect be reported?
14. Please outline the likely characteristic of someone who is vulnerable to abuse / neglect?

15. Please outline the likely characteristics of someone who is likely to abuse / neglect an elderly person?
16. Could you please outline to me, what interventions in regard to the area of elder abuse / neglect are available within W.A.? (Have you used any of these?)
17. What are the most prominent ethical issues which are associated with the area of Elder abuse / neglect?
18. What do you feel are the major causes of elder / abuse neglect? (economics, social abuse, power relationships, ideology, multiple causations etc)
19. Does your profession have a definition of elder abuse? If yes, could you outline it please?
20. Do you have anything else which you would like to add?

**THANK YOU FOR YOUR PARTICIPATION IN THIS INTERVIEW**



### Schedule For GPs Face To Face

1. Could you please give me your definition of elder abuse / neglect?
2. Do you feel that elder abuse / neglect is a social concern within W.A. ? How would you classify it against a social concern such as child abuse? (or domestic violence?)
3. Have you ever dealt with a case of elder abuse / neglect? If yes, could you please outline to me how you identified the patient as being a victim of abuse /neglect?
- 3b. Could you outline a little about the case(s) you have seen.
4. A 67 year-old female enters your surgery. There are bruises around her jaw-line, a cut over her left eye, and multiple bruises on her upper torso and arms. Close examination reveals additional bruises of varying ages. When you ask how she received these injuries, she tells you that her son has beaten her on repeated occasions. What action would you take with the patient?
5. Do you feel there is a need for specialist gerontology training within your profession. If yes, when should this training be undertaken (ie undergraduate or postgraduate)? Who should provide the training if you feel it is required?
6. How much professional training have you undertaken in the area of gerontology?
7. How does this compare with other areas of professional training you have undertaken for your job? (If there is a significant difference between the areas of training ask why)
8. What do you see as being the role of a doctor within the area of elder abuse / neglect?
9. In your opinion, do you feel that GPs have a responsibility to identify cases of abuse / neglect in elderly people, or should they just be involved in dealing with a patient's symptoms?
10. Could you describe your doctor / patient relationship with regard to elderly people? Is it different from that of younger people?
11. What is the average length of time you allocate for a consultation?
12. On average, do elderly people take up more consultation time per visit than other patients? If yes, does this impact on your practice in any way? (ie: financially, number of consultations per day, etc.)

13. Suppose that an elderly male who was caring for his demented wife at home, could no longer deal with the constant stress associated with the situation, and started physically abusing his wife. If the male carer came to you and asked for help, what assistance would you provide?

14. An elderly patient tells you in strict confidence that he is being psychologically and physically abused by his daughter, who also is financially abusing him. He tells you that his daughter (the abuser) is a heroin addict, and abuses him when he does not give her enough money to support her habit. The injuries which have been inflicted on the elderly man appear to be severe, and if they continue, could lead to hospitalisation and a permanent physical disability. How would you deal with this situation?

15. Thank you for your time and support of this research, is there anything else that you would like to add?

Dear Doctor \_\_\_\_\_

Earlier this year, you responded to a questionnaire which focussed on the area of elder abuse, or the abuse of elderly people. This research is part of my Master of Human Service program, at Edith Cowan University, Perth

On the completed questionnaire, you indicated that you would be prepared to be involved in a follow-up interview to discuss the subject area further. As I am now in a position to undertake these interviews, I will contact your practice by telephone shortly, to ascertain if you are still able to be involved with section of the study, and to arrange a possible interview time.

I would like to interview you at a time and location which is suitable to yourself. The interview should take no more than 30 - 40 minutes of your time, and will be recorded using a tape recorder. Please be assured there will be no publication of any identifiable or possible identifiable information which could lead to your identity being known, and any such information, will be held in the strictest of confidence. This study is not being funded by any organisation, and your participation would be strictly voluntary. If you are available to be involved, you will be required to complete a consent form, similar to one outlined below, which will be given to you prior to the interview.

## PARTICIPATION CONSENT

I.....am aware of the study being undertaken, and any questions I have asked have been answered to my satisfaction. I agree to participate in this research, realising that I may withdraw at any time.

I agree that research data gathered for this study may be published provided my name is not used.

Participant.....Date.....

Investigator.....Date.....

I would like to take this opportunity to thank you for your consideration of this study, and I look forward to being given the opportunity to talk to you further about the area of elder abuse, in the very near future. Should you require any further information regarding the study, please do not hesitate to contact me on.

Yours sincerely,

Paul Howrie.