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Elder Abuse and Neglect in Institutions: Recognition by Social Work Practitioners

Maria Szymanska

A thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of Masters of Social Work,

University of Manitoba
Faculty of Social Work

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FACULTY OF GRADUATE STUDIES

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BY

Maria Szymanska

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

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ABSTRACT

This study focuses on social work practitioners working in Personal Care Homes (P.C.H.) in Manitoba. It explores knowledge of different aspects of aging, issues of abuse and neglect, attitudes toward the elderly and how maltreatment of residents is recognized.

Data has been collected by means of a mail-out survey (conducted in April and May of 1999). The findings show that social workers score highly on knowledge but exhibit an average practical recognition level for abuse and neglect. Furthermore, social workers are more confident in identification of psychological forms of neglect and abuse.

In addition, results of this study show that social workers' attitudes toward the elderly tend to be neutral rather than strongly positive or negative.

The social workers identified the need: To include institutional abuse in the social work curriculum; to develop continuing courses on elder mistreatment in nursing homes and for interdisciplinary education on elder abuse and neglect.

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CHAPTER 1

Introduction

This exploratory survey of social workers employed in Manitoba's system of Personal Care Homes will examine the knowledge, attitudes and recognition in relation to institutional elder abuse and neglect.

People tend to enter these facilities at relatively advanced ages in poor health and requiring assistance with many basic activities. These elderly are a vulnerable group for abuse, neglect and exploitation by formal caregivers, family, friends and co-residents (Decalmer & Glendenning, 1993; Clough, 1996; Office of the Inspector General, Washington, D.C., 1990).

Kimsey (1981) suggested that the elderly do not complain about abuse because of fear of retaliation by formal caregivers. Sengstock, McFarland & Hwalek (1990) state, "...institutionalized elderly are usually poor and lacking in social support" (p.32). Furthermore, some residents may not be aware of legal rights or are unable to communicate their plight.

This situation creates both challenges and opportunities for social workers. They are often in leadership positions in raising awareness about elder abuse and neglect and are resident's advocate within the institutional system. "The social workers' assessment skills and counselling abilities provide the opportunity for the most objective perception of the situation to ensure that the residents' rights are respected" (Holosko & Feit, 1996, p.193).

This report was organized in the following manner:

Chapter 2 provides a review of the literature pertaining to elder abuse and neglect in institutions. Issues addressed in this chapter include, the prevalence of elder abuse and neglect in institutions, definitions of this abuse, as well as its predictors and causes. In addition, theoretical explanation of the process of abuse recognition, attitudes toward the elderly and their impact on gerontological knowledge are also explored.

Chapter 3 describes the design of this study. Population selection, data gathering methods and instruments are also discussed there, as well as statistical methods used in data analysis.

Chapter 4 presents the findings of this study. Discussion of the results is also included.

The authors' conclusions and study implications are presented in the concluding Chapter 5 of this report.

CHAPTER 2

Literature Review

Although institutional abuse and neglect is well represented in the popular press, most of the scholarly literature on elder mistreatment has focused on elder abuse and neglect in the community, rather than on institutionalized abuse and neglect (Hudson, 1988; McGregor, 1995; Penhale, 1993; Pillemer & Finkelhor, 1988; Podnieks, 1989). In addition, the majority of available material presents an American perspective and is not reflective of the problems and practices in Canada and Manitoba.

Prevalence of elder Abuse and Neglect in Institutions

The prevalence of elder abuse and neglect in institutions in Canada is not known (Decalmer & Glendenning, 1993). This is due partially to minimal research on abuse in these settings, lack of national study (Blossom & Wigdon, 1991) and the lack of measurement instruments targeted to identifying institutional abuse (Sengstock, McFarland & Hwalek, 1999). Spencer (1994) states that precise figures are still fairly rudimentary. Nevertheless, Blossom and Wigdor suggest that "the fact that mandatory reporting of mistreatment of residents in institutions has become law in a number of provinces can be taken as evidence that claims of abuse have been real and frequent enough to require legislative action" (Blossom & Wigdor, 1991, p.8).

Pillemer and Moore (1989) examined the extent of abuse by nursing home staff in the U.S.A. They conducted a telephone survey of a random sample of nursing home staff in one state. Fifty-seven nursing homes were invited to participate and the final sample was drawn from 32 homes, which ranged in size from 19 to 300 beds. This yielded a sample of 577 nurses and nursing aides.

Their research provided much quantitative information on abuse in nursing homes at that time. They indicated that abuse perpetrated by nursing aides was a prevalent phenomenon within the random sample of facilities they selected. Thirty-six percent of the sample had seen at least one incident of physical abuse during the preceding year and 40% had committed at least one act of psychological abuse during the last year. Six percent had used excessive restraints and 13% denied their clients food or privileges. Pillemer and Moore suggest that, as the survey was based on self-reporting, some under-reporting of negative actions had probably occurred (Pillemer & Moore, 1989).

Although researchers in Canada have been unable to report meaningful rates of abuse for nursing homes, they are significant (Doty & Sulivan, 1983) and underestimated (Hudson, 1983). Monk's survey (1984) found that over half of the nursing home residents in the sample refrained from making a complaint, because they were fearful of reprisal.

Elder Abuse and Neglect in Institutions: Definition of Concept

There is lack of definitional clarity and consensus around the term elder abuse in institutions. According to Pillemer, the definition of maltreatment is as follows: "any deviation from socially accepted (including regulatory or legal) standards for management of the interpersonal process, carried out with the intent of harming a patient" (p. 228).

Pillemer included three specific types of action as maltreatment: physical violence, verbal aggression and neglect. In defining physical violence, he follows Strauss's (1980) definition: "An act carried out with the intention, or perceived intention, of causing physical pain or injury to another person" (p.228).

Verbal aggression is defined as "an act carried out with the intention of causing emotional pain to another person [such as threats and insults]" (p. 228).

Neglect is defined as "The intentional failure of a nursing home staff member to meet a patient's need for care" (p.228).

Sundram (1984) also presented a comprehensive definition of institutionalized abuse such as the failure to provide a nutritious diet and lack of cleanliness within the facility.

Aside from obvious prescriptions against physical and sexual abuse, this definition includes "the failure to provide appropriate care and treatment for any patient and conditions whereby patients do not receive sufficient, consistent, or appropriate services, treatments, medication, or nutrition to meet their needs" (Sundram, 1984, p. 239). To operationalize this definition, Sundram delineated it further into minor abuse (verbal abuse, hair pulling, slapping) and major abuse (sadistic behaviour, sexual exploitation, kicking).

Meddough (1993) uses the expression "covert abuse", which she describes as a lack of personal choice, isolation, labeling and thoughtless practices.

Definitions also vary among professional affiliations. The Social Work profession has its input in trying to understand and define elder mistreatment. Although most of the theoretical discussion was based on elder abuse as a part of family violence, some of the concepts can be transferable to the field of institutional abuse of the elderly. For example the Ontario Association of Social Workers (1992) presents a definition where elder abuse "is any action by a person in a position of thrust – a family member, a friend, a neighbor or paid caregivers which cause harm to a senior." (p.3). Spencer (1994) adds that harm perpetrated by other residents may also be considered abuse when the facility has failed to protect the resident.

Social work definitions of elder mistreatment are essential for the recognition and then intervention by social work practitioners. Valentine & Cash, after reviewing several social work definitions of elder maltreatment, came to the conclusion that this term:

" refers to the non-accidental situation in which an elder suffers physical trauma, deprivation of basic physical needs or mental injury as a result of an act or omission by a caretaker or guardian" (Valentine & Cash, 1986, p.22).

The authors propose three major categories that comprise the overall phenomenon of elder maltreatment: elder neglect, elder abuse and violation of rights. Acts of omission or withholding of necessary care characterizes elder neglect. Elder abuse is described as an act of commission toward an elder person. Finally, violation of rights involves financial and material exploitation or violation of the elder persons' authority.

Spencer (1994) has a similar concept of abuse and neglect in institutional settings and defines it as: "any act or omission directed at a resident of an institution that causes harm or wrongfully deprives that person of his/her independence" (p .19).

As noted in the literature review, the differentiation of abuse from neglect has typically been based on the notion that neglect is an omission, while abuse is a commission. However, neglect and abuse cannot be differentiated solely on this basis. Neglect is typified by omission or carelessness in the provision of warranted care, while abuse is characterized by destructive behaviour toward an improper or indecent use of a resident of his/her property (Hudson, 1989). Hudson says that both can be intentional or un-intentional and both can have physical, psychological and financial effects that result in unnecessary suffering. The effects of neglect may be as serious as those of abuse. Thus, only the method by and manner in which harm is inflicted, differentiate abuse and neglect (Hudson, 1989). Spencer (1994) supports this point of view. She argues that: "proper care of residents, is the responsibility of the institutions, the effect of an act or omission becomes the issue, not whether harm was intended" (p.25).

This distinction is important to discovery of kinds of elder abuse and neglect. Generally, the literature covers six dimensions of abuse and neglect, as described by different authors:

Physical Abuse - "actions which are direct attacks against the elderly and are deliberate" (Senstock, McFarland & Hwalek, 1990, p.33). Physical abuse includes pushing, grabbing, shoving, pinching, throwing something on residents, slapping, kicking, punching, excessive use of restraints, and sexual assault. Misuse of restraints (Beyond physician's orders or not in accordance with accepted medical practice) is also a form of physical abuse.

Physical Neglect - "a failure to provide an aged and dependent individual with the necessities of life, such as food, shelter, clothing, and medical care" (Sengstock, McFarland & Hwalek, 1990, p.37). It can also include a failure to provide fresh, nutritious meals, ignoring special diets, scalding in the bath, leaving residents in dirty clothing, lack of grooming, infrequent change of diapers or soiled linens, under or over-medication, not calling a physician when necessary, lack of environmental stimulation and below average cleanliness.

Sexual Abuse – "Sexual contact that results from threats, force, or the inability of the person to give consent, including but not limited to assault, rape, and sexual harassment" (CARIE, 1991, p. 31). These may include a resident fondling a confused female resident, staff intimately touching a resident during bathing, or visitors (e.g. husband) having sex with a demented resident who cannot understand what is happening to him/her.

Psychological Abuse - "includes verbal assault and threats such as screaming and ridicule" (Sengstock, McFarland & Hwalek, 1990, p.39). Psychological abuse can include insulting or swearing at a resident, threatening to hit or throw something on a resident, labelling, isolating, or denying the resident's right to personal choice. Other examples may include humiliation or intimidation of the resident.

Psychological Neglect - "failure to give proper attention to the emotional needs of the elderly person" (Sengstock, McFarland & Hwalek, 1990, p.40). It includes not considering residents' wishes, restricting contact with family and friends and other residents, ignoring the resident's need

for verbal and emotional contact, and benign neglect. In such situations resident's self-esteem is not fostered.

Material Abuse - is defined as "stealing money, belongings and other valuables belonging to an elderly person" (Sengstock, McFarland, and Hwalek, 1990, p.41). It can include theft of clothing and personal items, fiscal abuse by institutions (charging residents extra money for things which should be included in the regular fee, such as marking one's clothing with the proper name, or unjustified withdrawals from the resident's trust account).

The terms "elder abuse" and "elder neglect" is used throughout this paper in relation to abusive and neglectful behaviour that occurs in nursing homes. These terms are also used interchangeably with other synonyms such as 'mistreatment' or 'maltreatment'. Although the new phrase "abuse and neglect of older adults" has been gaining more acceptance in Canada over the past few years, the term "elder abuse and neglect" is most common in the literature. In this study, "elder" or "elderly" will refer to residents of institutional care. The majority of nursing home residents are so-called "older old" meaning people over 75 years of age. (National Population Health Survey, 1995)

Predictors and Causes of Elder Abuse and Neglect in Institutions

Various explanations of predictors have been developed in the field of institionalized abuse. One by Clough (1996) included three factors:

1. Structural abuse where "older people are held in low esteem and receive poor services; there is little concern with the welfare of older people" (p.6).
2. Environmental abuse – where "the environments in which dependent adults live and in which carers undertake care, create stresses that are intolerable; this affects the behaviour of adult and carer, which leads to abuse" (p.6).
3. Individual characteristics in which "people with particular personality types or with particular histories (perhaps of feeling out of control or of being abused by others) are more likely to abuse than others" (p.6).

Pillemer (1988) develops a theoretical model of resident maltreatment where, "maltreatment of patients is modelled as the outcome of staff members' and patients' characteristics that are influenced by aspects of the nursing home environment and by certain factors exogenous to the facility in question" (Pillemer, 1988, p.230). First, in regard to exogenous causes, resident abuse should be greater in geographic areas, which experience a shortage of nursing home beds and low unemployment. It seems logical that, in the locations with low unemployment, qualified staff may choose other work, since employment in a nursing home is seen as undesirable (Goodridge, Johnson & Thomson, 1994; Mercer, 1993; Sundram, 1984; Tellis-Nayak & Tellis Nayak, 1989)

This model suggests that nursing home environments [physical setting, ownership and the range and intensity of service provided] (Pillemer, 1988) can be used as a predictor of elder abuse. There were some research studies which supported this idea. Quality care is higher and incidents of abuse are lower in non-profit nursing homes (Elwell, 1984, Fottler and Smith, 1981, Lemke and Moos, 1989), where management is not so focused on profits. The nature of the physical environment and physical settings in some nursing homes can also cause residents' abuse and neglect. Tarbox (1983) discussed environmental deprivation, which can affect cognitive, intellectual and emotional functions of elderly people in institutions.

Pillemer (1988) concludes that the level of care is an important environmental determinant of the quality of care and potential for abuse in nursing homes. He notes that intermediate, rather than skilled facilities are usually the locations in which abuse occurs, largely because of lack of supervision. Some researchers also support this view (Mercer, 1993: Office of Inspector General, Washington DC, 1990, Sundram, 1984). However, other studies suggest that clients with dementia and the most fragile and dependent on care, are often victims of abuse, regardless of the nature of the institution (Meddough, 1989).

The third element in Pillemer's model (1988) affecting quality of care, is staff characteristics. He identifies several variables related to staff attitudes toward elderly clients: education, age, gender, position, experience and burnout.

Age and gender of staff is a significant indicator of likelihood of abuse (Pillemer, 1988). Younger nurses aides are more apt to act in an abusive manner toward the residents (Pillemer & Bachman-Prehn, 1991; Duquett, Sandhu & Beaudet, 1994; Tellis-Nayak & Tellis-Nayak, 1988). Tellis-Nayak and Tellis-Nayak (1988) in their ethnographic study of nursing homes in Illinois profile two categories of nurses aides: strivers, who are younger and treat nursing home employment as temporary, while waiting for better opportunities; and endurers, usually older and employed by nursing homes for a long time. They conclude that the first group is more abusive in their everyday contact with clients. The authors found that staff with better attitudes towards the elderly stay on longer at the nursing homes and develop loyalty, devotion and attachment towards residents. Males, while under represented in the profession are over-represented in cases of abuse (Payne, 1995, Pillemer, 1988).

The position held by an employee of a nursing home is also a possible correlate of elder abuse and neglect. Nurses' aides are often involved in incidents of residents' maltreatment. (Goodridge, Johnson & Thomas 1994; Heiselman & Noelker, 1991, Lemke & Moos, 1989, Pillemer, 1988; Pillemer & Bachman-Prehn, 1991, Pillemer & Moore, 1989). Other staff members such as Registered Nurses (RN) and Licensed Practical Nurses (LPN) have more positive verbal interaction and are less likely to depersonalize patients than nurses' aides (Burgio, Engel, Hawkins, McCormick & Schere, 1990). Qualitative research done by Payne (1995) which involved analyzing data from National (USA) Incidents Reports in Nursing Homes in years 1987-1992, showed that 62% of persons accused of elder abuse in nursing homes were nurses aides.

Length of service in a nursing home is mentioned in the literature as another possible correlate of abuse. "Staff who have worked for longer periods of time in geriatric settings have been found to hold fewer negative attitudes toward patients and toward the aged in general" (Pillemer & Bachman-Prehn, 1991, p.78) and this is reflected in better service (Tellis-Nayak & Tellis-Nayak, 1989).

There are examples in the literature that indicated high levels of job stress and burnout as factors contributing to residents' maltreatment (Chappell & Novak, 1992; Goodridge, Johnson & Thomson; 1995; Heine, 1986; Office of Inspector General Washington DC, 1990; Pillemer & Bachman-Prehn, 1991; Pillemer & Moore, 1989). "Burnout is characterized by physical, emotional and spiritual exhaustion and ultimately involves the loss of concern with whom one is working" (Heine, 1986, p.14). Although this phenomena can affect workers in many different ways (high absenteeism, increased physical complains, conflicts in personal life) the most serious consequences of burnout in nursing home employees is how it ultimately affects the resident (Heine, 1986).

Beyond facility and staff characteristics, aspects of day to day interaction may be related to patient abuse. Pillemer and Bachman-Prehn (1991) call them "situational characteristics of elder abuse in institutions". These include verbal conflicts and disagreements between staff and residents, which may escalate into abuse. They also assert that, when staff commit violence and verbal aggression, it is sometimes retaliatory. The suggestion that situational factors might cause the abuse is supported by other research. Payne (1995) quoted one employee saying "If the patient scratches me, I'll do it back to them" (p. 68). That is not to say that the victims caused

the abuse. Rather, it is possible that the abusers used the precipitating events to justify their actions

Specific client characteristics such as the health of patient, social isolation and the gender of residents (Pillemer, 1988) can increase the likelihood of abuse.

Meddough (1991) found that clients who were cognitively impaired and often verbally or physically abusive to caregivers were usually left alone for long periods of time and generally avoided by staff. Meddough concludes that reaching out and communicating with challenging residents – instead of avoidance – could bring the aggressive behaviour more quickly under control.

The tendency in many institutions is to administer psychotropic drugs to "control" the person, rather than to "understand" the behaviour within its psycho-social/environmental context. While drugs are supposed to be used as a "last resort", they are becoming the first choice, significantly affecting the quality of lives of thousands of older persons, especially ones with Alzheimer's Disease (Cossit, 1999).

Meddough (1989) supports Pillemer's theory (1988) that less healthy patients may be subject to maltreatment by staff. After analyzing data (collected retrospectively through charts and incident reports for a three month time period, in a 72 bed nursing home in the Northeastern U.S), she concludes that residents who are frail and more dependent on staff (requiring a lot of help with activities of daily living) were abused more frequently than others.

Both Meddough and Pillemer (1988) conclude that social isolation places residents at greater risk of abuse. According to Meddough (1989), patients who do not have significant others for support are abused more often. They are also described by staff as being abusive and having many conflicts with their formal caregivers. The researcher suggests that lack of close friends and family can make these residents feel alone and rejected. In return they may act out in an abusive way in frustration over this inability to control his/her life.

Gender (Pillemer, 1988) appears to be related to abuse. He says "women are more likely than men to be victims of seniors domestic abuse and they are also more likely to become victims of abuse in institutions" (p. 233). Watson (1993) supports Pillemer's (1988) statement. Out of 162 reports of abuse – 109 victims were women (66.7%). However, other findings (Meddough, 1989) indicate, that due to the traditional socialization, males are usually more aggressive and this makes them prone to abuse by staff.

Recognition of Elder Abuse and Neglect

Lucas (1991) points to obstacles facing social workers in the recognition of elder abuse and neglect in institutions, and notes that "the connection between elder abuse and protection of the abused individual is recognition of the existence of the abuse and recommendation of an appropriate intervention strategy" (1991, p.9). This ensures that recognition, is the first step in its prevention.

Penhale (1993), identified barriers preventing social workers from adequately recognizing elder abuse including the following points:

1) There is no generally agreed upon definition of abuse.
2) Claims about the likely incidence of abuse in this country are difficult to substantiate (lack of large-scale research).
3) The aetiology of elder abuse is insufficiently understood.
4) Simplistic comparison with child abuse tends to mask the issues involved.

(Penhale, 1993, p. 97).

She points out that, professionals may fail to detect abuse for a number of reasons including, a lack of knowledge about this issue. Adequate training and education are important if a social worker wants to become a competent professional able to properly recognize elder abuse and neglect in institutions. In order to do that, they need knowledge about forms, causes and indicators of elder maltreatment in nursing homes and must also know how to apply this knowledge in practice (Spencer, 1994).

Spencer has indicated other elements, which may complicate the recognition of maltreatment in institutionalized settings. First, identifying the abuser may be more difficult. Many people have contact with the resident. Some staff members may provide personal care, others may assist with activities of daily living. Second, there can be more than one abuser. Finally, the resident may be in poor mental or physical health, making it harder to separate the effects of abuse and neglect from the underlying mental or physical condition.

Although, in most cases, it is possible for a social worker to notice bruises, lacerations, or abrasions (especially in places such as on the face or hands) other visible signs like pressure ulcers, changes in the skin, or malnutrition are more difficult to detect. These may not always be the result of neglectful care. Some might be attributed to normal changes that result from aging. "Little attention is given in social work training to physical aspects of aging. This lack of knowledge can exacerbate difficulties in differentiating between suspicious factors and normal processes" (Decalmer & Glendenning, 1993, p.90).

This situation is slowly changing in Canada. Researchers and organizations try to develop elder abuse protocols. These are intended to aid professionals in proper recognition of behavioural, psychological or environmental indicators of elder mistreatment (Interdepartmental Working Group on Elder Abuse, 1993; Ontario Association of Social Workers, 1992; Spencer, 1994). Most recently, during the Second National Conference on Elder Abuse (Toronto, March 21-23, 1999) these issues have been discussed. According to Gloria Dixon (Age and Opportunity, Winnipeg, Manitoba who chaired a Long Term Care Interest session at the conference) several

needs have been expressed regarding building in system sensitivity in recognition and prevention of elder abuse on behalf of clients, as well as caregivers (both formal and informal).

In order to ensure proper recognition of elder abuse and neglect, it is extremely important that institutions develop and implement policies that address the existence of mistreatment (Spencer, 1994). Spencer suggests that identification of abuse and neglect in an institution should be based on two concepts: "the need for accepted standards; and the recognition that a certain behaviour does not meet those standards" (p.46).

Attitudes of Social Workers and Other Professionals toward Aging

Tuckman and Large (1953) began one of the first empirical studies on attitudes toward old age. Since then, studies of attitudes toward elderly people have defined 'attitudes' as "consolidated tenacious predisposition resulting from the clustering of thoughts, feelings, and a tendency to act in a particular way toward a specific target object" (Freedman, Carlsmith & Sears, 1974, p.247). This understanding has been a significant part of the socio-psychological perspective in gerontology.

Literature on attitudes held by social work practitioners about the elderly is limited. Only a few studies have examined that issue, and usually in connection with other professionals. Most research has examined the views of professionals already practising with the elderly, mostly in community settings (Baker, 1984; Coe, 1967; Gardner & Perrit, 1983; Lucas, 1991). Some studies also included students in health care and social services professions (Aday & Campbell, 1995; Carmel, Cwikel & Galinsky, 1992; Reed, Beall & Baumhover, 1992).

Research shows that professionals who work with the elderly were not immune to the negative attitudes toward their clients. In commenting about social workers, Coe (1967) notes that "many look on working with the aged as something that is almost useless and a waste of energy" (p.112). Despite the study being over 30 years old, it is still worth mentioning, because the author was one of the first to suggest that stereotypes (without indicating if these were distinct from attitudes) can affect social workers' responses to elderly people.

Chandler, Rachel & Kazelskis' (1986) research explored the attitudes of nursing home personnel (n = 101) employed in long term settings. In this experimental design they measured attitudes toward the elderly (Kogan's Scale 1961) held by nursing personnel before and after completing five educational classes about aspects of aging. The results suggested that attitudes became either neutral or more positive in nature. Nevertheless, there were significant differences in attitude among the three levels of nursing (RN, L.P.N. and N.A.). RN's appeared to hold the most positive attitudes and the NA's were found to be least positive, although still within the neutral range. Although it seems that the level of education positively impacts on nursing personnel attitudes toward residents, it is interesting that offered classes (one hour each) had no significant impact on the neutral or more positive attitudes.

Baker's study (1984) involves a variety of professionals working with the elderly (social workers, doctors, nurses, dentists, and rehabilitation therapists). It supports the notion that health and social care providers have neutral or at least a more positive attitude toward this age group than other professionals from this sample do.

A more recent study conducted by Lucas (1991) in Pennsylvania (involving 55 subjects mostly nurses and social workers) tries to establish their attitudes and attributions toward the elderly in the community. Using the survey questionnaire the author confirms her hypothesis that professionals working with the elderly are more likely to have positive attitudes towards them.

Holosko & Feit (1996) also claim that social workers have positive attitudes toward the elderly and are "largely responsible for confronting and shattering myths about aging" (p. 21). However, these authors did not mention if such attitudes help social work practitioners in recognition of elder mistreatment. Nevertheless, it has been suggested that in many cases positive attitudes toward the elderly are necessary for the social work profession to be creatively involved within existing institutions in promotion of quality of life and empowerment of people in institutional care (Wells, 1992). Independence and personal growth of residents should be encouraged because the more services the staff provide, the more power they have over their lives, which might finally result in acts of violence (Clough, 1996).

Impact of Gerontological Knowledge on Attitudes toward the Elderly

Several studies have been conducted to determine how gerontological knowledge and education influence social workers' and other professionals' attitudes toward the elderly. It seemed that related training has a good chance of increasing positive attitudes toward the aging population (Pallmore, 1988). This author of the most popular and widely used test of gerontological knowledge, Facts on Aging Quiz, also came to the conclusion that "training in gerontology usually results in a significant improvement in test scores" (1988, p.340). In a study of social work, nursing, physical and occupational therapy, Gardner & Perritt (1983) found an increase in positive attitude scores and a decrease in negative attitude scores with gerontological training. Brubaker and Barresi (1979) compared knowledge scores with completion of a graduate gerontology course. Findings indicate that "of the 22 out of the total sample who had ever taken gerontology courses, 13 of them (59%) had high knowledge scores and 9 (41%), low scores" (p. 219).

Carmel, Cwikiel & Galinsky (1992) tested the association between knowledge and attitudes and work preferences among students in the faculties of medicine, nursing and social work. The results show that an increase in knowledge about the elderly does not necessarily lead to changes in attitudes, and may even have an opposite, negative effect. A lack of correlation between attitudes, knowledge, and work preference was found in all the student groups. Although authors agreed that participation in gerontological courses could increase students' knowledge, attitudes and work preferences were too complex to be changed after such a short exposure to gerontological education.

Reed et al. (1992) claim that attitudes and knowledge are related and that the direction of this association is unclear. This study examined knowledge about aging and attitudes toward elderly people by Masters students in nursing and social work. The study utilized the Facts on Aging Quiz (Pallmore, 1977) and the Old People scale (Kogan, 1961). In Reeds (1992) study, nursing students reported an inadequate gerontological curriculum. Most of their extensive knowledge came from work experience with the elderly. In the same study, students of social work did not complain about insufficient gerontology courses. However, they did point out the "lower status of working with problems of the elderly, limited experience with healthy older adults, and fragmentation and discontinuities of service" were the biggest obstacles in gerontological training (Reed, 1992, p. 632). This correlates to Jack's (1992) suggestion that social workers do not choose gerontological practice as Borsay (1989) states "first child care, second mental health, thirdly the elderly".

CHAPTER 3

Methodology

The purpose of this study is to examine the attitudes toward the elderly, gerontological knowledge and their influence on social workers' recognition of elder mistreatment in nursing homes. This chapter describes the general research design of the study, the description of the instruments, the procedure for data collection, ethical considerations and data analysis.

Population Selection and Data Gathering Methods

A cross-sectional survey design which "involves making only a simple observation or measurement at one time period" (Grinnel, 1997, p.281), has been used in this study. Rubin & Babbie (1997), recommend this method as useful in measuring the attitudes and orientations in a group of people and an efficient means of data collection, which provides an opportunity to learn more about a chosen population of interest.

A mail-out survey design was chosen because of the following assets; the design was economical, incurring only minor costs such as postage and printing, it allowed a greater geographic outreach, important, considering the fact that this research included all the social workers employed in nursing homes in Manitoba and provided a greater sense of anonymity than alternative methods such as the interview. Finally, participating individuals could read and respond to questions at their own pace and interviewer was eliminated (Grinell, 1997).

This survey used the "total design method" (TDM), developed by Dillman (1978). It relies on a theoretically based view of why people do and do not respond to questionnaires and a belief that attention to administrative details, is essential to conducting successful surveys. The goal is to present an attractive well-organized questionnaire, that was easy to complete.

An introductory letter (Appendix A) and covering letter for the questionnaire (Appendix B) were utilized to emphasize how important it was for social work practitioners to complete this survey. Dillman recommends that the initial mailing occur on Tuesday, rather than Monday or Friday. A week after sending the letter, the first mail-out took place on Tuesday, April 20, 1999. Unmarked questionnaires and envelopes were used in order to protect respondents' anonymity. This factor was important because the author intended to encourage more candid responses. However, due to this, it was not possible to re-mail only to non-respondents. Therefore, a total re-mailing was sent of the follow-up letters on Wednesday, May 5, 1999 (Appendix D) thanking those who have already participated and encouraging the remaining respondents to do so. With these letters, additional questionnaires were enclosed.

This study focuses on social workers employed in nursing homes in the Province of Manitoba. Officially, the term Personal Care Home (PCH) is used in Manitoba to refer to institutional care of the elderly. The Manitoba Council on Aging (1996) defined Personal Care Homes as: "premises in which personal care (basic nursing care under supervision of an RN, personal assistance in the activities of daily living or supervision of activities of daily living) is provided to persons residing there" (Manitoba Council on Aging, 1996, p.4).

The list of PCH's in Manitoba has been obtained from Manitoba Health. The author telephoned each facility to obtain the total number of social workers employed there. Due to the relatively small sample (n = 71), non-probability purposive sampling (Grinell, 1996) was utilized. All the social workers had been contacted. The survey population comprised of individuals with social work degrees, currently employed in social work positions (either part-time or full time) in Manitoba Personal Care Homes who voluntarily agreed to participate in the study.

Ethical Considerations

Grinell (1997) pointed out that, before beginning any research study, three pre-cautionary measures must be taken. Specifically, the researcher must ensure:

1) that participants consent is voluntary and informed, without penalty for refusal to participate
2) that the study is designated in an ethical manner
3) that others will be properly informed about the findings.

All these considerations were addressed in the study design.

Participants were informed in writing or verbally (as was the case with MSW students participating in the pre-test) about the purpose of the study and their rights as the respondents in the research. They were assured about the voluntary nature of study participation and their right to withdraw at any time.

In addition, participants were informed that the study would be conducted in a manner protecting their anonymity. All social workers were not to provide any information on the questionnaire that would reveal their name or that of their nursing home.

In regards to ethical design of the study, the participants were informed that, a Faculty Ethics Committee would oversee the students' work. This was to ensure that its integrity and all the ethical standards were met. In addition, all the potential participants were provided with the telephone number where they could talk with the chair of the student thesis committee or the student herself, in case of any concerns. Few participants used this opportunity.

To comply with the third ethical requirement, the student also informed all the potential respondents that research findings would be published in the form of a thesis report and made available to them and others through the University of Manitoba Library System and in The Faculty of Social Work.

Research Questions and Objectives

The following section outlines the specific research questions that were addressed by this study. The primary research question of this study tries to establish if there is a relationship between social workers' gerontological knowledge, their attitudes toward the elderly and their recognition of residents' abuse and neglect in nursing homes?

The plan is to explore whether these variables are associated and if there is a significant relationship between gerontological knowledge, attitudes toward the elderly and recognition of elder abuse and neglect in nursing homes. However, due to the character of this study, (exploratory) causality among these variables will not be established. The goal is to conclude whether there is a significant relationship between social workers' scores on knowledge and attitude scales and their scores on recognition. In order to achieve this, the following specific questions have been developed:

1. Do social workers employed in long-term facilities have knowledge about different aging problems?

The Psychological Facts on Aging Quiz (McCutcheon, 1986) is used to establish social workers' knowledge in this area. Using descriptive statistics, the author analyzed some potentially extraneous variables gathered in demographic Section D of the survey questionnaire (age, education, work experience with the elderly, frequency of contact with the elderly family

members), that may influence the level of gerontological knowledge obtained on the previously identified quiz. This is to provide a profile of the respondents.

2. Is the knowledge about elder abuse and neglect in institutions part of this knowledge?

Nominal and ranking questions are incorporated in Section D of the questionnaire to survey this issue. Participants are asked to estimate what percentage (in their opinions), of residents experienced some form of abuse or neglect while living in Personal Care Homes. Additionally, questions dealing with most prevalent forms of abuse and neglect, as well as what group of people, according to respondents, were most often responsible for acts of mistreatment toward residents, have been included in the questionnaire (Please refer to Appendix C). Subjects are also asked to provide their own definition of elder abuse and neglect in open-ended questions.

3. What attitudes do social workers working in nursing homes have toward the elderly?

The Old People Scale (Kogan, 1961) is used to establish social workers attitudes towards the elderly. Descriptive statistics have been utilized to analyze exploratory variables. These are gathered in Section D of the survey questionnaire (age, education, work experience with the elderly, family member, size of the facility) and may have influenced attitudes toward the elderly as represented by scores obtained on the Old People Scale (OPS).

4. Is there a relationship between gerontological knowledge and social workers' attitudes toward the elderly?

The relationship between these variables is examined by comparing scores on measurements of gerontological knowledge and attitudes toward older people. However, this question is not intended to establish causality, rather to demonstrate the relationship.

5. Are social workers able to recognize potential and real cases of elder abuse and neglect in institutions?

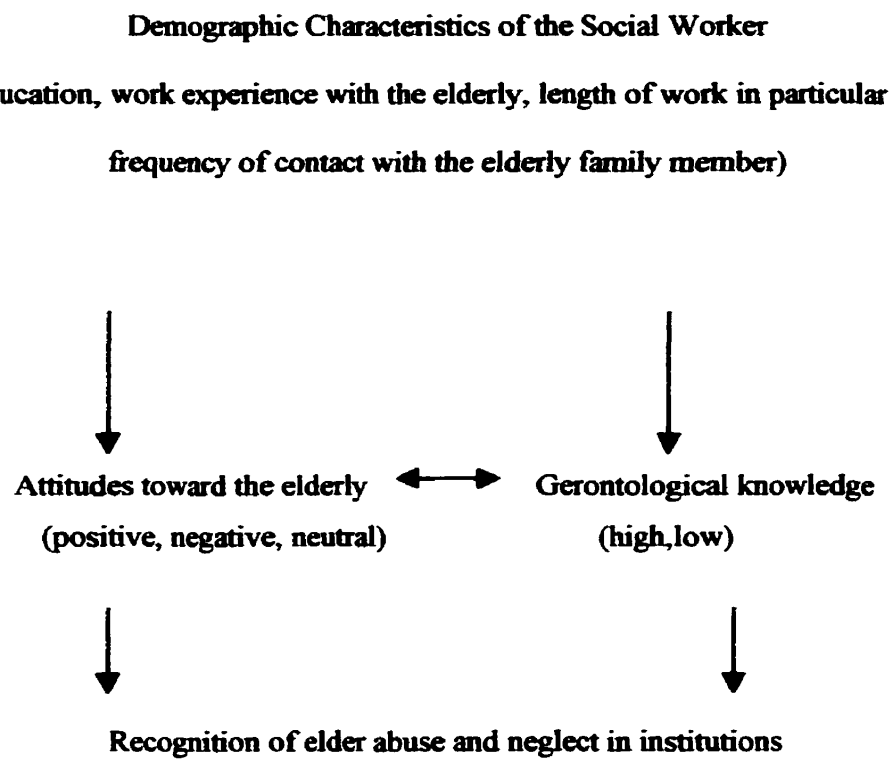
In order to study recognition of elder abuse and neglect in institutions, the Recognition Test has been utilized. Six vignettes have been created as a part of it. The types of abuse and neglect which served as the basis for construction of the vignettes, included physical, psychological, financial and sexual abuse, as well as psychological and physical neglect.

By using descriptive statistics, the impact of variables (such as age, education, work experience with the elderly, length of time working in the particular facility and frequency of contact with an elderly family member) on the recognition of elder abuse/neglect are examined.

Content analysis is used to help understand participants' reasons for selecting specific types of abuse/neglect as presented by vignettes.

Model of Recognition of Elder Abuse and Neglect in Institutions by Social Workers

A model, which enhanced better understanding of relationships among variables explored in this study, has been created by the author. Some concepts of this model were adapted from the literature such as Lucas, 1991 and Pallmore, 1982.



Two independent variables, attitudes toward the elderly and gerontological knowledge, served as the focal point of this study. These two may influence the recognition of elder abuse and neglect in institutions (dependent variable).

Demographic characteristics of social workers may effect their knowledge about different aspects of aging, as well as attitudes toward the elderly. These personal characteristics such as age, education, work experience with the elderly, length of work in the particular facility and frequency of contact with the elderly family member, were identified by Lucas (1991), as exploratory variables and were also analyzed in this study. This was to see their impact upon independent variables (gerontological knowledge and attitudes) and a dependent variable (recognition of elder abuse and neglect in institutions).

Instruments

The survey instrument consisted of four sections (A, B, C & D) measuring different concepts such as knowledge, attitudes and recognition. The self-administered questionnaire contained two standardized scales required to measure social workers' gerontological knowledge and their attitudes toward the elderly. Recognition of elder abuse and neglect in institutions was measured using a questionnaire developed by the student. The last part included demographic questions. (Appendix C).

Section A:

The Psychological Facts on Aging Quiz (McCutcheon, 1986) is used to assess social workers' knowledge about aging (Appendix C). Permission from the publisher to use this instrument has been obtained (Appendix E).

The Psychological Facts on Aging Quiz combines items from the FAQ#1 (Pallmore, 1977), and the FAQ#2 (Pallmore, 1981) with three original items to form a quiz dealing exclusively with psychological and sociological facts about aging.

The PFAQ contains 22 items, six of which are original items from the FAQ#1 (Pallmore, 1977) and 10 original items from FAQ#2 (Pallmore, 1981). Three items were selected from FAQ#1, but were revised and altered by Miller and Dodder (1980). The final three items were created by McCutcheon. The highest possible score is 22 (100% of questions answered correctly).

When the resulting Psychological Facts on Aging Quiz (PFAQ) was administered to 121 subjects in introductory psychology classes, the mean score correct was 60% (McCutcheon, 1986), which is similar to the scores of college students on the FAQ#1 and the FAQ#2, without the "don't know" option. The scores were not significantly different by gender and age, which is also similar to the results on the FAQ#1 and FAQ #2 (Pallmore, 1988). Comparability of these items adds to the reliability of the test. Two other contributors to reliability and validity are the fact that FPAQ is "based largely on the test items for which the reliability and validity have been previously demonstrated" (McCutcheon, 1986, p.127). The instrument is easy to score and requires a short time (5-10 min) for completion.

Section B:

Attitudes of social workers toward the elderly were assessed by employing Kogan's (1961), Old People Scale (OPS). For further reference, please see Appendix C. This instrument consists of 17 matched pairs of positive and negative statements about old people. Subjects were asked to indicate the extent of their agreement with each statement using a 6-point Likert Scale that ranges from "strongly disagree" to "strongly agree". Each category of answers is scored 1, 2, 3, 4, 5, and 7, respectively, with a score of 4 assigned in case of failure to respond to an item. The attitude score is obtained by adding the individual item scores for each sub-scale. The range of possible scores is from a minimum of 17 points to a maximum of 119 points on either scale. Thus, a high score on the OP(+) scale indicates a positive attitude toward old people, whereas a high score on the OP(-) scale indicates negative attitudes toward old people (Shaw & Wright, 1967).

According to Kogan (1961) the scale seeks to assess how individual respondents feel about the elderly on such issues as their intellectual capacity, dependence, personality, living arrangements, personal appearance, and influence on business and industry. Likewise, items that measure discomfort or tension in the presence of old people are also included in the scale.

The Kogan's OP Scale was tested by its developer for reliability and correlation with similar attitudinal scales (Kogan, 1961). In three different samples, the reliability co-efficient ranged from .73 to .83 for the OP(-) scale, and .66 to .77 for the OP(+) scale (Shaw & Wright, 1967). The OP Scale has reasonably good content validity (Shaw & Wright, 1967). In addition, Kogan reported a significant correlation between scores on this scale and others measuring attitudes

toward ethnic minorities, and physically disabled groups. He also derived a nurturant factor from a brief personality inventory given to his subjects, which was significantly correlated with OP

Scale scores. Since the more nurturant subjects were more positively disposed toward old people, this may be taken as some evidence of validity (Shaw & Wright, 1967).

Despite the fact that this is a relatively old instrument (1961), it has been widely used by researchers throughout the 1980s and 1990s (Chandler, Rachel & Kazelskis, 1986; Gardner & Perrit, 1983; Reed, Beall & Baumhover, 1992; McCracken, Fitzwater & Locwood, 1995). The content of its questions is still relevant, and its ease in scoring and the short length of time required to complete are additional advantages of the Old People Scale.

Permission from the author to use this scale has been obtained (Appendix E).

Section C:

An instrument designed by the student, measured recognition of elder abuse and neglect in institutions by social work practitioners. It was assessed through nominal scales which follow the vignettes.

There were several reasons for employing this technique in the student's survey research. It specifies precisely the elements of the situation to which participants will respond and allow open-ended questions to be built into it, leaving maximum opportunity for respondents' own interpretations. (Finch, 1985). In addition, vignettes, "offer the opportunity to explore issues in

a way which approximates to the complexities than other techniques commonly used in surveys". (Finch, 1985, p.111).

The student developed each of six vignettes based on the literature describing different types of abuse and neglect in institutions (Baum, 1977; Baumhover & Beall, 1996; Bohuslawski, 1989; CARIE, 1991; Clough, 1996; Lucas, 1991; Meddough, 1993). Each vignette indicates only one type of abuse according to definitions provided in an earlier section of this manuscript. (Situation A – physical abuse, Situation B – psychological abuse, Situation C – physical neglect, Situation D – sexual abuse, Situation E – material abuse, and Situation F – psychological neglect). The number of correct answers was totalled for each respondent reflecting his/her level of recognition of elder abuse and neglect with 6 being the highest number (one point assigned for each correct answer and zero for incorrect or lack of response).

Other questions were intended to provide some answers as to how social workers recognize when abuse might have occurred, and how confident they feel about their own ability to identify elder abuse and neglect in their place of employment. The last question, which asked respondents to choose the high risk factors, that precipitate elder abuse in institutions, was adapted from the list provided by Podnieks (1989).

Section D:

This section included demographic information about respondents as well as some additional questions, which helped to further investigate relationships between variables in the analysis. Gender was excluded from the questionnaire in order to further protect the anonymity of any men involved in the study, as the majority of social work practitioners are women.

This section included ordinal questions related to demographic characteristics of respondents (age; work experience; work preference). It also included open-ended questions to provide the researcher with information about social workers knowledge, related to elder abuse and neglect in institutions. The last few questions in this section ask respondents to name the most important sources of knowledge about institutional abuse and how they would like to improve their knowledge (if at all).

Pre-Test

The survey questionnaire used in this study was pre-tested prior to its distribution. Members of the Informal Support Group within the MSW Program (who did not take part in the final study), were asked to volunteer to pre-test the measuring instrument for its face, content and construct validity. Some volunteers possessed clinical social work experience and are currently upgrading their education. Others hold degrees in other professions (nursing; education) and intend to become social workers.

In addition, the author gathered some feedback on the clarity of the questions and instruction and established the time required to complete the questionnaire.

Several changes were made in the survey questionnaire to accommodate valuable suggestions of pre-test participants. For example, in The Recognition Test (Section C), instruction "circle one answer", was added under the first question of each vignette to ensure that respondents select only one type of abuse/neglect (Please refer to Appendix C).

In addition, some categories in ranking questions (Section C and Section D) were extended and clarified to ensure more choices for the respondents.

Data Analysis

The Statistical Package for the Social Services (SPSS 6.1), computer program, was utilized in examining the data. Beside measures of central tendency, a variety of quantitative techniques were employed to analyze respondents' scores on the knowledge test, responses on the attitudes scales, as well as answers on the recognition section. Relationships between variables were explored. Wherever it was suitable, a cross-tabulation was employed to show the relationship between two variables.

The independent t-test was used to determine significant differences between respondents from each level of education (BSW and MSW), and their scores on knowledge and attitude tests. Similarly, the impact of nursing home locations (rural, Winnipeg) and scores on the PFAQ test and OP Scale, was examined by an independent t-test.

The influence of other variables (such as age, length of time working in the particular facility, length of work experience with the elderly and the frequency of contact with older family members), were also examined. This was in relation to scores obtained on the PFAQ test, the OP Scale and The Recognition Test. In order to compare means of these other variables, a one-way analysis (ANOVA) was performed. To find out which categories of different variables are different from each other, multiple comparison procedures were used. Due to the fact that Levene's Test for Homogeneity of Variance did not meet the assumption of equality of variance, Dunnett's C Test, where equal variances are not assumed, was utilized. Pearson's Correlation

Test was used to determine the strength of the relationship between social workers' attitudes toward the elderly and there scores on knowledge and recognition tests.

CHAPTER 4

Results and Discussions of Survey Findings

Results of Survey

This chapter presents a description of the findings of this study. The data was collected by means of a questionnaire distributed by mail to all social workers employed in Personal Care Homes in Manitoba. The following factors pertaining to the participating social workers were analyzed; age, education, length of time in the facility, size of the facility, work experience with the elderly and frequency of contact with an elderly family member. This was performed to measure their association with gerontological knowledge attitudes toward the elderly and their recognition of abuse and neglect in institutions. Content analysis of open-ended questions was also conducted to examine participants' understanding of the different types of abuse and neglect that exist in nursing homes.

The first part of this chapter presents a descriptive analysis of the survey, beginning with the response rate. In the latter part of this chapter, a more specific account is given. This latter account highlights the findings, which are trying to answer the research questions stated earlier in this report.

Response Rate

Out of 71 questionnaires mailed out to all the people employed in social work positions in Personal Care Homes (P.C.H.) in Manitoba, 50 were returned. The response rate was 70.4%. Although there are no absolute standards for response rates in mail surveys used by social workers, Babbie (1995), offers a rough guide of 50 percent as an "adequate" response rate, 60 percent as a "good" rate, and 70 percent as "very" good. However, according to the authors' inclusion criteria outlined in the study design section, only responses from social workers with social work degrees were used for statistical analysis.

Five respondents (among 50 participants) were nurses (4 from rural areas and 1 from Winnipeg). Due to the inclusion criteria, a total of 45 questionnaires were analyzed (63.3%).

Description of P.C.H.'s

There are a total of 120 Personal Care Homes (P.C.H.) in Manitoba. In rural areas, there are 85 facilities and the remaining 35 are located in the City of Winnipeg. They range in size from a P.C.H. with only 17 beds to 248 in rural areas and from 22 beds to 320 beds in Winnipeg. In the City of Winnipeg, four of the homes contacted, reported not having social workers and two others used social work services from larger long-term facilities. Among the remaining P.C.H.'s, two social workers were employed part-time and the rest were full time.

The number of social workers employed at each institution also varied, depending on the facility. Some P.C.H.'s (usually the larger ones) employ two to four social workers. However, one P.C.H. with 213 beds, reported having no social workers on staff. In total, there are currently 42 social workers employed either part-time or full-time in all Winnipeg P.C.H.'s.

The situation was different in rural P.C.H.'s. Out of 85 facilities, only 27 have at least one social worker on staff. One nursing home with the highest number of beds among all the P.C.H.'s in rural Manitoba (248), employs 2 social workers. Five social workers are employed part-time and the remainder is full-time. Smaller facilities, ranging usually from 17 to 44 beds, did not have social workers on staff or used social work services from other agencies in the area on an "as needed" basis. One P.C.H with 104 beds reported having no social workers on staff at all.

Characteristics of the Sample

Age. There were no participants under 25 or over 66 years of age. Fifteen social workers were between 26-35 years of age (33.3%) and thirteen were between 36-45, with the same number between the ages of 56-65 years of age.

Education. Twenty eight (62.2%) respondents possessed Bachelor of Social Work degrees and the remaining 17 social workers held their Masters degrees in Social Work (37.8%). Table 1 illustrates the cross-tabulation of age and education.

Table 1

Cross-Tabulation of Age of the Respondents by their Education

Age	Education		Total
	BSW	MSW	
26-35 (n)	13	2	15
(%)	86.7	13.3	33.3
36-45 (n)	5	8	13
(%)	38.5	61.5	28.9
46-55 (n)	7	6	13
(%)	53.8	46.2	28.9
56-65 (n)	3	1	4
(%)	75.0	25.0	8.9
Total (n)	28	17	45
(%)	62.2	37.8	100.0

It seems that the youngest group of respondents (26-35) and the oldest (56-65) had the highest number of people with BSW degrees. Middle age participants tend to have a higher education, with 61.5% of social workers between 36 and 45 years of age, holding MSW degrees

Work experience. The length of work experience with the elderly as a social worker varied from less than 6 months to over 16 years. One participant from rural Manitoba had less than 6 months of experience (2.2%). Three participants had between 6 months to 1 year (6.6%) and 14 participants had between 2-5 years (31.3%). Ten participants (22.2%) had over 16 years of experience working with the elderly.

The majority of respondents indicated that employment in their current P.C.H. was equal or slightly less than their overall experience working with the elderly population.

Place of employment. Twenty-six respondents were from Winnipeg (57.8%) and 19 from other parts of Manitoba (42.2%). Fourteen respondents (31.3%) worked in facilities with fewer than 10 beds, which were considered small sized facilities. Twelve of those were situated in rural Manitoba. Fifteen participants (33.3%) identified their facility as having between 71 and 150 beds (medium size). Only five of those were from rural Manitoba. The remaining 13 respondents (28.8%) were employed in P.C.H.'s with over 151 beds (large facility). One of those was from rural Manitoba. Please refer to Table 2.

Table 2

Cross-tabulation of Respondents' Education by their Place of Employment

Education	Rural	Winnipeg	Total
BSW (n)	14	14	28
(%)	73.7	53.8	62.2
MSW (n)	5	12	17
(%)	26.3	46.2	37.8
Total (n)	19	26	45
(%)	100.0	100.0	100.0

Based on results presented in Table 2, the majority of social workers from rural area P.C.H.'s had BSW degrees (73.7%), while only 26.3% had MSW degrees. This situation is somehow different in Winnipeg, where these proportions are closer: 53.8% of respondents had BSW degrees and 46.2% had MSW degrees. However, there was no significant differences in educational level between rural and urban respondents ($x^2 = 1.84$, $p = .148$).

The circumstances are different when comparing respondents' education and the size of the facility they are employed in. Chi-square testing for independence in a cross-tabulation of those two variables revealed that, education and size of the P.C.H. were significantly different

($x^2 = 6.61$, p=.037), meaning that respondents with higher degrees (MSW) tend to work in larger facilities. Table 3 illustrates this finding.

Table 3

Cross-tabulation of Respondents Education by the Size of the Facility

	P.C.H. SIZE			
Education	Under 70	71-150	Over 151	Total
BSW (n)	12	10	5	27
(%)	44.4	37.0	18.5	100.0
MSW (n)	2	5	8	15
(%)	13.3	33.3	53.3	100.0
Total (n)	14	15	13	42
(%)	33.3	35.7	31.0	100.0

Table 3 shows that social workers with BSW degrees tend to work in smaller facilities. The highest percentage of these is employed in institutions with under 70 beds (44.4%). In the case of social workers with MSW degrees the opposite is true. Most of these are employed in large P.C.H.'s (53.3%) with over 150 beds.

Frequency of contact with elderly family members. An equal number of respondents (17 people or 37.7%) indicated that, they have contact with their elderly family members every day or every week. Five participants (11.1%) disclosed seeing their elderly relatives a few times a month and four respondents (8.8%) only a few times a year. Two respondents (4.4%) indicated that they never see their elderly family members.

Work preference. The elderly (65+) ranked as the first choice among social workers as the age group they would most prefer to work with. The majority of respondents (66.7%) made this age group their number one choice of employment.

Table 4

Rankings of Social Workers' Work Preference with Different Age Groups

Age Group		1st Choice of Work Selection (%)	Rank
elderly	65+	66.7	1
adults	25-64	15.6	2
children	6-12	6.7	3
young adults	19-24	4.4	4
children	0-5	2.2	5
adolescents	13-18	4.4	6

The above table shows that in the case of adults, 25-64 years of age ranked as the second most common. Children 6-12 years were third while adolescents 13-18 and young adults were both

fourth. Children 0-5 years were the least popular group to work with among social workers participating in this study.

Answers for Research Questions of the Study

The main goal of this study was to conclude whether there was a significant relationship between social workers' scores on knowledge (PFAQ), attitude (OPS) and their scores on the Recognition Test.

Due to the fact that all the variables were measured at the interval level, the Pearson Correlation Co-efficient Test had been selected to investigate the strength of the association among these variables (knowledge about different aspects of aging, attitudes toward the elderly and recognition of elder abuse/neglect). As shown in Table 5, the correlations among these variables, based on data results, were small and not significant.

The calculated correlation co-efficient between scores on the Recognition Test and scores on the attitude test (OPS), was very low ($r = .07$, $p = .61$). The correlation is slightly stronger, with scores on the knowledge test (PFAQ), where $r = .22$. However, these results are not statistically significant ($p = .14$). Results of this test are shown in Table 5.

Table 5

Relationships between Social Workers' Gerontological Knowledge, their Attitudes toward the Elderly and their Recognition of Residents' Abuse and Neglect in P.C.H.s

		OPS (total)	PFAQ (total)	Recognition (total)
OPS(total)	Pearson Correlation	1.00	-.02	.07
	significance		.87	.61
	N	45	45	45
PFAQ (total)	Pearson Correlation	-.02	1.00	.22
	significance	.89		.14
	N	45	45	45
Recognition (total)	Pearson Correlation	.07	.22	1.00
	significance	.61	.14	
	N	45	45	45

This research did not indicate high and significant correlation's between social workers attitudes, their gerontological knowledge and the recognition of elder abuse. These results are explained further in this chapter. However, answers to other research questions yield interesting and significant results.

Q1. Do social workers employed in long-term facilities have knowledge about different aspects of aging?

The Psychological Facts on Aging Quiz (McCutcheon, 1986) was included in the survey in order to collect data helpful in answering this question. On the basis of these data, knowledge about aging appears to be well within and even above the norm. The average score was 70.8% (SD=8.6) or approximately 15.6 out of 22. The minimum score was 12 and the maximum score was 19 (relatively 55% and 86% correct answers). This level of performance is higher than the levels of performance reported by McCutcheon (1986) where the mean score was 13.2 (60%) with standard deviations of 2. The test was administered to 121 undergraduate psychology students. In this case 37.8% of respondents had graduate degrees (MSW) and 82.2% had attended at least 3 credit hours of gerontological courses. Considering these facts, higher scores were expected. Other studies where subjects had obtained their MSW degrees or completed a number of gerontological courses, displayed similarly high scores (Brubaker & Baressi, 1979; Chandler et al., 1986; Reed et al., 1992).

In this study, the mean score on the PFAQ for the respondents with a BSW degree was 15.1 points or 68.5% correct answers (SD = 8.3) and for participants with MSW degree, 16.4 points or 74.7% correct answers (SD = 8.1).

An independent t-test indicated a significant difference at the .05 level between the level of education (BSW or MSW) and scores on the PFAQ ($t = 2.38$, $p=.020$). Table 6 illustrates the cross-tabulation of scores on the PFAQ by education.

Table 6

Cross-tabulation of Scores on the PFAQ by Education

	EDUCATION		
Scores on PFAQ	BSW	MSW	Row Total
n	16	5	21
15 and less	57.1 %	29.4%	46.7%
n	12	12	24
16 and more	42.9%	70.6%	53.3%
n	28	17	45
Column Total	62.2%	37.8%	100.0%
	100.0%	100.0%	100.0%

The author decided to divide the PFAQ scores obtained by the participants at the median of 15 into low scores (15 or less) and high scores (16 and more). Table 6 shows that 57.1% of respondents with BSW degrees had low scores on the PFAQ while only 29.4% of participants with MSW degrees were in that position.

Overall scores (for BSW's and MSW's) were considered high with 53.3% of all respondents achieving 16 or more points on the PFAQ scale. The observed significance level based on a chi-square distribution was statistically significant ($p = .05$) meaning that respondents with higher degrees (MSW) tend to have higher scores on the PFAQ.

The mean score on the PFAQ for the respondents from rural Manitoba was 15.4 points or 70.1% (SD = 7.9) and for respondents from Winnipeg, 15.7 points or 71.3% (SD = 9.3). An independent t-test indicated that there was no significant difference between location of respondents' place of employment (rural Manitoba or the City of Winnipeg) and their scores on the PFAQ ($t=-.46$, $p=.64$).

The influence of other variables such as age, length of time employed in the particular facility, work experience with the elderly and the frequency of contact with older family member was also examined. This was to determine their impact on the relationships with scores on the Psychological Facts on Aging Quiz (PFAQ). Table 7 shows respondents' characteristics and their scores on the PFAQ.

Table 7

Characteristics of Respondents by Level of Knowledge about Aging

(Scores on PFAQ)

Characteristics of Respondents (n total = 45)		N (%)	Level of Knowledge Maximum score = 22 (mean score on PFAQ)	Standard Deviation	p. value
Education	BSW Degree	28 (62.3)	15.07	8.30	p = .020
	MSW Degree	17 (37.7)	16.42	8.12	
Age	26-35	15 (33.3)	14.27	1.58	p = 000
	36-45	13 (28.8)	17.00	1.41	
	46-55	13 (28.8)	16.75	1.75	
	56-65	4 (9.1)	15.31	1.71	
Work exp. w. the elderly	6 months to 1 year	3 (6.6)	12.33	0.58	p = .020
	2-5	14 (31.1)	14.77	1.64	
	6-10	11 (24.4)	16.20	0.95	
	11-15	6 (15.7)	16.83	2.23	
	over 16	10 (22.2)	16.00	2.04	
Length of work in P.C.H.	Less than 6 months	3 (6.6)	14.00	2.65	p = .160
	6 months – 1 year	4 (9.1)	13.75	1.50	
	2-5	14 (31.1)	15.50	1.65	
	6-10	15 (33.3)	16.27	1.53	
	11-15	4 (9.1)	16.00	3.16	
	over 16	5 (11.8)	15.80	1.92	
Freq. Contact w. elderly family member	Never	2 (3.7)	13.50	0.71	p = .490
	Few times a year	4 (9.1)	14.75	2.75	
	Few times a month	5 (11.8)	15.80	2.77	
	Every week	17 (37.7)	15.82	1.91	
	Every day	17 (37.7)	15.71	1.53	

A one way analysis of variance (Anova) was performed to compare the means of other groups of variables. In this study, groups were based on their values for the following factors: age, work experience with the elderly, length of work in the P.C.H. and frequency of contact with an elderly family member. It was observed that only age ($p < .000$) and work experience with the elderly

($p < .020$) were statistically significant at the .05 level when compared with respondents' scores on the PFAQ (beside education, which was determined using an independent t – test). Since the Anova test did not indicate which means are significantly different from each other, multiple comparison procedures were used to see which means in age and work experience with the elderly categories were significantly different from each other.

First, the means for each age were calculated. The age group 26-35 scored on average 14.3 points on the PFAQ (SD = 1.6), the group 36-45 achieved on average 17.0 points (SD = 1.4) and the group 46-55 scored 16.7 points (SD = 1.8). The final age group of 56-65 rated a mean score of 15.3 points (SD = 1.7).

Second, the statistically significant F value ($F = 7.7$, $p=.00$) suggested that it appears unlikely that all population means are equal. To find out which age groups are significantly different from each other, multiple comparison procedures as mentioned above were used. Dunnett's C test, where equal variances are not assumed, was utilized. It determined which categories of the factor variable are significantly different from which other categories. It was observed that there were significant differences in mean scores on the PFAQ between the two age groups; the first age group (26-35) and the second (36-45) at a significance level of $p = .05$.

The variable "work experience with the elderly", was also statistically significant with scores on the PFAQ. After completing descriptive statistics, the first groups' (6 months to 1 year experience) mean score was 12.3 (SD = .6). The second groups' (2-5 years) average score was 14.8 (SD = 1.6). The third groups' (6-10 years) average score was 16.0 (SD = .9) and the

fourth groups' (11-15 years) average score was 16.8 (SD = 2.2). The fifth groups' (over 16 years) mean score was 16.2 (SD = 2.0).

Average scores appeared to increase with the amount of experience. The obtained F-value for the one-way Anova was 5.1 (p=.002) The Dunnett C-test indicated that there was a statistically significant difference of mean scores on the PFAQ between the first group (6 months – 1 year experience), the third group (6-10 years), the fourth group (11-15 years) and the fifth group (over 16 years of experience). It suggests that knowledge about different aspects of aging is increasing with years of experience, showing slight decrease in workers with over 16 years on the job.

The Pearson Correlation Co-efficient also revealed a relationship between the number of credit hours of gerontological courses completed by social workers and their total scores on the PFAQ ($r = .35$, $p = < .02$). It seems that the quantity of courses about different aspects of aging, taken by the respondents during their university years is positively related and statistically significant with their gerontological knowledge.

Q.2 Is the knowledge about elder abuse and neglect in institutions part of this knowledge?

Approximately half of all the participants (49.0%) were confident that they have enough knowledge about elder abuse and neglect in institutions. When asked " Do you believe you have enough knowledge in the area of forms and causes of elder abuse and neglect in institutions?" (Question 14, Section D, Appendix C) 45.5% of respondents said "No" and 8.9% were "Not sure".

However, 89.0% of social workers would like to improve their current knowledge about these issues, mostly saying "There is always something new to learn in this area". Comparison of positive answers to the mentioned above question 14 in Section D, to participants' degrees indicated that social workers with Masters degrees were more confident about their knowledge about elder mistreatment in institutions that their colleagues with Bachelor of Social Work degrees. Table 8 illustrates this finding. Over half (52.9%) of respondents with MSW degrees said that they have enough knowledge about elder abuse/neglect in institutions, while only 42.8% of participants with BSW degrees said "Yes" to the same question.

Table 8

Cross-tabulation of Respondents' Education by their Confidence about Elder Abuse/Neglect Knowledge

Enough Knowledge about Abuse/Neglect	Education		Row Total
	BSW	MSW	
n	12	9	21
YES	42.8%	52.9%	46.6%
n	13	7	20
NO	46.4%	41.3%	45.5%
n	3	8	4
NOT SURE	10.8%	8.8%	8.9%
n	28	17	45
Column	62.2%	37.8%	100.0%
Total	100.0%	100.0%	100.0%

In order to see how the participants' have gained knowledge about institutional abuse of the elderly, they were asked to rank the following selections: university courses, professional development training, self-study and work experience.

As shown in Table 9, university courses had the lowest rank in helping respondents to gain knowledge about elder abuse in nursing homes. However they would like to see that changed. When asked "How would you like to improve that knowledge?" specialized courses through university continuing education ranked second. The most important was professional development training which was ranked first. Self study and work experience were both ranked as third (Table 10).

Table 9

Rankings of Methods of Gaining Knowledge about Institutional Abuse by Social Workers

Method of Gaining Knowledge	1st Choice of Method Selection n (%)	Rank
Professional Devel. Training	16 (35.7)	1
Work experience	14 (32.2)	2
Self-study	10 21.4	3
University courses	5 (10.7)	4

Table 10

Rankings of Methods of Improving Knowledge about Elder Abuse/Neglect in Institutions by Social Workers

Method of Improving Knowledge	1st Choice of Method Selection n (%)	Rank
Professional Devel. Training	34 (76.9)	1
Continuing educ. Courses through university	9 (19.9)	2
Self-study	1 (2.6)	3
Work experience	1 (2.6)	3

Respondents were also asked in what areas of elder abuse and neglect they need more knowledge (Question 18, Section D, Appendix C). Physical neglect was mentioned most frequently by social workers as the area they need to know more about. The next on the ranking scale was knowledge about sexual abuse and financial abuse. Psychological neglect was placed fourth on the ranking scale. Knowledge about physical abuse and psychological abuse were fifth and sixth. Table 11 illustrates these findings.

Table 11

Rankings of Areas of Elder Abuse/Neglect in which Social Workers Feel they Need More Knowledge

Areas of Elder Abuse/Neglect Where S.W. Feel They Need More Knowledge	First Choice Selection n (%)	Rank
Physical neglect	17 (37.8)	1
Sexual abuse	12 (26.7)	2
Financial/material abuse	7 (15.5)	3
Psychological neglect	4 (8.9)	4
Physical abuse	3 (6.7)	5
Psychological abuse	2 (4.4)	6

Respondents had been asked a variety of questions to determine their awareness about elder abuse in institutions. They were asked to estimate what percentage of residents experienced some form of abuse or neglect while living in Personal Care Homes (Question 9, Section D, Appendix C). Answers ranged from 5% to 100%. Two respondents stated that the number is unknown and they were unable to make an estimate.

The mean percentage for all the participants was 42.2%. This is a fairly high number which indicates that social workers perceive that almost half of nursing home residents are being abused or neglected at some point of their lives in institutions.

At the same time, 65% of respondents admitted that they knew of at least one confirmed and or investigated case of elder abuse/neglect in their facility during the last year. Mostly social workers (32.0%), family members (28.9%) and nurses (21.4%) reported these cases. Residents reporting such acts committed against him/her, were rare occurrences (14.3% of all reports). These findings

are comparable with Watson's (1993) study where skilled nursing facility employees reported the highest number of abuses (50.0%) compared to family members and residents of the facilities. Abuse reported by the victims accounted for only 1.2% of reports (Watson, 1993). In addition, 92% of participants stated that their facility has a special policy to deal exclusively with elder abuse and neglect. Social workers, who indicated that their nursing homes have no such policy, were employed in small facilities (all under 70 beds) and mostly in rural areas (3 out of 4).

Participants were also asked to share their opinion about what group of people they thought were most often responsible for acts of abuse/neglect toward residents (Question 9, Section C, Appendix C). Consistent with other studies, (Goodridge et al, 1994; Heiselman et al, 1989; Payne & Cikovic, 1995; Pillemer & Bachman-Prehn, 1991) direct care staff (nurses' aides and orderlies) were identified as number one on the ranking scale. Number two were visitors. Other residents were placed third and the last group was medical personnel (nurses and doctors). One respondent selected "other people", specifying it as kitchen and cleaning staff. Table 12 portrays these results.

Table 12

Rankings of Groups of People who were Most Responsible for Residents' Abuse/Neglect

Groups of People	1st Choice Selection as the most Abusive Group n (%)	Rank
Direct staff (nurses' aides, orderlies)	22 (48.9)	1
Visitors	11 (24.4)	2
Other residents	8 (17.8)	3
Medical personnel (nurses, doctors)	3 (6.7)	4
Other people	1 (2.2)	5

Respondents were also asked what type of abuse/neglect was most common in Personal Care Homes (Question 8, Section C, Appendix C). According to collected data, the three most prevalent forms of abuse/neglect identified by social workers were:

1. Psychological neglect
2. Psychological abuse
3. Physical neglect

Financial abuse, physical abuse and sexual abuse were ranked respectively fourth, fifth and sixth. Table 13 illustrates these findings.

Table 13

Rankings of the Most Common Forms of Abuse/Neglect in P.C.H.'s
(in the Opinion of Social Workers)

Forms of Abuse/Neglect	1st Choice Selection as the Most Common Abuse/Neglect n (%)	Rank
Psychological neglect	22 (48.9)	1
Psychological abuse	8 (17.9)	2
Physical neglect	7 (15.5)	3
Financial abuse	5 (11.1)	4
Physical abuse	2 (4.4)	5
Sexual abuse	1 (2.2)	6

These results differ from the results of other studies (Payne & Cikovic, 1995; Watson, 1993) where physical abuse was the most frequently reported act of mistreatment toward nursing home residents. Discussion about possible explanations will follow in the next part of this report.

The questionnaire contained questions about factors that could precipitate elder abuse and neglect in institutions (Question 10, Section C, Appendix C). The most frequent answer was lack of an adequate number of staff. Lack of understanding of the aging process, inadequate preparation of staff, lack of legislation and negative attitudes toward the elderly were also frequently selected. Table 14 shows these findings.

Studies revealed similar determinants of elder mistreatment in institutions. Research conducted by Goodridge et al (1994) and Pillemer (1988) both pointed on the lack of qualifications and training of staff (mostly nurses' aides) while Podnieks (1985) emphasized negative attitudes toward aging and lack of understanding of the aging process.

The Winnipeg Free Press (March 22, 1999), after conducting it's own investigation, reported that lack of adequate numbers of staff greatly contributed to occurrences of elder mistreatment in nursing homes in the Province of Manitoba. The newspaper also announced that staffing levels in Manitoba are based on 1973 guidelines. According to the article, this does not reflect the growing demands on staff because it was created at a time when most nursing home clientele were low-needs residents. Today, the residents are more high-needs and as a result, require close supervision. However, based on the results of this study, as well as the report in the Free Press, there has not been a corresponding increase in staffing.

Table 14

Rankings of the Most Important Factors which could Precipitate Elder Abuse/Neglect

(in the Opinion of Respondent Social Workers)

Factors Precipitating Elder Abuse/Neglect	1st Choice Selection as Most Important Factor n (%)	Rank
Other (specify) Inadequate staffing	12 (26.7)	1
Lack of understanding of aging process (complex health needs of elderly)	7 (15.6)	2
Inadequate preparation of staff	6 (13.3)	3
Poor working environment	6 (13.3)	3
Lack of legislation and policies to ensure quality care in institutions	5 (11.1)	4
Negative attitudes toward aging	3 (6.7)	5
Increasing dependency of elderly	3 (6.7)	5
Insensitivity to needs of elderly and families	1 (2.2)	6
Lack of positive communication between staff/clients/families	1 (2.2)	6
Lack of opportunity for staff professional/personal growth	1 (2.2)	6

The social workers participating in the study were asked what constitutes different types of abuse, and what is included in the theoretical definition of elder abuse and neglect. These were open-ended questions that elicited qualitative data. Gathered this way, material was later examined using content analysis. In order to establish social workers' perception of attributes of elder abuse and neglect in institutions, content analysis was used to record the frequency with which certain words and terms appeared as descriptions of specific kinds of abuse and neglect.

Statements such as unexplained injuries, marks, bruises and cuts were mentioned in 95.5% of responses to questions about signs of physical abuse. Fearfulness of a particular person (other residents, caregivers), appearing withdrawn and depression, were included in 86.6% of responses. Less frequent statements included fearfulness in non-threatening situations, being "jumpy" and evidence of broken bones.

According to the survey, the most common sign of physical neglect was an unkempt appearance (statements such as poor hygiene and dirty clothing were considered in the same category), which was identified by 97.7% of respondents.

In describing signs of psychological abuse, the most frequent statements were depression (68.8% of respondents) and isolation (51.1%) (words such as withdrawal and introversion were also included in the isolation category). Other often mentioned signs of psychological abuse were prone to crying, decrease in verbal expression (keeping things to themselves), and decreased self-worth.

When asked to describe signs of psychological neglect, the respondents most often used expressions such as deterioration in daily functions (not associated with a disease process) (24.4% of respondents), depression and apparent passiveness (both identified by 22.2% of participants). Social isolation, attention seeking behavior and wanting to die (suicidal), was also mentioned several times.

Signs of material /financial abuse were characterized as lack of proper clothing (outdated, too small, too big or worn out: 53.3% of respondents used this category), lack of money for extra daily needs (hairdresser, coffee and outings), (92.2%), extreme cautiousness over one's material possessions (visitors with known addictions, unpaid monthly bills) were some of the most often mentioned responses.

The most frequently mentioned signs of sexual abuse were resistances to personal care (change of clothing, bath time: 66.6% of respondents used these descriptives) and unexplained changes in genital areas (injury, pain, STD's), (62.2%). Fear of being alone with certain people (caregiver, family, other residents), were described by the participants. Table 15 gives the signs of elder abuse and neglect in institutions, as identified by the surveyed social workers.

Table 15

Signs of Elder Abuse and Neglect in Institutions

(as Identified by Participants)

Type of abuse/neglect	Signs
Physical Abuse	Unexplained injuries (marks, bruises) Fearfulness of particular person (other residents, caregiver) Resident is jumpy Fractures, burns Observation of excessive or harmful restraint / outward effects of excessive medication
Physical Neglect	Unkempt appearance / lack of personal hygiene Unexplained weight loss / dehydration / failure to thrive Unsafe environment / inadequate supervision of disabled residents Inadequate diet (not following diabetic / low-cholesterol diet. Not providing adequate amounts of food / fluids
Psychological Abuse	Depression / unexplained crying/ decreased self-esteem Isolation / patterns of humiliation Decrease in verbal expression (keeping things to themselves)/resistance to help or self-determination Observations of verbal harassment, threats, assaults or intimidation Infantilization / coercion / derogation
Psychological Neglect	Deterioration of daily functions (not associated with a disease process) Depression / passiveness / social isolation Attention seeking behavior / feelings of loneliness Wanting to die (suicidal) / apathy Exclusion from participation in activities / observation of avoidance of the resident
Material/ Financial Abuse	Lack of proper clothing (outdated, too small, too big, worn out) Lack of money for extra daily needs (hairdresser, coffee, ect) / unpaid bills Extreme cautiousness over one's material possessions Theft or misuse of the residents' money or property (using residents' creams, perfumes, borrowing clothes, ect)
Sexual Abuse	Resistance to personal care (change of clothing, bath time) Unexplained changes in genital areas (injury, pain, STDs) Fear of being alone with certain people Change of mood / behavior after being with certain people

Content analysis was also employed to examine the social workers' understanding of differences between abuse and neglect. Respondents were asked to define in their own words "elder abuse" and "elder neglect". The plan was to determine the most common themes in their definitions, as well as their consistency with the literature. After completing open-coding, axial coding (Berg, 1998) was selected to organize data around these two categories: elder abuse as an act of commission and elder neglect as an act of omission

The phrases used by respondents in the definition of elder abuse included:

"intentional or not, harm to the elderly resident"

"taking advantage of residents with harmful consequences"

"maltreatment"

"denying residents their rights and jeopardizing their safety"

Several respondents indicated forms of abuse ranging from physical to psychological harm to the elderly residents while trying to define elder abuse. The phrases and themes used to define elder neglect included:

"withholding services"

"failure to provide for the needs of the elderly"

"ignoring residents"

"not allowing self-determination"

violation of residents' rights"

Survey findings revealed that over half of respondents (54.0%) provided definitions of elder abuse agreeable with an act of commission. On the other hand, 60.0% of social workers defined elder neglect as an act of omission. In general, a majority of respondents provided definitions of elder abuse and neglect, which were consistent with the literature. However, very few people (5) included intentions of the perpetrators as the base for defining elder abuse or neglect. Among those who did, only one person stated that harmful actions could be either intentional or not intentional.

According to the literature (Hudson, 1989), it is important to stress that ,as long as some behavior results in unnecessary suffering of the elderly, it should be considered abuse (commission) or neglect (omission) regardless of intentions.

Q.3 What attitudes do social workers working in nursing homes, have toward the elderly?

Another objective of this study, was to establish social workers' attitudes toward the elderly and to see what variables (age, education, work experience with the elderly, length of work in particular P.C.H., frequency of contact with elder family members and size/location of the facility) may have potentially influenced attitudes.

Kogan's (1961) Attitudes Toward Old People Scale (OPS), was used to assess the attitudes of social workers employed in Personal Care Homes toward the elder person on such issues as intellectual capacity, dependence, personality, living arrangements, personal appearance and influence on business and industry.

Items that measure discomfort or tension in the presence of old people are also included in the scale. Reactions to the statements were obtained on a 6-point Likert scale that range from "strongly agree" to "strongly disagree". Scores may range from a low of 34 to an upper limit (most positive), of 238. Scores between 102 and 136 represent neutral attitudes toward aging and the elderly.

On the O.P.S., the mean score for all respondents was 123.02 (SD=10.45), which is within the neutral range. In comparison with another study conducted by Reed (1992), social workers reached much higher scores (150.2 on OP scale).

It still remains unclear if professional affiliation (in this case, nurses and social workers), has any significant implications on attitudes toward older people.

Nevertheless, a positive attitude toward the elderly and gerontological work preference, was not necessarily related, as demonstrated by this study. Although overall scores on Kogan's test showed neutral attitudes of respondents toward the elderly, most of them selected working with this age group (65+), as their first choice of employment. This suggests that work preference is not always affected by attitudes. (Please refer to Table 4 p.47 to see more detailed results about work preference).

According to collected data, respondents with BSW degrees had higher average scores on the OP scale than respondents with MSW degrees. The BSW average score was 131.9 (SD = 11.6) and MSW average score was 124.8 (SD = 9.5). An independent t-test showed that there was a significant difference ($t = 2.08$, $p=.044$).

The influence of other variables such as age, length of time with an agency and frequency of contact with an elderly family member were also examined to determine their impact upon scores on Kogan's test.

A one-way analysis of variance (Anova) was performed to compare the means of different categories of mentioned above variables. None of the analyzed variables revealed statistically significant differences in means at the .05 level. The same test also did not indicate statistical significance between scores on the OP scale and the size of the facility where the respondents worked ($p = .555$).

The mean score on Kogan's test for social workers from rural areas was 123.6 (SD = 10.8) and for social workers from Winnipeg, the mean score was 122.6 (SD = 10.4). However, an independent t-test did not reveal a statistically significant difference ($p = .662$). Table 16 shows respondents characteristics and their scores on the attitude test.

Table 16

Respondents' Characteristics by their Scores on the Attitude Test (Kogan Old People Scale)

Characteristics of Respondents (n total = 45)		N (%)	Attitudes toward elderly mean scores on OP scale > 102 – negative attitude 102-136 – neutral attitude 136- positive attitude	Standard Deviation	p. value
Education	BSW Degree	28 (62.3)	131.92	11.67	p = .044
	MSW Degree	17 (37.7)	124.82	9.54	
Age	26-35	15 (33.3)	119.26	12.23	p = .200
	36-45	13 (28.8)	122.15	9.83	
	46-55	13 (28.8)	127.46	7.69	
	56-65	4 (9.1)	125.50	10.63	
Work exp. w. the elderly	6 months to 1 year	3 (6.6)	118.00	12.35	p = .466
	2-5	14 (51.1)	123.86	10.60	
	6-10	11 (24.4)	124.28	8.74	
	11-15	6 (15.7)	130.25	4.50	
	over 16	10 (22.2)	125.80	8.61	
Length of work in P.C.H.	Less than 6 months	3 (6.6)	117.00	13.11	p = .320
	6 months – 1 year	4 (9.1)	122.76	12.90	
	2-5	14 (31.1)	123.83	8.68	
	6-10	15 (33.3)	118.66	10.21	
	11-15	4 (9.1)	123.72	9.28	
	over 16	5 (11.8)	128.30	6.51	
Freq. Contact w. elderly family member	Never	2 (3.7)	121.00	9.89	p = .934
	Few times a year	4 (9.1)	120.25	13.04	
	Few times a month	5 (11.8)	123.20	13.60	
	Every week	17 (37.7)	122.23	12.35	
	Every day	17 (37.7)	124.64	7.59	

Q.4 Is there a relationship between gerontological knowledge and social workers' attitudes toward the elderly?

To find an answer for the above question, the Pearson Correlation Co-efficient test was utilized. It tested the relationship between scores on the Old People scale (attitudes) and scores on the Psychological Facts on Aging Quiz (gerontological knowledge). The correlation between the obtained average values was $r = -.020$ and the observed significance level was $p = .897$. The correlation between the two variables was very low and statistically non-significant. This negative correlation is close to zero and its probability level is greater than .05. Therefore, in this sample of respondents', scores on gerontological knowledge (as measured on the PFAQ) are not related to scores on the social workers' attitudes toward the elderly test (OP scale).

Q.5 Are social workers' able to recognize potential or real cases of elder abuse and neglect in institutions?

In order to find an answer for the above question, sum scores across all six vignettes in the Recognition Test (Appendix C), were used for the analysis (0 was the minimum score and 6 was the highest). The mean score for all respondents was 3.71 (SD = 1.14). The minimum was 1 and the maximum was 6. Ten participants (22.2%) achieved a high level of elder abuse recognition (5-6 points). Twenty-nine respondents (64.4%) obtained a medium level of elder abuse recognition (3-4 points) and 6 respondents (13.3%) were assigned a low level of recognition (1-2 points) on the Recognition Test. Two responses were not valid, because participants selected more than one answer to the question.

Situation A

Mrs. Smith is an 83-year old widow, who is bedridden and has Alzheimer's Disease. During one of her weekly visits, her sister complained to you that she had witnessed the nurses' aide stuffing food in Mrs. Smith's mouth and trying to force it open with a spoon. The nurses' aide explained that Mrs. Smith has a very poor appetite and otherwise, would die from starvation and dehydration.

The above vignette describes physical abuse. Thirty-eight respondents out of 43 selected it correctly (88.3%). Participants were also asked to assess the severity of the situation on the scale from 0 to 5. The mean score for severity of the Situation A was 3.62 (SD = .95). The majority of the respondents mentioned "forced feeding" and "forcing the mouth open with a spoon" as main indicators of physical abuse in the described situation.

Some respondents have seen this situation as physical endangerment of the client ".... the nurses' aide may also be putting this lady at risk of choking with the force feeding...", "...forcing a spoon in Mrs. Smith's mouth may physically harm her lips and inside of her mouth....".

Other social workers blamed the nurses' aides lack of knowledge about different stages of Alzheimer's, "...force feeding is a contradiction at the last stages of Alzheimer's. Comfort measures and small amounts of food and drink are more appropriate.....", "...forcing someone to eat is unacceptable. First, it must be assessed by a geriatrition, to see to what degree this person is capable of making this decision for herself, and if not, a next of kin should be making this decision, not a H.C.A. !!".

Nevertheless, one respondent classified the situation as non-abusive, with arguments that the nurses' aides did not have the intent to do harm to the client and she believes that she did the right thing for the client. Another participant also mentioned that there was no direct intention to hurt the client, but the intent was "misguided".

Considering the differences in the existing definitions of elder abuse/neglect, it is understandable that the participating social workers in this study could have different perspectives on the presented Situation A. However, according to the social work definition (Valentine & Cash, 1986), elder mistreatment refers to the "non-accidental" situation, which can be intentional or un-intentional but always have either physical, psychological or financial effect. These may result in un-necessary suffering. When this approach is utilized, the demonstrated above Situation A can be regarded as physically abusive.

Situation B

Mrs. Johnson is a 70-year old woman who is small, frail and appears younger than her age. She has a history of MS. Recently, her condition deteriorated and she just moved to the nursing home. While walking down the hall, you noticed one nurses' aide greeting Mrs. Johnson by her first name and patting her on the head. You also heard this same nurse's' aide saying that she picked a particular dress for Mrs. Johnson because it makes her look like a perfect little grandma.

The above situation describes psychological abuse. 34 respondents (79.0%) classified it as such. The mean score for the severity of this vignette was 2.82 (SD = .96).

The majority of social workers participating in the survey selected the following as main "giveaways" that situation B described psychological abuse:

i) Patronizing manner

ii) Treating an older person like a child ("adults don't generally go around patting each other on the head!").

iii) Not allowing residents' choices.

iv) The use of first names without making sure if a person wishes to be called that.

v) Discriminatory treatment based on physical size, gender and age.

Three people selected this situation as non-abusive, with one person saying that " although the aide's patronizing behavior is inappropriate, it does not result in any injury and does not deprive the resident of basic needs (food, shelter, water, medical care, etc.)".

However, the literature clearly states that behavior described as patronizing residents, labeling and restriction of personal choice is part of so called "covert abuse" (Meddough, 1993) and is very common in nursing homes.

Three participants in this study, did not see it as serious, since it did not leave scars or visible marks. However, it still may lead to unnecessary mental suffering of the resident (Valentine & Cash, 1986) and violates her/her rights to be treated with dignity and respect.

Situation C

Mr. Brown, a 90-year old nursing home resident, was alert, lucid and physically capable until two months ago when he suffered a mild stroke, leaving him slightly paralyzed on one side. He also became occasionally incontinent. Recently, Mr. Brown complained to you that after another wet accident occurred, a RN ordered his fluids and favorite afternoon tea to be cut down until he improved his wetting problem.

This vignette describes physical neglect. 12 respondents (27.9%) selected a correct answer. The mean score for severity was 3.75 (SD = .62).

This was one of the least recognized vignetts. Nevertheless, respondents who correctly selected "physical neglect" were able to point main indicators of described type of abuse.

The most common answers justifying the selection of "physical neglect" were:

i) Deprivation of fluids

ii) Withholding nourishment

iii) Punishing resident for behavior beyond his control

iv) Neglect to ensure normal level of hydration.

Some respondents offered more elaborate answers:

" Removal of fluids may cause more physical harm and may decrease cognitive ability if dehydration occurs".

"The RN is neglectful of physical needs of Mr. Brown and in that, the RN is not investigating the variable issues for this incontinence, the condition may not be actually treated, i.e. UTI".

" If only occasionally incontinent due to stroke, it is unnecessary to reduce fluids as this is unrelated to specific intake. However, if a resident is suffering skin breakdown or other problems, he may be offered reduced fluids as an option, to decrease the risk of incontinence. The resident should make the decision, not the staff ".

Although all the respondents agreed that Situation C describes some form of abuse or neglect, the majority of them (72.1%) failed to recognize that it was physical neglect. It was often confused with physical abuse or psychological abuse. For that reason, it could not be classified as a correct answer.

This test did not study social work intervention, which should follow the recognition of elder abuse/neglect. However, it would be interesting to see if the interventions would vary for different

types of abuse, because then recognition could be extremely important. This is discussed more broadly in Chapter IV: Implications of the Study.

Situation D

Mrs. Evanson is a 73-year old demented and very confused woman in relatively good physical health. Her husband visits occasionally and they usually spend time in her room, since she lives alone in her semi-private room. During his last visit, Mr. Evanson discovered that his wife now has a roommate. He came to you requesting that they be given privacy to have sexual relations to which they have a right, as a married couple.

The above situation describes sexual abuse. Eleven respondents (25.5%) selected properly. The mean score for the severity of the Situation D was 3.81 (SD = .60). This was one of the most controversial vignettes. Respondents who correctly selected "sexual abuse", argued that:

i "Sexual partners must both be able to consent."

ii "Mrs. Evanson is very confused, can she comprehend and accept sexual relations without becoming anxious and upset?"

iii "I have concerns that Mrs. Evanson is very confused and may not be able to understand and consent to sexual relations, even with her own husband (from an experience recently at work)".

However, several participants selected psychological abuse or physical neglect on the part of the Personal Care Home, for not providing the couple with privacy to have a sexual relationship:

i "Residents in a LTC facility should be provided with privacy, no matter what their needs are. Couples privacy should be respected and advocated."

ii "Neglect of physical psychological needs by denying this couples' privacy for intimacy."

iii " Ignorance of human needs of patients' husband."

Some respondents (27.2%) opted for describing this situation as non-abusive:

i "Although the patient is very confused, she may still recognize her husband and be receptive to his sexual advances"

ii "If Mrs. Evanson is consenting, this should be allowed. Perhaps a psychiatric assessment should be done."

These results corresponded with findings for question 18, Section D, where respondents were asked in what area of elder abuse/neglect they need more knowledge. Physical neglect and sexual abuse have been selected by social workers as the first and the second area they need to know more about. The Recognition Test also revealed that physical neglect and sexual abuse were the least recognized forms of elder mistreatment. Education is needed to emphasize these forms of abuse/neglect. Literature on this topic also clearly states that among other classifiers "inability to give consent," (Carie, 1991) is one of the most important factors defining sexual abuse of elderly people. Nevertheless, as the results indicated, many respondents did not take this important issue under consideration.

Situation E

Mrs. Keaton is an 84-year old resident suffering from dementia. She has a large family and many friends who visit often. For her recent birthday, she received several gifts, among them a pretty nightgown sent by a daughter from another city. A nurses' aide came to you saying that one of Mrs. Keaton's relatives decided to take the nightgown home, explaining that Mrs. Keaton is too confused to appreciate beautiful things anyway.

This situation describes financial/material abuse. Thirty-five respondents (81.3%) correctly selected this type of abuse. The mean score for the severity of Situation E was 2.74 (SD = 1.03). The overwhelming majority of participants agreed that stealing from the resident, even though she is demented, is unacceptable. Most of the respondents classified this act as theft with some commenting that "the item must be returned and the daughter notified".

One respondent wrote that "although (the situation) is not abusive, the relative clearly have no right to help herself to Mrs. Keaton's belongings".

General understanding in the literature is that taking or stealing money or belongings from the elderly is considered financial/material abuse (Sengstock et al., 1990; Valentine & Cash, 1986). Five respondents wrote that Situation E described psychological abuse, emphasizing the emotional value of a gift (from the daughter) and the fact that it was taken by a relative (difficult to deal with a thief in a family).

Situation F

Mr. Watson is an 80-year old resident whose speech is difficult to understand due to a stroke. You noticed that he is being excluded from daily recreational activities and left alone in front of the TV. An activity worker says that, with so many residents' in her group, she really has no time to try to figure out what Mr. Watson is saying and without him, everything goes much smoother.

The last situation describes psychological neglect. 37 respondents (86.0%), answered correctly. The mean score for the severity of the abuse described in Situation F was 3.72 (SD = .76). The majority of respondents in their justification for selecting "psychological neglect", wrote about:

i) Isolation of Mr. Watson from activities

ii) Exclusion from the group

iii) Neglecting his needs for stimulation, socialization and self-expression.

In this case, there was no respondent who would classify this situation as non-abusive. Reasons for selecting this situation as psychological abuse were also consistent with the literature (Segnstock at el., 1990: Valentine & Cash, 1986). Table 17 summarizes the results of the Recognition Test.

Table 17

Summary of the Recognition Test

Situation	(%) of Respondents with correct recognition n	Severity of the Situation (mean)	Standard Deviation
A: physical abuse	38 (88.3)	3.5	.95
B: psychological abuse	34 (79.0)	2.8	.96
C: physical neglect	12 (27.9)	3.7	.62
D: sexual abuse	11 (25.5)	3.8	.60
E: financial abuse	35 (81.3)	2.7	1.03
F: psychological neglect	37 (86.0)	3.7	.76

In order to determine if there was a statistically significant relationship between scores on recognition tests and social workers' education and recognition and the location of the P.C.H., an independent t-test was conducted.

Although there was no statistically significant relationship between education and scores on the abuse and neglect recognition test ($t = .290, p < .773$), significance was observed between the test and the location of the P.C. H.. Mean scores on abuse and neglect recognition tests were higher for social workers from rural areas (mean = 4.1053, SD = 1.0485), than from Winnipeg (mean = 3.4231, SD = 1.1375) with significance ($t = 2.079$, $p = .044$).

This may be explained by the fact that P.C.H. in rural areas are much smaller from P.C.H. in the city of Winnipeg (out of 19 respondents from rural Manitoba, 13 worked in nursing homes with

less than 70 beds). Smaller institutions facilitate more personal and frequent contact with residents. Because of that, social workers might be more aware of residents' problems and recognize possible abusive situations for the residents.

Other statistically significant categories in recognition of elder abuse and neglect was the number of credit hours of aging related courses the respondents took during their university years ($F = 4.778$ and the level of significance was $p < .002$). Respondents with a higher number of aging related courses, had higher scores on the Recognition Test. Social workers who were more confidant in their knowledge about issues of elder abuse claimed "yes" to the question: "Do you believe you have enough knowledge in the area of forms and causes of elder abuse and neglect in institution?" They also received slightly higher scores on the recognition test. This category was very close to being statistically significant at the significance level of $p < .05$. ($F > 3.156$ and $p = .053$).

The influence of other variables such as age, work experience with the elderly, length of time with an agency and frequency of contact with an elderly family member were also examined to determine their impact on the Recognition Test. A one-way analysis of variance (ANOVA) was performed to compare means of the different categories of the mentioned above variables. None of the analyzed variables revealed statistically significant differences in means at the .05 level. Table 18 illustrates characteristics of the respondents and their scores on the Recognition Test.

Table 18

Respondents' Characteristics by their Scores on the Recognition Test

Characteristics of Respondents (n total = 43)		N (%)	Level of recognition of elder abuse and neglect on the Recognition Test High level: 5-6 points Medium level: 3-4 points Low level: 1-2 points	Standard Deviation	p. value
Education	BSW Degree	26 (60.5)	3.75	1.17	p = .770
	MSW Degree	17 (39.5)	3.69	1.11	
Age	26-35	13 (30.2)	3.46	1.03	p = .104
	36-45	13 (30.2)	3.75	0.77	
	46-55	13 (30.2)	3.61	0.95	
	56-65	4 (9.4)	4.20	1.05	
Work exp. w. the elderly	6 months to 1 year	3 (6.9)	2.66	1.83	p = .12
	2-5	12 (30.5)	4.00	1.07	
	6-10	11 (25.5)	4.10	0.95	
	11-15	6 (13.9)	3.75	1.16	
	over 16	10 (23.2)	3.60	2.12	
Length of work in P.C.H.	Less than 6 months	3 (6.9)	3.00	2.04	p = .632
	6 months – 1 year	4 (9.4)	3.50	1.05	
	2-5	12 (30.5)	3.85	1.07	
	6-10	15 (32.2)	3.73	1.50	
	11-15	4 (9.4)	4.20	1.09	
	over 16	5 (11.6)	4.25	1.30	
Freq. Contact w. elderly family member	Never	2 (4.4)	4.00	1.37	p = .689
	Few times a year	4 (9.4)	3.50	1.50	
	Few times a month	5 (11.6)	3.20	0.85	
	Every week	16 (37.2)	4.00	1.61	
	Every day	16 (37.3)	3.82	0.70	

Discussion of Results

The purpose of this study was to examine issues regarding social workers employed in nursing homes and their knowledge of different aspects of aging that involve abuse and neglect. These included their attitudes toward the elderly and how these factors affected the process of recognition of residents' maltreatment. This survey produced a number of findings that are of interest. This chapter highlights the major findings and their implications.

Summary of Findings

Demographic. Based on the results of the survey, several demographic characteristics of social workers employed in Personal Care Homes in Manitoba were revealed.

It was a relatively young sample of respondents with almost 1/3 of all participants under the age of 35 years. Due to their ages, their work experience was not long, with the largest category working with the elderly from 2 to 5 years.

The majority of social workers (62.2%) had BSW degrees. However, this number tended to be even higher among younger participants (up to 35 years of age) and older participants (over 56). Social workers with a Masters degree were mostly middle aged, with the highest number being between 36-45 years old. In addition, respondents with higher degrees (MSW) tended to work mostly in Winnipeg and in large facilities (over 151 beds).

The majority of social workers participating in this study saw their older family members very often (daily or at least once a week).

It seems the participants were satisfied with their line of work, as over 75.0% of them selected elderly (65+) as the age group they would most prefer to work with.

Gerontological knowledge. Knowledge levels (as measured by the PFAQ) seemed to range significantly only between age groups and between groups with different amounts of work experience with the elderly.

Two age groups (26-35 and 56-65) had the lowest mean scores on the PFAQ test. This is rather a surprising conclusion when considering the results of the latter group. Related literature suggests that living through different life stages, a person could learn different facts about a particular age group from experience. However, it is also possible that besides facts, one can also acquire some misconceptions. Education is helpful in generating factual knowledge about different aspects of aging. This study shows that this is true for this sample. The majority of respondents with the highest scores on the PFAQ had at least 7.8 credit hours of completed gerontological courses, in comparison with 6.4 credit hours for participants with lower scores on the PFAQ.

The degree also seemed significant when considering scores on the knowledge test. Respondents with MSW degrees tended to obtain higher scores on the PFAQ than their colleagues with BSW degrees. The average score on the knowledge test increased with years of experience with the elderly. This suggests that beside formal education, work experience with the elderly is valuable in gaining knowledge about this age group.

The study found no effect of contact with an elderly family member on gerontological knowledge. This survey did not reveal what kind of contact it was. Some respondents volunteered answers, saying that for example, they might telephone their Mother once a week and see her a

few times a year. This would be a completely different dynamic than if other respondents saw his/her mother everyday. Due to this limitation, it was difficult to assess the impact of contact with an elder family member on gerontological knowledge.

Knowledge about elder abuse and neglect in institutions. The survey findings revealed that approximately half of participating social workers thought they had enough knowledge in the area of elder abuse in nursing homes, but the majority indicated interest in improving their knowledge level. Those who claimed they had enough information about elder mistreatment in long-term facilities, have gained this knowledge mainly through professional development training. Among other choices, university courses were the last category on the list.
However, the participants expressed the need for greater involvement of the university (mainly through continuing education programs) in improving the level of knowledge about institutional abuse of the elderly. These findings are discussed further in the next chapter of this report.

Significant findings were obtained regarding predictors of elder abuse and neglect in institutions. Respondents stated that the lack of adequate number of staff, greatly contributed to occurrences of elder mistreatment in nursing homes in the Province of Manitoba. This factor may contribute to higher episodes of psychological and physical neglect. Participants identified this as one of the major causes of elder mistreatment in Personal Care Homes.
The overwhelming majority of social workers stated that their facilities have special policies dealing with cases of elder abuse and neglect. This fact may help to eliminate occurrences of explicit physical and sexual abuse of residents. Respondents said that these types of maltreatment are the least prevalent in P.C.H.'s in Manitoba.

However, it is more difficult to eradicate the so-called "covered" forms of abuse/neglect, which are harder to detect and recognize, since they rarely leave physical evidence. Knowing that there is inadequate staffing in nursing homes, one may come to the conclusion that nurses and nurses' aides, are overwhelmed with the staff-resident ratio and are simply not physically able to provide more than basic, minimal care. This situation can lead to an increase of psychological and physical neglect, as well as psychological abuse. The article in the Winnipeg Free Press (March 22, 1999) provided many examples of such treatment; a resident may be left on the toilet for hours because the aide is busy elsewhere attending other clients. Was this intentional? Perhaps not, but it still caused the elderly resident unnecessary suffering. One nurses' aide was quoted in the newspaper said she has very little time to attend to the 28 residents on her floor, with only one other aide to help.

"They are lucky if they get between 3 to 5 minutes each. You do not sit with them or talk to them because we just do not have the time to do it." (Winnipeg Free Press, March 22, 1999).

The time crunch means the potential for errors in administering medication increases, along with the chance of residents hurting themselves in falls because no one is there to help. Until the issue of staffing is solved, it is difficult to expect changes for the better in nursing homes.

Knowledge about signs of elder abuse was also tested, by asking respondents to describe signs of different kinds of abuse and to define elder abuse and neglect.

Generally, respondents demonstrated good knowledge about signs of elder abuse and neglect. They were able to provide an average of 6 or 7 words describing different types of abuse and neglect. However, this relatively comprehensive theoretical knowledge was not reflected on the Recognition Test, where respondents had to match the described situation with one presented type

of abuse and neglect. The results were much lower than expected. These findings will be discussed later in this chapter.

Attitudes toward the elderly. Based on the results of this survey, attitudes toward older people tend to be neutral, rather than strongly positive or negative among the sample of social workers in Manitoba. Perhaps, several factors could have contributed to this result.

First, the sample was relatively young and scores on the OPS tended to increase with age. Although, in this study, this was not statistically significant, it could affect the mean scores on the Kogan's Scale. If the sample were larger, it would have had a more significant impact.

Second, scores on the attitude test had a tendency to increase with years of experience with the elderly. Due to the fact that the majority of participants have worked with the elderly less than 5 years, this again could affect the mean scores on the OP scale.

The only statistically significant relationship was discovered between attitudes (as measured on the OPS scale) and education of respondents. The test demonstrated that social workers with lower degrees (BSW) showed higher scores on the attitude scale. It is unusual because several different studies in this area (Carmel et al., 1992; Chandler et al., 1986, Reed et al., 1992) indicated that professionals with a higher level of education, represented more positive attitudes toward the elderly. The authors would explain that accurate knowledge could dispel many of the inaccurate stereotypes, upon which agism is based. Since persons with Masters degrees had more years of formal education, they should have acquired more knowledge in this area, according to the literature.

However, a positive relationship between years of education and attitudes was not indicated in this study. Perhaps one reason could have been that respondents' MSW degrees did not possess sufficient elderly content. According to data collected in this study, 35.0% of respondents with MSW degrees did not complete any gerontological courses. Based on the students' own observations, the graduate program in Social Work is lacking consistency in the area of specialized gerontological courses for those who are interested in enhancing their education for use in practice with the growing elderly population. During the last three years (1996 – 1999) there was no aging course offered to the students on at the graduate level.

Despite neutral attitudes, Kogan's scores were not associated with the preference to work with the elderly because the majority of respondents stated that work with this age group (65+) was their first choice of employment.

Recognition of elder abuse and neglect. The mean score on the Recognition Test indicated medium levels of recognition of different types of abuse and neglect. This was a surprise finding, since it was expected that scores on the Recognition Test would be high. This was because of the suspicion that the level of difficulty presented in the vignettes was not set high enough. However, less than a quarter of respondents achieved the highest scores. It can lead to the conclusion that theoretical knowledge about signs of abuse (which was good, as discussed before) does not necessarily influence the correct recognition of elder maltreatment in practice. Another exploration of relatively low scores on the Recognition Test is lack of a universally accepted definition of elder mistreatment. The majority of participants did not include intentions

of the perpetrator in their definitions of elder abuse/neglect. For some respondents, only intentional actions to harm a resident were classified as abuse/neglect. In that light, it is understandable why force feeding was seen as acceptable to some social workers, if seen as being essential for adequate nourishment. This finding indicated that clear definitions of different types of abuse are necessary to aid identification of cases of abuse.

The results of the Recognition Test also showed that social workers perceived situations describing neglect as generally more severe than those describing abuse. Psychological abuse and financial abuse (Situation B and Situation E) were assigned the lowest severity, while physical neglect (Situation C) and psychological neglect (Situation B) received one of the highest severity scores. It is interesting that sexual abuse (Situation D) although the least recognized by social workers, was perceived as very severe and received the highest score on the severity scale. Perhaps this is related to the construction of the vignettes, which did not describe extreme cases of elder abuse or neglect. In comparison to the presented abuse situations, the vignettes describing neglect could be seen as more severe.

Social workers also perceived they would be more confident recognizing psychological types of abuse than physical. Perhaps it could be that by training, social workers feel more prepared to identify less obvious types of abuse, not so readily identified by others.

On the other side, the literature suggests that social work practitioners do not have well-developed physical assessment skills, which are more likely to be the nurses' domain (although some participants in this study seemed to be fully knowledgeable in this area). A study conducted with nurses in Canada and Australia (Trevitt & Gallagher, 1996) showed that in both countries, nurses were more comfortable in recognizing physical types of abuse and neglect. The study explained

that they need to increase their skills in interviewing and asking the right questions in order to be more proficient in identification of psychological forms of elder maltreatment. Both these implications can have some implications for social work practice discussed later in this report.

Relationships between gerontological knowledge, attitudes toward the elderly and recognition of elder abuse/neglect. The statistical test (Pearson Correlation – Coefficient) indicated that the PFAQ and the OPS scores were not highly related to recognition of abuse/neglect in nursing homes. However, respondents with a higher number of aging related courses, achieved higher scores on the Recognition Test. Since it can be assumed that during the university gerontological courses, respondents gained some knowledge about different aspects of aging, the lack of higher correlations between the PFAQ and the Recognition Test is surprising.

There can be explanations why the expected results (higher correlations among PFAQ, OPS and the Recognition Test) were not found. The assumption that the process of recognition of residents' maltreatment is based on social workers' gerontological knowledge and attitudes ,needs further explanation. Perhaps, attitudes and knowledge may not be conclusive measures of recognition of elder abuse and neglect and different factors (discussed broader in "study implications" section) should be examined.

In this study however, the issue of measurement appears to be a major concern. The two standardized instruments (PFAQ and OPS) measured respectively, the general knowledge about aging and attitudes towards elderly people in the general population. The intention of the Recognition Test was to measure recognition of elder abuse/neglect in nursing homes. Perhaps, a higher correlation could be achieved if the two first tests were specifically designated to

measure knowledge and attitudes toward elderly people in institutions. These tools would have to be developed, since no existing measures were found in the current literature.

Finally, the role of training and education, in the area of elder abuse and neglect, warrants a more thorough examination. Questions such as, which methods of information presentation are most effective and what types of information are found to be the most useful to social work practitioners, should be explored. In addition, further analysis of the effect of training and education on attitudes toward the elderly and elder abuse in institutions should be conducted.

Limitations of the Study

The sample used for this study was small, homogenous and voluntary, therefore the results cannot be generalized to other settings. This is a common occurrence in social work research (Grinell, 1997). However, there is also no reason to believe that the findings are not representative of the larger population (perhaps, a national study in this area, with a sizable sample, could resolve this problem).

The second limitation of this research is the pre-testing instrument, which was not tested on the actual population, but on a student group. However, the small number of social workers employed in P.C.H.'s in Manitoba prevented the author from selecting a piloting sample from this population. The authors' financial and time constraints made it extremely difficult to include professionals from out of the province, to participate in a pilot study.

It is also possible that people who completed the self-administered questionnaire, created a response bias. Since there is no information about almost 30.0% of social workers that did not respond to this survey, it is difficult to determine what motivated others to do so. Judging by the

sample, some factors, such as age (a relatively young sample) and work experience (relatively short) could affect the general response to the survey.

However, errors due to personal styles of respondents such as social desirability (a tendency to give a favorable impression of oneself), acquiescence (a tendency to agree with statements regardless of their content) and deviation (a tendency to give unusual responses) (Grinell, 1997) were generally avoided. It was mostly through incorporation of various response sets and partial concealment of the instruments true purpose.

CHAPTER 5

Implications of the Study

This research explores social workers' gerontological knowledge, attitudes pertaining to elderly people and how both those factors affect recognition of residents' maltreatment. In addition, impacts of demographic variables have also been considered.

Findings reveal that, social workers participating in the study possess a good level of gerontological knowledge. Respondents with the most number of gerontological courses had the highest scores on the Psychological Facts on Aging Quiz. They were also more confident in recognizing different types of residents' abuse and neglect.

Results of this study indicate that, social workers' attitudes toward the elderly tend to be neutral, rather than strongly positive or negative. However, these findings do not seem to affect the desire to work with the 65+ age group. Most respondents indicated gerontological social work as their first choice of employment.

Participants of the study exhibited, on average, practical recognition of residents' maltreatment. The study also reveals that, social workers are generally more confident in recognizing psychological forms of abuse and neglect, than physical (overall scores of recognition of psychological abuse and neglect were higher than physical and sexual abuse).

These findings can have several implications for social work education, practice and further research.

Implications for Social Work Education

Social work curricula should incorporate issues of institutional abuse. Only about half of respondents declared that they have enough knowledge in the area of elder abuse and neglect. At the same time, the majority of social workers stated that, although issues of institutional abuse of elderly were discussed during their aging courses, "it was not enough".

Another reason for broader coverage of elder mistreatment in nursing homes, is the prevalence of such incidents in Personal Care Homes in Manitoba. In this research, 65% of participants admitted that they know at least one confirmed and / or investigated case of elder abuse or neglect in their facility in the last year. This suggests that more emphasis should be put on educating social workers on how to deal with staff and visitors causing abuse. These topics should be a part of gerontological courses and made available for all interested students of social work.

Social workers participating in this study indicate that university courses have not taught them enough about institutional abuse in nursing homes. They would like to upgrade their knowledge in this area, through university continuing education programs. The Faculty of Social Work could play a significant role in developing continuing education courses for institutional staff of all disciplines. The School of Social Work in Winnipeg should try to respond to increasing demands for highly qualified gerontological social workers. It would seem incumbent on educators to initiate and maintain an atmosphere, which could foster an interest in working with older individuals. The number of social work practitioners working in the gerontological field, who have not had any courses in aging, is of concern. It suggests the need to consider aging as part of the curriculum in social work.

Implications for Social Work Practice

This study indicates that social workers are most often the first reporters of elder abuse and neglect. This fact can have implications for social work practice in long-term facilities. The social worker can help other staff members to better understand issues involving elder abuse, as well as break barriers in reporting and properly dealing with such cases.

Results of this survey show that social work practitioners seem to be more confident in recognizing psychological forms of abuse and neglect. This would seem to highlight the need for social workers to be able to increase their physical assessment skills. These findings also provide strong support for multi-disciplinary teams in the recognition of elder abuse and neglect in Personal Care Homes. Close cooperation with other disciplines more familiar by profession, with physical care for the elderly, can ensure the best services for nursing home residents who are, or might be, at risk of mistreatment. Specific skills of different professionals (such as social workers' counseling and interviewing skills; nurses' ability to distinguish between signs of physical abuse and normal signs of aging or illness) should complement each other and be helpful in recognizing and caring for the mistreated resident.

The study findings also include implications for a Long-Term Care policy regarding elder abuse and neglect. Since such regulations are already in place in the majority of P.C.H.'s in Manitoba, practicing social workers should concentrate on their implementation and proper understanding by staff. In addition, staffing policies should be also re-evaluated to reflect a more realistic staff–resident ratio. Knowing that this factor can contribute to residents' maltreatment, social

work practitioners should be a driving force in lobbying for an increase of direct service workers in Personal Care Homes in Manitoba.

Implications for Future Research

Much research has yet to be conducted in the recognition of elder abuse and neglect in institutions by social work practitioners. The findings of this study pointed to several areas for future research. More work is needed to determine: the impact of values and ethics on social workers' decisions about which acts should be classified as abusive and neglectful; intervention strategies after the initial recognition of cases of elder abuse and neglect; specific strategies related to different types of abuse, and to determine the most adequate and beneficial action for residents in an abusive situation.

Additionally, the role of training and education in the area of elder abuse and neglect warrants a more through examination. Questions such as how should training be undertaken and what is needed in professional education of social work practitioners should be explored. Further analysis of the effect of training and education on attitudes toward the elderly and elder abuse in institutions is also needed.

Future research could include examining staffing levels and their relationship to the reporting and prevalence of elder maltreatment in institutions (since staffing was the number one cause of abuse/neglect in P.C.H.'s as identified by respondents).

Finally, a national study and a multi-disciplinary study, involving professionals and para-professionals working in institutions could expand on issues of residents' abuse and neglect.

SUMMARY

With increased longevity, chances are that frail, elderly persons, more than any other group of people, will spend some time living in institutional settings such as nursing homes. This research has revealed that social workers are concerned about the prevalence of institutional abuse and neglect. This situation calls for more attention and research in the area of abuse and neglect in institutional settings. Until recently, this lagged behind studies of elder mistreatment in the community. However, it is beginning to change and the issue has gained more prominence in public forums and professional conferences.

The first meeting of the Canadian Network for the Prevention of Elder Abuse, took place at the Canadian Association on Gerontology's annual conference in October, 1998 in Halifax. The second meeting will take place in the fall of 1999 (Dixon, 1999).

It is timely, since this year is designated by the United Nations as the International Year of Older Persons. This draws attention to the needs and rights of the elderly people in our society. The UN has adopted eighteen Principles for Older Persons, under five headings:

Independence

Participation

Care

Self-fulfillment

Dignity

Some of these principles are especially important for older people residing in a long-term care facility;

(13) Older persons should be able to utilize appropriate levels of institutional care, providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.

(14) Older persons should be able to enjoy human rights and fundamental freedoms when residing in any shelter, care of treatment facility. This includes full respect for their dignity, beliefs, needs and privacy. Also for the right to make decisions about their care and the quality of their lives.

(17) Older persons should be able to live in dignity and security and be free of exploitation and physical or mental abuse (International Year of Older Person, 1999, Internet Web Site).

It is the student's hope that the above guidelines will provide social workers in Personal Care Homes, with challenges and opportunities to help residents, who find themselves being abused or neglected. With proper knowledge about different aspects of aging, more positive attitudes towards their clients and the ability to adequately recognize abuse and neglect occurring in institutional settings, social workers can make a great difference in the lives of senior citizens residing in institutions.

This study is just a step in trying to understand the factors that influence the recognition of elder mistreatment in institutions among social work practitioners. Hopefully, it has also increased awareness about these issues and, in the future, will stimulate discussions and actions among social work professionals to find and implement some practical directions in limiting and, finally, eradicating incidents of elder abuse and neglect in Personal Care Homes. We all have to remember that; " ...the respect and care for the elderly, which has been one of the few constants in human

culture everywhere, reflects a basic inter-play between self-preserving impulses, which has conditioned the survival and progress of the human race" (International Plan of Action on Aging, Web Site of The International Year of Older Persons, 1999).

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APPENDIX A

Letter of Introduction

Maria Szymanska
The Faculty of Social Work General Office
525 Tier Building U of M
WINNIPEG MB R3T 2N2

Dear Sir or Madam:

My name is Maria Szymanska. I am currently a graduate student of the Faculty of Social Work at the University of Manitoba. I am writing to you in regards to my Master's thesis research. My topic involves the recognition of elder abuse and neglect in institutions. As such, I am approaching social workers in Personal Care Homes (PCHs) across the Province of Manitoba to be respondents for my research.

Very few studies have been conducted in this area. The literature for social work practitioners focusing on the recognition of elder abuse and neglect in institutions is sparse. Because recognition of abuse and neglect is often the first step in its prevention, I feel it is necessary to conduct this study. Considering the importance of this topic your input is **extremely** valuable.

The research will involve approximately ___ minutes of your time. Participation will involve filling out a simple questionnaire and answering some demographic questions.

This letter serves as a preliminary request for your participation in the study. Participation is completely voluntary. A week from today, a survey questionnaire will be mailed to you, including an unmarked, self-addressed envelope. Neither your name nor that of the PCH will have to appear on the questionnaire. Your participation will be **completely anonymous**. You are free to withdraw at any time and may refuse to answer any questions, without any negative consequences. An anonymous response to this questionnaire is the only requirement to participate.

Again, participation is strictly voluntary and anonymous. I thank you for your time and consideration in this matter. **Your contribution is crucial for this study**.

Please feel free to contact me if you have any questions.

Sincerely,

Maria Szymanska (Phone 474-6669)
Graduate Student
Faculty of Social Work

APPENDIX B

Cover Letter for Questionnaire

Maria Szymanska
The Faculty of Social Work General Office
525 Tier Building, University of Manitoba
WINNIPEG MB R3T 2N2

Dear Sir or Madam:

Hi again. As indicated in my previous letter I am sending you this questionnaire as a part of my graduate thesis research. The following questions pertain to one's knowledge about different aspects of ageing, attitudes toward the elderly, recognition of different forms of abuse and neglect in nursing homes, as well as some demographics. It takes approximately __ minutes to complete the survey.

You may feel free to withdraw from the study at any time and/or refuse to answer any questions without any negative consequences. The study ensures complete anonymity. Please do not write your name or that of the PCH on the questionnaire as your responses should remain anonymous. There is no way I can identify the information provided by any participants as there are no identifying marks or numbers on the questionnaire and envelope.

Your participant in this study is strongly encouraged, since the issues of elder abuse and neglect in institutions still requires additional research. Adequate recognition will help in finding appropriate and effective interventions and solutions for this serious problem.

Please complete the questionnaire as soon as possible and return it in the enclosed self-addressed envelope. Share this letter and enclosed questionnaires with other social workers in your facility.

The results of this research will be published in the form of a thesis report and will be available to you through the University of Manitoba library system and in the Faculty of Social Work in the late fall of 1999.

Thank you for your cooperation and understanding.

Sincerely,

Maria Szymanska (Phone 474-6669)
Graduate Student
Faculty of Social Work

APPENDIX C

Questionnaire

Section B: Old People Scale

On the following pages you will find a number of statements expressing opinions with which you may or may not agree. Following each statement are six spaces labelled: STRONGLY DISAGREE, DISAGREE, SLIGHTLY DISAGREE, SLIGHTLY AGREE, AGREE, STRONGLY AGREE.

Please indicate the degree to which you agree or disagree with each statement by checking the appropriate space. Consider each statement carefully, but do not spend too much time on any one statement. DO NOT SKIP ANY ITEMS. There are no "right" or "wrong" answers. THIS INVENTORY IS FOR RESEARCH PURPOSES ONLY AND IS COMPLETELY ANONYMO

	STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
1. It would probably be better if most old people lived in residential units with people of their own age.						
2. Most old people are really no different from anybody else; they're as easy to understand as younger people.						
3. Most old people would prefer to quit work as soon as pensions or their children can support them.						
4. Most old people can generally be counted on to maintain a clean attractive home.						
5. Old people have too much power in business and politics.						
6. Most old people are very relaxing to be with.						

	STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
7. Most old people spend too much time prying into the affairs of others and giving unsought advice.						
8. When you think about it, old people have the same faults as anybody else.						
9. There are a few exceptions, but in general most old people are pretty much alike.						
10. Most old people seem to be quite clean and neat in their personal appearance.						
11. Most old people are constantly complaining about the behavior of the younger generation.						
12. Most old people need no more love and reassurance than anyone else.						
13. It would probably be better if most people lived in residential units that also housed younger people.						
14. Most old people get set in their ways and are unable to change.						
15. Most old people would prefer to continue working just as long as they possibly can rather than be dependent on anybody.						
16. It is foolish to claim that wisdom comes with old age.						
17. Old people have too little power in business and politics.						

	STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
18. Most old people bore others by their insistence on talking about the "good old days."						
19. Most old people respect others privacy and give advice only when asked.						
20. In order to maintain a nice residential neighborhood, it would be best if too many old people did not live in it.						
21. It is evident that most old people are very different from one another.						
22. Most old people are irritable, grouchy, and unpleasant.						
23. One seldom hears old people complaining about the behavior of the younger generation.						
24. There is something different about most old people; it's hard to figure out what makes them tick.						
25. Most old people are capable of new adjustments when the situation demands it.						
26. Most old people tend to let their homes become shabby and unattractive.						
27. People grow wiser with the coming of old age.						

	STRONGLY DISAGREE	DISAGREE	SLIGHTLY DISAGREE	SLIGHTLY AGREE	AGREE	STRONGLY AGREE
28. Most old people make one feel ill at ease.	_____	_____	_____	_____	_____	_____
29. One of the most interesting qualities of old people is their accounts of their past experiences.	_____	_____	_____	_____	_____	_____
30. If old people expect to be liked, their first step is to try to get rid of their irritating faults.	_____	_____	_____	_____	_____	_____
31. You can count on finding a nice residential neighborhood when there is a sizeable number of old people living in it.	_____	_____	_____	_____	_____	_____
32. Most old people should be more concerned with their personal appearance; they're too untidy.	_____	_____	_____	_____	_____	_____
33. Most old people are cheerful, agreeable, and good humored.	_____	_____	_____	_____	_____	_____
34. Most old people make excessive demands for love and reassurance.	_____	_____	_____	_____	_____	_____

Section C : The Recognition Test

Please read each vignette, then try to answer the questions below. It is essential that you respond with your honest feeling about each vignette. Do not spend too long on any one question.

Situation A

Mrs. Smith is an 83-year old widow who is bedridden and has Alzheimer's disease. During one of the weekly visits her sister complained to you that she witnessed the nurses' aide stuffing food in Mrs. Smith's mouth and trying to force it open with a spoon. The nurses' aide explained that Mrs. Smith has a very poor appetite and otherwise would die from starvation and dehydration.

1. In your opinion, what type of abuse or neglect (if any) does the described situation indicate. (circle one answer).
   a. physical abuse
   b. psychological abuse
   c. physical neglect
   d. psychological neglect
   e. financial/material abuse
   f. sexual abuse
   g. none of the above/situation is not abuse/neglectful

2. If you selected one of the answers from a to f for the question #1, what are the signs indicating abuse or neglect in Situation A?

   _____
   _____
   _____
   _____

3. On the scale of 0 to 5 assess the severity of abuse or neglect you selected in question 1 (Circle the Number).

   0 1 2 3 4 5

   Non Abusive **Severely Abusive**

Situation B

Mrs. Johnson is a 70-year old woman who is small, frail and appears younger than her age. She has a history of M.S. Recently, her condition deteriorated and she just moved to the nursing home. While walking down the hall you noticed one nurses' aide greeting Mrs. Johnson by her first name and patting her on the head. You also heard this same nurses' aide saying that she picked a particular dress for Mrs. Johnson because it makes her look like a perfect little grandma.

1. In your opinion, what type of abuse or neglect (if any) does the described situation indicate. (circle one answer).
   a. physical abuse
   b. psychological abuse
   c. physical neglect
   d. psychological neglect
   e. financial/material abuse
   f. sexual abuse
   g. none of the above/situation is not abuse/neglectful

2. If you selected one of the answers from a to f for the question #1, what are the signs indicating abuse or neglect in Situation B?

   _____
   _____
   _____
   _____

3. On the scale of 0 to 5 assess the severity of abuse or neglect you selected in question 1 (Circle the Number).

   0 1 2 3 4 5

   _____

   Non Abusive **Severely Abusive**

Situation C

Mr. Brown, a 90-year old, nursing home resident, was alert, lucid and physically capable until two months ago when he suffered a mild stroke that left him slightly paralyzed on one side. He also became occasionally incontinent. Recently, Mr. Brown complained to you that after another wet accident occurred, a RN ordered his fluids and favorite afternoon tea to be cut down until he improves his wetting problem.

1. In your opinion, what type of abuse or neglect (if any) does the described situation indicate. (circle the answer).
   a. physical abuse
   b. psychological abuse
   c. physical neglect
   d. psychological neglect
   e. financial/material abuse
   f. sexual abuse
   g. none of the above/situation is not abuse/neglectful

2. If you selected one of the answers from a to f for the question #1, what are the signs indicating abuse or neglect in Situation C?

   _____
   _____
   _____
   _____

3. On the scale of 0 to 5 assess the severity of abuse or neglect you selected in question 1 (Circle the Number).

   0 1 2 3 4 5

   Non Abusive **Severely Abusive**

Situation D

Mrs. Evanson is a 73 year old very confused woman in relatively good physical health. Her husband visits occasionally and they usually spend time in her room since she lives alone in her semi-private room. During his last visit Mr. Evanson discovered that his wife now has a roommate. He came to you requesting that they be given privacy to have sexual relations to which they have a right, as a married couple.

1. In your opinion, what type of abuse or neglect (if any) does the described situation indicate. (circle one answer).
   a. physical abuse
   b. psychological abuse
   c. physical neglect
   d. psychological neglect
   e. financial/material abuse
   f. sexual abuse
   g. none of the above/situation is not abuse/neglectful

2. If you selected one of the answers a to f for the question #1, what are the signs indicating abuse or neglect in Situation D?

   _____
   _____
   _____
   _____

3. On the scale of 0 to 5 assess the severity of abuse or neglect you selected in question 1 (Circle the Number).

   0 1 2 3 4 5

   _____

   Non Abusive **Severely Abusive**

Situation E

Mrs. Keaton is an 84 year-old resident suffering from dementia. She has a large family and many friends who visit often. For her recent birthday she received several gifts among them a pretty nightgown sent by a daughter from another city. A nurses' aide came to you saying that one of Mrs. Keaton's relatives decided to take the nightgown home, explaining that Mrs. Keaton is too confused to appreciate beautiful things anyway.

1. In your opinion, what type of abuse or neglect (if any) does the described situation indicate. (circle one answer).
   a. physical abuse
   b. psychological abuse
   c. physical neglect
   d. psychological neglect
   e. financial/material abuse
   f. sexual abuse
   g. none of the above/situation is not abuse/neglectful

2. If you selected one of the answers from a to f for the question #1, what are the signs indicating abuse or neglect in Situation E?

   _____
   _____
   _____
   _____

3. On the scale of 0 to 5 assess the severity of abuse or neglect you selected in question 1 (Circle the Number).

   0 1 2 3 4 5

   _____

   Non Abusive **Severely Abusive**

•

Situation F

Mr. Watson is an 80 year-old resident whose speech is difficult to understand due to a stroke. You noticed that he is being excluded from daily recreational activities and left alone in front of the T.V. An activity worker says that with so many other residents in her group she really has no time to try to figure out what Mr. Watson is saying and without him everything goes smoother.

1. In your opinion, what type of abuse or neglect (if any) does the described situation indicate. (circle one answer).
   a. physical abuse
   b. psychological abuse
   c. physical neglect
   d. psychological neglect
   e. financial/material abuse
   f. sexual abuse
   g. none of the above/situation is not abuse/neglectful

2. If you selected one of the answers from a to f for the question #1, what are the signs indicating abuse or neglect in Situation F?

   _____
   _____
   _____
   _____

3. On the scale of 0 to 5 assess the severity of abuse or neglect you selected in question 1 (Circle the Number).

   0 1 2 3 4 5

   Non Abusive **Severely Abusive**

Thank you for sharing your feelings about each vignette. Now, I have a number of questions I would like you to answer.

---

4. What could be some of the signs you might see in a resident that might be associated with sexual abuse?

   _____
   _____

---

5. What could be some of the signs you might see in a resident that might be associated with physical abuse and neglect?

Physical Abuse

Physical Neglect

6. What could be some of the signs you might see in a resident that might be associated with psychological abuse and neglect?

Psychological Abuse

Psychological Neglect

7. What could be some of the signs you might see in a resident that might be associated with material/financial abuse?

8. In your opinion what type of abuse is most common in PCH's? Rank each category in order of prevalence from #1 being most prevalent and so on.

Category	Rank
a) Physical Abuse	
b) Physical Neglect	
c) Psychological Abuse	
d) Psychological Neglect	
e) Material/Financial Abuse	
f) Sexual Abuse	
g) None of the above/ there is no abuse in nursing homes	

9. In your opinion, what group of people is the most responsible for acts of abuse and neglect toward the residents? Rank your answer with #1 being the most responsible group of people for resident's abuse and so on.

Group of People	**Rank**
a) medical personnel (nurses, doctors)	_____
b) direct care staff (nurses aides, orderly)	_____
c) visitors (family, friends)	_____
d) other residents	_____
e) other people (specify)	_____
f) none of the above/there is no abuse of residents in nursing homes	_____

10. In your opinion, which factors could precipitate elder abuse and neglect in institutions. Rank you answer with #1 being the most important factor and so on.

	Rank
a) poor working environment	_____
b) inadequate preparation of staff	_____
c) lack of opportunity for staff professional/personal growth	_____
d) increasing dependency of elderly/extreme impairments	_____
e) lack of understanding of aging process, complex health needs of elderly	_____
f) negative attitudes toward aging	_____
g) insensitivity to needs of elderly and families	_____
h) lack of positive communication between staff/clients/families	_____
i) lack of legislation and policies to ensure quality care in institutions	_____
j) other (specify)	_____

Section D

Would you please circle the answer that best describes you.

1. What is your professional education?

   a) Bachelor of Social Work
   b) Master of Social Work
   c) Other (specify) _____

2. Where is your PCH located?

   a) rural/northern Manitoba
   b) Winnipeg

3. What is the size of your facility?

   a) under 70 beds
   b) 71 - 150 beds
   c) 151 and more

4. What is your age?

   a) under 25
   b) 26 - 35
   c) 36 - 45
   d) 46 - 55
   e) 56 - 65
   f) 66 and older

5. How long have you worked with the elderly as a social worker?

   a) less than 6 months
   b) 6 months to one year
   c) 2 - 5years
   d) 6 - 10 years
   e) 11 - 15 years
   f) more than 15 years

6. How long have you worked in this facility?

a) less than 6 months
b) 6 months to one year
c) 2 - 5years
d) 6 - 10 years
e) 11 - 15 years
f) more than 15 years

7. Rank your preference for work with different age groups. Rank with "Number 1" the age group you would most prefer to work with and so on.

Age Group	Rank
a) children (0 to 5)	_____
b) children (6 to 12)	_____
c) adolescents (13 to 18)	_____
d) young adults (19 to 24)	_____
e) adults (25 to 64)	_____
f) elderly (65 +)	_____

8. In your family, how often do you have contact with an immediate members (mother, fathers, husband, wife, brother, sister) who is 65 or older?

a) never
b) every few years
c) few times a year
d) few times a month
e) every week
f) every day

9. In your opinion, what percentage of residents experienced some form of abuse or neglect while living in Personal Care Homes? (Indicate the number).

_____
_____
_____

10. How would you define elder abuse and neglect in institutions?

Elder abuse: _____
_____
_____

Elder neglect: _____
_____
_____

11. Does your PCH have a special policy to deal exclusively with elder abuse and neglect?

a) yes
b) no
c) Don't know

12. Do you know of at least one confirmed and/or investigated case of elder abuse in your PCH in the last year?

a) yes
c) No

13. If "yes" do you know who first reported this case of elder abuse?

a) don't know
b) victimized resident
c) other resident
d) nurse (RN or LPN)
e) social worker
f) family member
g) nurses aide
h) other (specify) _____

14. Do you believe you have enough knowledge in the area of forms and causes of elder abuse and neglect in institutions?

a) yes
b) no
c) not sure

15. If 'Yes', to Question 14, how did you gain this knowledge. Please rank it accordingly, from the most important factor being #1 and so on down.

	Rank
a) university gerontological courses	_____
b) professional development training	_____
c) self study	_____
d) work experience	_____
e) other (Specify) _____	

16. Would you like to improve your knowledge about forms and causes of institutionalized abuse/neglect of the elderly?

a) yes
b) no

17. If 'Yes' to Question 16, how would you like to improve that knowledge? Please, rank it accordingly, with the most important factor ranked #1 and so on.

Factor	Rank
a) specialized courses through the university continuing education programs	_____
b) professional development training	_____
c) self-study	_____
d) work experience	_____
e) other (specify)	_____

18. In what areas of elder abuse and neglect you need more knowledge? Please, rank it accordingly, with the most important area ranked #1, and so on.

Area	Rank
a) Physical abuse	_____
b) Psychological abuse	_____
c) Physical neglect	_____
d) Psychological neglect	_____
e) Financial/material abuse	_____
f) Sexual Abuse	_____

19. How many credit hours of ageing related course work have you taken during your university years?

Type of Program	Number of credit hours
Undergraduate studies	_____
Graduate studies	_____

20. Was the issue of elder abuse and neglect in institutions discussed there?

a) no
b) yes, but not enough
c) yes, just enough
d) don't know/don't remember
e) didn't take any gerontological courses

21. Did you complete an Option in Ageing as a part of your undergraduate SW program?

a) Yes
b) No

That is all! You have made it! Thank you!

Do you have any comments that you would like to share?

APPENDIX D

Thank You/Reminder Letter

Maria Szymanska
The Faculty of Social Work General Office
525 Tier Building, University of Manitoba
WINNIPEG MB R3T 2N2

Dear Sir or Madam:

A few weeks ago, you received a survey questionnaire pertaining to your knowledge about different aspects of aging, attitudes toward the elderly, recognition of different forms of abuse and neglect in nursing homes, as well as some demographic information.

I would like to thank you for taking the time to fill out the questionnaire. If you have been unable to complete the questionnaire, I would appreciate it greatly if you could do so, as soon as possible. While your participation is strongly encouraged, it is completely voluntary and anonymous.

For your convenience, an additional copy of the questionnaire is included in this package. Please complete the questionnaire as soon as possible and return it in the enclosed self-addressed envelope.

Thank you for your cooperation and understanding.

Sincerely,

Maria Szymanska (Phone: 474-6669)
Graduate Student
Faculty of Social Work

Appendix E

Letters of Permission

65 Fifth Avenue New York NY 10003 212.229.5727

January 25, 1999

Maria Szymanska
66 Parashin Bay
Winnipeg, MB R2R 1A9
Canada

Dear

Ms. Szymanska

In response to your recent request, I hereby grant you permission to use my OP Scale in your proposed research project. My supply of copies of the Scale is exhausted, but please note that it has been reproduced in the following volume: Shaw, M., & Wright, J. (1967) Scales for the Measurement of Attitudes, McGraw-Hill, pp. 468-471.

If you are interested in more current reliability and validity information concerning the OP Scale, would recommend the following source: Mangen, D.J., & Peterson, W.A. (Eds.) (1982) Research Instruments in Social Gerontology, Vol. 1, Clinical and Social Psychology. University of Minnesota Press, pp. 549-556.

You have my best wishes for the success of your project. I should be please to learn about the outcomes of your research.

Sincerely,

NATHAN KOGAN
Professor

NK:sn

Academic Divisions
of the New School
for Social Research

The New School
Graduate Faculty
Graduate School
Parsons
Eugene Lang College
Mannes

Taylor & Francis
325 Chestnut Street, 8th Floor
Philadelphia, PA 19106

Fax Cover Sheet

DATE:	January 15, 1999	TIME:	4:21 PM
TO:	Maria Szymanske	PHONE: FAX:	(204) 633-3306 (204) 586-7569
FROM:	Ruth M. Rearick Taylor & Francis	PHONE: FAX:	(215) 625-8900 X245 (215) 625-2940
RE:	Copyright Permission		
CC:			

Number of pages including cover sheet: 2

I am in receipt of your request for copyright permission (see attached). Permission is granted to reproduce the requested material for one time use at no charge.

Should you have any questions or problems, please feel free to contact me at anytime.

Thank you.

Ruth M. Reanick
Permissions Coordinator

FAX MEMORANDUM : 1 page of the document
Jan 04, 1999

Hemisphere Publishing Corporation
Att. RUTH BEARICK (215) 625 2940

Maria Szymanska
66 Parashin Bay
Winnipeg, Mb, R2R 1A9
Canada

PURCHASE REQUEST

I would like to request permission to use testing instrument called The Psychological Fact on Aging Quiz. I require 90 copies of this instrument. Mentioned instrument was published in Community/Junior College Quarterly, 10, 1996, p. 123-129, copyright by Hemisphere Publishing Corporation also in 1986. The author is Lynn E. McCutcheon.

I am a graduate student of the Faculty of Social Work at the University of Manitoba in Canada. My intention is to use this instrument for educational purposes to collect data for my Master's thesis research. My topic involves the recognition of elder abuse and neglect in institutions. As such, I will approach social workers in nursing homes across the City of Winnipeg to be respondents for my study. The research will take place in late February and early March 1999.

If you have any questions or concerns please contact me directly: ph (204) 633 3305 or FAX (204) 586 7589. You can also contact my advisor, professor Sharon Taylor-Henley Faculty of Social Work, UofM, ph (204) 474 5669 or FAX (204) 474 7594. Thank you for your consideration.

Sincerely,
Maria Szymanska
Graduate Student
Faculty of Social Work

M. Szymanska