

**The University of Manitoba**

**Elder Abuse: A Practicum Study in a Geriatric Rehabilitation  
and Extended Care Hospital**

by

**Barbara J. Hawryluk**

A Practicum Study Submitted to the Faculty of Graduate Studies  
in Partial Fulfillment of the Requirements for the Degree

Master's of Social Work

Department of Social Work

Winnipeg, Manitoba

September, 1990



National Library  
of Canada

Bibliothèque nationale  
du Canada

Canadian Theses Service    Service des thèses canadiennes

Ottawa, Canada  
K1A 0N4

The author has granted an irrevocable non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of his/her thesis by any means and in any form or format, making this thesis available to interested persons.

The author retains ownership of the copyright in his/her thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without his/her permission.

L'auteur a accordé une licence irrévocable et non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de sa thèse de quelque manière et sous quelque forme que ce soit pour mettre des exemplaires de cette thèse à la disposition des personnes intéressées.

L'auteur conserve la propriété du droit d'auteur qui protège sa thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

ISBN 0-315-76779-0

Canada

*ELDER ABUSE: A PRACTICUM STUDY IN A GERIATRIC  
REHABILITATION AND EXTENDED CARE HOSPITAL*

*BY*

*BARBARA J. HAWRYLUK*

A 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*

© 1991

Permission has been granted to the LIBRARY OF THE UNIVERSITY  
OF MANITOBA to lend or sell copies of this practicum, to  
the NATIONAL LIBRARY OF CANADA to microfilm this practicum  
and to lend or sell copies of the film, and UNIVERSITY MICRO-  
FILMS to publish an abstract of this practicum.

The author reserves other publication rights, and neither  
the practicum nor extensive extracts from it may be printed  
or otherwise reproduced without the author's permission.

## **Abstract**

The focus of this practicum concentrated on the most recent and least explored area of domestic violence, namely that of elder abuse. Eight suspected abuse/neglect cases were screened within a geriatric health care facility and referred to this student for further assessment and intervention over an eleven month period. An ecological approach formed the basis of assessment and intervention utilizing concepts taken from the child and spouse abuse literature as well as from some of the current elder abuse literature. The evaluation tools which were used included the quality assurance form on elder abuse and neglect protocol developed by the Quality Assurance Committee of the Department of Social Work at Harborview Medical Centre, the eco map and a consumer satisfaction questionnaire.

## Acknowledgements

There are many people that I would like to thank for their support during my practicum study.

Ruth Rachlis, who agreed to be my advisor, contributed much to my overall growth and learning. I have appreciated the opportunity of benefitting from her own integration of theoretical knowledge and extensive practical experience.

I have also appreciated the experience and support of my committee, Jeanette Block and Dianna Wierucki. I am especially grateful to Diana who has not only been my supervisor over the last 7½ years but my mentor as well. If it were not for her unshakeable, if not at times, relentless belief in me, this whole endeavour would not have been possible.

I am grateful to my colleagues, the inter-disciplinary teams with whom I worked, the Elder Abuse Committee and the administration of the Winnipeg Municipal Hospital for their support in a very delicate and controversial practicum study.

Also, a very special thank you to my family - to my mother, Joyce, father, Stan and sister Debi for all their support and encouragement and to my husband Garry as well as my children Jaimie, Graham and Kelsey for their understanding, patience and the personal sacrifices which enabled me to pursue this project. Garry, I am particularly grateful for your practical assistance and the many occasions when you intervened to prevent me from becoming a perpetrator of computer abuse.

## Table of Contents

Abstract	ii
Acknowledgements	iii
Table of Contents	iv
Introduction	1
Literature Review	4
Defining the Problem	5
Problems in Defining Elder Abuse	5
The Impact of Legislation	6
Formulation of a Definitional Framework	8
Nature and Scope of the Problem	20
Epidemiology	20
Profile of the Victim and Abuser	22
Etiology	23
The Situational Model	24
Social Exchange Theory	30
Symbolic Interactionism	31
Addressing the Problem	33
Levels of Possible Intervention	33
Impact of Mandatory Reporting on Intervention	35
Model Proposed by Tomita and Quinn	37
Assessment Phase	37
Intervention Phase	39
Short-term Treatment	40
Ecological Approach	43
Belskey's Ecological Integration	44
Summary	47
Design of the Practicum	48
The Setting	48
Clients	48
Intervention	49
Assessment Phase	50

Intervention Phase	52
Termination Phase	53
Evaluation	54
The Practicum Experience	56
Overview	57
Family Case Studies	62
"A" Family	62
"B" Family	71
"C" Family	81
"D" Family	92
"E" Family	100
"F" Family	110
"G" Family	119
"H" Family	127
Evaluation of Learning Objectives	134
Evaluation of Literature Review	134
Evaluation of Model of Assessment and Intervention	135
Evaluation of Services to Client	136
Evaluation of Student's Skill Development	137
Evaluation of Educative and Committee Membership Role	140
General Learning	141
Recommendations	147
Bibliography	151
Appendices	158
Appendix A - Winnipeg Municipal Hospital Screening Tool	158
Appendix B - Allardyce Assessment Tool	160
Appendix C - Tomita and Quinn Protocol	172
Appendix D - Fulmer and O'Malley Flowchart	185
Appendix E - Consumer Satisfaction Questionnaire	187
Appendix F - Ecomap	193
Appendix G - Quality Assurance Form for Elder Abuse and Neglect Protocol	195

## Introduction

"Just as child abuse emerged as a social problem in the 1960's and wife abuse was identified as a major issue in the 1970's, so abuse of the elderly has become a topic of interest and concern for the public, journalists, social scientists, and policy makers in the 1980's" (Pedrick-Cornell and Gelles, 1981, p.1).

Clearly, we are coming to realize that family violence is not merely limited to a few sensational events, but is a fundamental part of all family life (Straus et al., 1980).

Within the context of family violence, this practicum focused on the most recent and least explored area, namely that of elder abuse.

Studies exploring the area of elder abuse emerged in the late 1970's and early 1980's and began to reveal that the problem existed with a frequency not reflected by disclosed complaints and charges (Shell, 1982). As we approach the 1990's, the incidence and etiology continue to be topics of research and there have been some beginning attempts at formulating assessment and intervention tools based on the current, albeit limited state of knowledge.

As a worker in a geriatric rehabilitation and extended care facility, this student, along with other health care providers, have become increasingly more aware of the existence of abuse. Since an interdisciplinary approach to patient care is practised at this facility, a wide range of opinions is often expressed in regard to intervention preferences. Some individuals advocate a protective, more paternalistic approach while others consider that



individual family privacy is of paramount importance and intervention should be outside the bounds of professional mandate. Between these polar views there is a continuum along which the remainder of opinions are found at varying points.

This diversity of viewpoints is not uncommon and certainly reflects the complex dynamics and competing values inherent in elder abuse situations. Adding to the complexity is a lack of standardized legislation and a paucity of empirical knowledge as well as support resources to deal with the problem.

It is for these reasons that the student selected the subject of elder abuse as a practicum study. The learning objectives included:

1. Gaining a comprehensive understanding of elder abuse within the context of family violence through a review of the literature and practical experience.
2. Assessing and intervening in suspected elder abuse situations using an ecological approach.
3. Evaluating the effects the intervention had on the target population through process recordings, eco-maps and use of a client satisfaction questionnaire, when appropriate.
4. Evaluating student's skill development through the use of process recordings, supervision sessions with an advisor and the quality assurance

form on elder abuse and neglect protocol from the Department of Social Work at Harborview Medical Centre (Tomita, Clark, Williams, and Rabbitt, 1982).

5. Providing education regarding the dynamics of domestic elder abuse situations to other health care staff, specifically the interdisciplinary team members with whom this student works.
  
6. Becoming an active member of the Winnipeg Municipal Hospital's committee on elder abuse during the course of the practicum and a social work representative on the steering committee of the Inter-hospital Committee on Family Violence.

## Literature Review

The study of elder abuse is still developmentally embryonic in comparison to child and spouse abuse although interest in the subject is escalating with great momentum. This in turn is resulting in a plethora of ongoing published literature on the topic. However there is little empirical research to date and the descriptive studies are plagued with many contradictions. Consequently, there is no standardized definition of abuse/neglect, many contradictions in terms of etiology and little is known about effective assessment and intervention techniques.

In an attempt to reconcile these difficulties for the purposes of the practicum, this student chose to take salient features from a variety of articles and formulate a definitional and profile structure. An ecological assessment framework was developed from two main literature sources in which the problem could be comprehensively explored and from which an intervention plan could be developed. This approach enabled the student to integrate the main theoretical models found in the literature and formulate possible intervention approaches at a variety of levels.

The literature review which follows, therefore concentrates on defining the problem, providing an overview of the nature and scope of the problem and addressing the problem using an ecological conceptualization.

### **Defining the Problem**

In an attempt to facilitate an understanding of this very complex area, discussion will take place under the following sub categories:

1. Problems in defining elder abuse.
2. Impact of legislation on defining the problem.
3. Formulation of a definitional framework for use in a non-legislated geriatric facility.

#### **Problems in Defining Elder Abuse**

The problems in defining elder abuse are mostly related to interpretation which is influenced by:

- A. Individualized perceptions of abuse or neglect which is often a product of ethno-cultural influences.
- B. Discrepancies among and within medical, psychological, sociological and legal perspectives.

### **The Impact of Legislation on Defining the Problem**

In spite of these problems, several provinces and states have implemented legislation with provisions for a central registry and some have also included mandatory reporting and intervention. Consequently they have negotiated and established their own standardized definitional structure. However no such standardization can be seen across these provinces and states.

In Manitoba, where there is presently no legal mandate to identify and intervene in situations of elder abuse/neglect<sup>1</sup>, there is also no standardized definitional structure to serve as a guideline for professionals working in this area.

Consequently a definitional framework was formulated by this student along with other members of the committee on elder abuse at the Winnipeg Municipal Hospital, taking into account the fact that there is no legal mandate for reporting and intervention. Following discussions with the hospital administration the committee decided to redefine abuse/neglect as unmet care needs of the elderly. Unmet care needs can range from a benign misunderstanding of care needs to more violent acts. The rationale for this redefinition is as follows:

- A. The term abuse/neglect conveys a powerful blaming position and view of victim-perpetuator which cannot be responded to by the same type of legally mandated resources which are available in child or spouse abuse situations and

---

<sup>1</sup> A mandate does exist, however, for legal intervention should an elder be involved in a situation of "spouse abuse grown old" or deemed incompetent by the provincial psychiatrist.

those elder abuse situations in provinces and states which have mandated reporting. These resources include legal protection for professionals and agencies working in the area as well as mandated community supports for individuals in identified abuse situations. It is, therefore, necessary to use engagement skills which alleviate defensiveness and offer a non-adversarial context in which individuals who are involved in the abusive situation can be motivated to participate in the intervention.

Redefinition of abuse/neglect to unmet care needs assists in this process by eliminating the blaming message. This does not mean that the health care professional does not support an elder who is expressing anger and blame toward a care-giver who is being abusive. It means that a context of non-judgement is set up on the part of the professional and agency which will facilitate engagement of persons who have been identified as receiving abuse/ neglect as well as those persons who have been identified as contributing to abuse/neglect.

B. In the experience of the committee, which is validated by some of the more recent literature, most situations referred to as elder abuse/neglect are not fully explainable in this simplified victim-perpetrator context (Fulmer and O'Malley, 1987). An assessment which utilizes this limiting view can result in an ineffective intervention plan. Indeed, the victim-perpetrator perspective can even result in a very destructive course of intervention.

The committee recognized that there was a significant caveat accompanying this redefinition. After years of trying to bring elder abuse/neglect into public

awareness and have it recognized as a serious social problem, the risk now existed for that significance to be minimized to the point where the problem would no longer receive the reaction and attention it deserved. However, given the administration's concerns regarding possible legal repercussions and the aforementioned findings of the more recent literature, it was considered a trade-off that had to be made.

### **Formulation of a Definitional Framework for Use in a Non-legislated Geriatric Facility**

Unmet care needs encompass physical, psycho-social and financial issues, all of which can have abusive or neglectful aspects. The distinction between abuse and neglect is frequently cited in the literature as:

A. *Physical, psycho-social and financial abuse* refers to those *commissive acts* defined as active intervention by a caretaker such that the unmet needs are created or sustained with resultant physical, psychological or financial injury (O'Malley, 1983).

B. *Physical, psycho-social and financial neglect* refers to those *omissive acts* which occur due to the failure of a caretaker<sup>2</sup> to intervene to resolve significant needs (adapted from O'Malley, 1983).

The terms abuse and neglect have been substituted with commissive and omissive acts in the definitional framework.

Relabelling abuse/neglect as commissive/omissive acts also facilitates a more realistic appraisal of the severity of the situation. The term abuse seems to automatically evoke more concern than the term neglect, the assumption being that abuse is harsher or more serious than neglect. However, it is not the action or lack of action, in and of itself which determines severity. For example, a non deliberate intent to inflict harm can be seen when a spouse, attempts to protect his or her partner (who has Alzheimer's Disease), by using restraints to prevent him/her from wandering in the streets at night. While this example falls into the category of abuse or a commissive act, it does not hold the same concern as the neglectful or omissive act of a spouse deliberately withholding life-saving drugs.

As health care workers, it is important to attempt to determine, inasmuch as possible, the degree of intentionality in any act, be it commissive or omissive, following initial assessment confirming abuse/neglect, since this will influence the intervention strategy.

---

<sup>2</sup>The term caretaker will be used to describe those persons who provide any type of service to the elder, from occasional supervisory visits to daily "hands on" care. While there is usually some form of service provided to the eight elders in this study, it is acknowledged that there are abuse/neglect situations where no amount of service is provided.



It should also be noted that any omissive act which has been determined by a court of law to be deliberate or intentional is considered commissive.

Caution must be taken when using the following definitional framework or indeed, any definition. Many of the descriptors or behaviours listed could be due to normal pathology of ageing or have other explanations unrelated to abuse or neglect. The framework should only be used as a guideline to alert one to the possibility of abuse or neglect and the need for further, careful investigation.

This student, as a member of the Winnipeg Municipal Hospital Committee on Elder Abuse, formulated the following definitional framework which served as the basis of this practicum and was adopted for use at the Winnipeg Municipal Hospital. As mentioned, salient and similar features of those definitions established by legislated Provinces and States were used. Corresponding risk indicators were also included.

There are two parts to the framework:

1. A list of general indicators which can apply to all aspects, (i.e. physical, psycho-social and financial).
2. Specific categorization of physical, psycho-social and financial acts resulting in unmet care needs with corresponding indicators.

### General Indicators

There are certain indicators which can be found in situations of physical abuse/neglect; psycho-social abuse/neglect; and/or financial abuse/neglect. These are listed below:

1. Self abuse.
2. Verbal expression of abuse by elder or significant other.
3. Indications in significant other's behaviour that own dependency needs are not being met.
4. Circumstances which force significant other to provide care.
5. Unemployment of significant other, insufficient funds, significant other's dependence on elder for housing/money.
6. Certain hostile/frustrated behaviour of significant other such as:
  - poor self control
  - exaggerated defensiveness, denial
  - blaming of elder
  - demonstrations of little concern toward elder
7. Presence of substance use/misuse/abuse in the client system.
8. Presence of mental illness and/or mental impairment, i.e. symptoms such as suicidal ideation, psychosis, mania, cognitive impairments.
9. Presence of poor health or chronic illness in the client system.

10. Family history which reveals that violence is a family norm, a learned behaviour for dealing with anger, stress, interpersonal conflict and frustration.
11. An observed interactional pattern between elder and significant other which suggests excessive strain between them.
12. An unexpected or anticipated event occurring within the family network which is perceived as a crisis situation.

### Unmet Care Needs: Commissive Acts

PHYSICAL ACTS	INDICATORS
<p>1) Homicide</p> <p>2) Physical Assault</p> <ul style="list-style-type: none"> <li>- beating</li> <li>- slapping</li> <li>- hitting</li> <li>- kicking</li> <li>- pinching</li> <li>- burning</li> <li>- pushing/shoving</li> <li>- rough handling</li> <li>- shaking</li> <li>- pulling hair</li> </ul> <p>3) Forcing medication</p> <p>4) Inappropriate use of physical restraints causing physical harm</p> <p>5) Sexual molestation and/or assault</p>	<p>2) Unexplained injuries or explanation inconsistent with injuries</p> <p>Healing injuries present with new injuries</p> <p>History of a variety of doctors or treatment centres ("doctor hopping")</p> <p>Haematomas eg., soft spots, inner/outer thigh bruises, clustered bruises as from repeated striking</p> <p>3) Drowsiness and/or confusion</p> <p>4) Rope burns, muscle contractures, circulation problems, immobility and/or weakness unrelated to condition; decubiti (bed sores)</p> <p>5) Pain, bruising, bleeding in genital area and/or no apparent reason for difficulty in walking</p>

## Unmet Care Needs: Commissive Acts

PSYCHO-SOCIAL ACTS	INDICATORS
<p>1) Verbal abuse</p> <ul style="list-style-type: none"> <li>- shouting</li> <li>- scolding</li> <li>- dehumanizing and derogatory comments</li> <li>- intimidation and coercion, threats of physical abuse and/or institutionalization</li> </ul>	<p>1) Elder demonstrates learned helplessness/guilt, suggestion of low self-esteem, self-degrading comments, self-blame, hesitancy to express own needs</p> <p>Elder demonstrates withdrawal, passivity, shame, depression, expressed fear and sense of hopelessness or alternatively is overly aggressive and/or defensive in behaviour</p>
<p>2) Infantilization</p>	<p>2) Presence of "baby talk", toys, condescension toward elder</p>
<p>3) Resource abuse: Used as housekeeper, babysitter, against own free will or feeling under pressure</p>	<p>3) Elder feels used, expresses lack of recognition</p>
<p>4) Desertion, threats of abandonment or institutionalization</p>	<p>4) Elder left alone for long periods of time</p> <p>Elder is hurt and may express feelings of abandonment</p>
<p>5) Inducement of fear</p>	<p>5) Withdrawal, depression, helplessness, hopelessness, fearful reactions in general and more specifically to caretaker</p>
<p>6) Imposed social isolation</p>	<p>6) Excluded from family gatherings, not permitted to have friends visit, attend church, denied access to grandchildren</p>

Unmet Care Needs: Commissive Acts

FINANCIAL ACTS	INDICATORS
<p>1) Misappropriating an elder's liquid assets, real property, or personal possessions by:</p> <p>Trickery: Taking control of an elder's finances through some form of coercion</p> <p>Fraud: Forging an elder's signature, posing as elder, misuse of funds or property</p> <p>Theft: Removing money or possessions without permission</p> <p>All of these can happen in two ways:</p> <p>a) Longterm systematic abuse - Taking cheques and monies from accounts periodically and on an ongoing basis</p> <p>b) Short term abuse - Sudden expropriation of property, personal goods and/or funds usually on a large scale</p>	<p>1) Bank account slowly dwindles, elder expresses shock, confusion, depression or resignation toward financial or material losses; frequent expensive purchases for others; unemployed or low income significant others with need for elder's shelter or money</p> <p>Over-charge for home repairs, etc.; illegal use of elder's possessions or property investments for personal gain; forced to sign POA, change will or sell house; no money for food, clothing; abuser supports drug or alcohol dependency with elder's money</p> <p>Insufficient funds for elder's necessities; precipitation of financial crisis</p> <p>Note: In some situations there may be no behavioural indicators on the elder's part, since he/she may not be aware that abuse is occurring</p>

**Unmet Care Needs: Omissive Acts**

<b>FINANCIAL ACTS</b>	<b>INDICATORS</b>
1) Withholding of elder's funds or lack of provision of sufficient funds	1) No money for food, clothing, and medical needs  Inadequate living environment and inability to afford social activities

## Unmet Care Needs: Omissive Acts

PHYSICAL ACTS	INDICATORS
1) Withholding of food	1) Malnutrition, emaciation, dehydration and/or intestinal/digestive problems; oral and dental neglect
2) Withholding of medication or medical services/treatment	2) Symptoms which should be alleviated by medications are present; not taken to physician or dentist
3) Withholding functional aids	3) Walker, cane, ADL aids
4) Inadequate hygiene/personal care	4) Mouth sores, unkempt appearance urine burns and/or decubiti (bed sores)
5) Inadequate clothing/heating	5) Clothing in poor condition and/or inappropriate for season
6) Lack of supervision and safety precautions	6) Left unattended for long periods of time; dangerous environment; desertion/abandonment
7) Exposure to extreme temperatures	7) Hypo- or hyperthermia



## Unmet Care Needs: Omissive Acts

PSYCHO-SOCIAL ACTS	INDICATORS
<p>1) Sensory deprivation</p> <p>a) Physical - Touch, taste, sight, smell, hearing</p> <p>b) Emotional - Social isolation, confinement, deprivation of supportive human contact</p> <p>2) Removal of decision-making process</p>	<p>1) Elder kept in dark, bare room; no access to books, TV, music or other forms of stimulation; denied glasses, hearing aid, dentures</p> <p>Continuous withholding of companionship and/or affection, exclusion from family gatherings or restriction of visitors</p> <p>Caretaker is cold and curt in speaking to elder, talks "around" elder as if not there</p> <p>2) Elder not allowed to express opinions or make decisions regarding his/her personal well-being</p> <p>Elder shows apathy regarding decision making; constantly defers decision-making to caretaker or others</p>

## Unmet Care Needs: Omissive Acts

FINANCIAL ACTS	INDICATORS
1) Withholding of elder's funds or lack of provision of sufficient funds	1) No money for food, clothing, and medical needs  Inadequate living environment and inability to afford social activities

## Nature and Scope of the Problem

### Epidemiology

There seems to be a general consensus in the recent literature that whatever numbers are revealed in any given study, it is only a small representation of a larger problem which is being seen (Shell, 1982). The primary reason for this seems to be related to a general reluctance on the part of the victim, significant others, as well as health care professionals to report incidents of abuse. Various articles discuss this reluctance, much of which seems to be related to the following:

1. Ageism, which is a term referring to the stereotyping of the elderly as sick, feeble, confused, dependent and non productive. Since they are viewed as non contributing members of society, their needs have not been considered a priority and their complaints of maltreatment are often dismissed as signs of confusion and senility (Edwards, 1985; Schlesinger and Schlesinger, 1988).
2. Value of family privacy, which refers to the belief that whatever happens within the realm of family living should be regarded as a private matter and the right to such privacy is of paramount importance (Edwards, 1985).
3. Embarrassment, fear, shame on the part of the elder and/or the abuser to reveal the problem are reasons that are frequently cited for under-reporting (Shell, 1982). While loyalty does not seem to have been mentioned specifically in the elder abuse literature,

it is cited by P. Cohen as another explanation for under-reporting and resistance to intervention in any area of domestic abuse/neglect (Cohen, 1984). Considering the strong values of family loyalty and loyalty to God and church held by many elderly, this could even be a stronger force in elder abuse than in child and spouse abuse.

4. Denial of the problem, which refers to the difficulty our society has in believing that elder abuse could actually happen - an occurrence which runs contrary to the mores of our society. Comments such as the following illustrates this point: "It took clinicians a long time to accept the existence of child abuse and wife abuse. The current preoccupations reflect values which lead to the belief that it is unacceptable to beat a wife and horrible to beat a child, but nobody beats an aged parent" (Rathbone-McCuan, 1982).

5. Lack of a standardized definition which makes recognition of some types of abuse difficult (Giordano and Giordano, 1986; Pedrick-Cornell and Gells, 1981).

6. Lack of a legal mandate and support resources. In view of this, many individuals who have identified an abuse situation don't respond for fear of legal repercussions and a lack of appropriate services to deal with the problems they find (Shell, 1982).

In spite of the many difficulties associated with gathering data on incidents of abuse, many studies have attempted to establish approximate numbers. Studies done in Canada and the United States estimate that the abused elderly constitute anywhere from 2-5% of the elderly population. This estimate is considered to be very conservative.

The most comprehensive study done in Manitoba was completed by D. Shell in 1982. Interviews (N = 105) were conducted within all regions of the province (Winnipeg Central, Norman, Interlake, Parklands, Westman, and Eastman) thereby representing both rural and urban areas and populations ethnically and socio-economically diverse. Respondents were public health nurses, social workers, psychiatric nurses, Victorian Order of Nurses, registered nurses in the home care programs as well as hospital settings, police officials, doctors, lawyers and clergy members. The report states that 18,000 (15%) of the 120,000 people in Manitoba over the age of 65 years receive some form of care from informal care providers or home service agencies. The 402 cases of elder abuse reported in this exploratory study suggests that at least 2.2% of these 18,000 people are experiencing some form of abuse/neglect. Since the well elderly population are not included in this study, it can be hypothesized the some portion of this population are experiencing some form of abuse, adding further strength to the argument that 2.2 percent is an underestimation of the problem. Findings from a more recent Canadian study reveal a 4 percent figure (Podnieks, Pillemer, Nicholson, Schillington and Frizzell, 1989).

### **Profile of the Victim and Abuser**

Some fairly consistent findings which can present a profile of both the victim and abuser are now emerging from a variety of studies (Douglas, 1983; Block and McGath, 1985; Edwards, 1985; Rounds, 1984; Shell, 1982).

The identified victim is most often female, over 75 years of age, living in close proximity to or with the identified abuser (usually for a period of ten years or longer),

is mentally or physically impaired to some degree, isolated from social contacts, and is usually reluctant to report abuse/neglect.

The identified abuser is most often a caretaker, a family member (studies differ in their findings as to whether the family member is most often a spouse, son or daughter) and is mentally, physically, or emotionally impaired (eg. ineffective coping skills) themselves and is oftentimes dependent on alcohol or drugs.

Caution must be exercised when profiling victims and abusers. While many studies support the presence of the listed characteristics, there are studies which have demonstrated the presence of these characteristics in many non-abusing situations. The usefulness of profiling is limited to heightening awareness of possible risk indicators in situations which deserve further investigation.

### **Etiology**

As outlined by Pillemer and Wolfe (1986), there seem to be three main competing theories in the literature which attempt to explain the reasons for elder abuse as it relates to family or domestic abuse/neglect. In reviewing the models, however, the question arises as to the need for viewing these theories as competitive or mutually exclusive. Indeed, as Gelles and Straus (1979) indicate, it is unlikely that one theoretical base will provide a comprehensive, all inclusive explanation of elder abuse. Rather, there is reason to believe that different forms of elder abuse may be explained by different theories or combinations of theories (Giordano and Giordano, 1986). Notwithstanding this, however, these theories will be presented separately for the purposes of clarity.

The three main theories discussed by Pillemer and Wolfe (1986) are presented separately here for the purpose of clarity. However, since this student will be viewing the phenomena of elder abuse in an ecological context, they will not be seen as mutually exclusive but rather as being interrelated with circular movement between and among them.

### *The Situational Model*

This model appears to be the most widely accepted and is derived from the theoretical base associated predominantly with child abuse. The basic premise is "as the stress associated with certain situational factors increases for the abuser, the likelihood increases for abusive acts directed at a vulnerable individual who is seen as being associated with the stress" (Pillemer and Wolfe, 1986).

The situational variables which have been linked with abuse of the elderly include the following (which are presented separately but are interactive in nature):

*A. Elder-related factors such as physical and emotional dependency, poor health, impaired mental status and a "difficult personality"*

These points have been discussed in several articles. Many studies have found a positive correlation between physical/ emotional dependency of an elder and the incidence of abuse/ neglect. Block and Sinott (1979) and Rathbone-McCuan (1980) contend that the responsibility of caring for a dependent, elderly relative can provoke family stress which in turn can result in abuse/neglect.

Schlesinger and Schlesinger (1988) discuss mutual resentment of a caretaker and a dependent elder. While the caretaker may want to do "the right thing", they may also be faced with multiple responsibilities to spouse, children and grandchildren. The additional duties involved with the increasing dependency of an elder may create such intolerable stress and exhaustion in the caretaker that an abuse/neglect situation results. In turn, the elder may resent his/her growing dependency and loss of control such that they become withdrawn and unmotivated, forcing further responsibilities onto the caretaker. Alternately, some elders may act out this resentment by displacing their anger and frustration on the caretaker which in turn accelerates the caretaker's own resentment.

It should be noted, however, that Pillemer found it was not dependency of the elder but rather dependency of the caretaker on the elder which correlated with elder abuse/neglect. Perhaps this discrepancy can be partially explained by the methodologies used. Interviews in the Block, Sinott (1979) and Rathbone-McCuan (1980) studies were conducted with the caretaker whereas the most recent Pillemer study (Pillemer and Tinkelhor, 1989) consisted of a 45 minute interview with only the elder.

Wolfe et al., (1982) refers to the possibility of a "web of mutual dependency" which the elder and caretaker are locked into together. This perspective offers an alternative to the notion of blaming either the elder or the caretaker and may have more explanatory power for many situations which have been identified as elder abuse because of its interactional view.



B. *Structural factors which include:*

i) Economic strain

With regard to economic strain, many studies, such as the one done by Shell in 1982 have found that financial abuse is the most common form of abuse. Studies such as the ones discussed by Pillemer and Wolfe (1986) cite a lack of financial resources as the reason identified by abusive caretakers to be a common source of pressure which they believe contributed toward the abusive action taken. This pressure can take several forms. In some situations, families contribute a great deal of support to home maintenance, health care (more of a concern in the States than in Canada) and other needs of the elderly, while attempting to maintain their own standard of living. Other situations involve women, usually the designated caretaker, having to give up their job in order to care for the elder. Not only does this reduce the family income, but it may create resentment on the part of the caretaker in having to leave a job which was important to her (Schlesinger and Schlesinger, 1988; Steinmetz, 1978; Block and Sinnot, 1979; Lau and Kosberg, 1979). Oftentimes, mutual dependency may exist with finances as a factor such that the elder offers financial security in return for caregiving services. Abuse can result when a caretaker needs this security but does not or cannot provide the care required.

## ii) Social Isolation

With regard to social isolation, Pillemer and Wolfe's study (1982) indicated a relationship between social isolation and elder abuse where abused elders had significantly less contact with others and significantly less satisfaction with their social relationships than did their non-abused counterparts. This factor appears to be consistently identified as a contributing factor pertaining to all forms of family abuse/neglect.

## iii) Environmental Problems

Environmental problems such as quality of housing, lack of community support services and crowded living conditions can also precipitate stress and lead to violence singly or in combination with other factors (Schlesinger and Schlesinger, 1988).

## iv) Caretaker Related Factors which include the following:

*Life crisis/burnout* - As Schlesinger and Schlesinger (1988) state, "the dramatic change which can occur when a frail elderly parent moves in with a family already struggling in several areas of family life crisis, produces intense stress". Also, "in many situations there is no history of close ties and sometimes little or no involvement. The sudden appearance of a dependent elder under these circumstances can precipitate stress and

frustration without the love and friendship necessary to counteract the new responsibilities of the caretaker" (p. 104).

Steinmetz (1978) and Block and Sinnott (1979) point out that in most situations the responsibility for caregiving rests with the woman, who is usually middle-aged or, in some cases, elderly herself. These women are generally still actively involved in meeting the needs of spouses, children or grandchildren or they are at the point of relinquishing some of these responsibilities in order to pursue their own educational, occupational or recreational goals (goals which may have been deferred for long periods of time while they have tended to the needs of their family.) This added responsibility can, therefore, be met with much resentment and frustration.

*Substance abuse* - Many studies, as stated by Schlesinger and Schlesinger (1988), have shown alcohol and drug abuse, as well as mental impairment on the part of abusers, to be a significant factor in abuse.

*Violence as a coping mechanism* - Previous social learning of violence as a coping mechanism, cycle of violence or transgenerational violence, with its roots in social learning theory, permeates the literature as an explanation for all forms of family abuse/neglect. Lau and Kosberg (1979), Rathbone-McCuan (1980), and Steinmetz (1979) all state that patterns of violence have been shown to be passed down from one generation to the next and violence is viewed as a normative response to stress. One study revealed that 0.21% of children reared non-violently were found to be

abusive, as compared to as many as 50% who were reared violently (Schlesinger and Schlesinger, 1988).

It should be noted that not all studies have supported the aforementioned variables as possible causal factors in elder abuse. However, Pillemer and Wolfe (1986) state that these differences in findings do not necessarily compromise the efficacy of the situational model. They offer two main reasons for the inconsistent fit between the situational model and some of the empirical data:

1) Certain methodological problems continue to plague elder abuse studies in general. Definitions of abuse vary from study to study. Samples have been small, non-representative, and few studies have used comparison groups. Some studies have focused on only one particular type of abuse.

2) Portions of the model may not be applicable to elder abuse in all its forms. This model has been used in elder abuse with the assumption that elder abuse, child abuse and other forms of intra-family violence share some obvious similarities, and therefore can all be explained by the same theories. This assumption, however has not been tested.

Pillemer and Wolfe (1986) state that one of the main reasons for the popularity of the situational model is its amenability to intervention and prevention techniques, at least in part, by addressing the structural stresses of any given situation (eg. caretaker education/support groups, respite programs, home care services, etc.).

### *Social Exchange Theory*

Social exchange theory is based on the premise that "social interaction involves the exchange of rewards and punishments between at least two people and that all individuals seek to maximize rewards and minimize punishments in their interaction with each other" (Pillemer and Wolfe, 1986).

The system operates on checks and balances and the interaction conforms to the norm of reciprocity which implies that each person has rights as well as duties to the other. Problems arise when, over time, one or more participants feel that the exchange is not equal. Philips (1980) refers to this imbalance as power. The more independent person, who is perceived as giving more rewards than receiving them has the power advantage which, translated in an abuse situation, he/she uses to manipulate or be unjust to the more dependent participant. Lau and Kosberg (1979) offer, as an example, the situation of a caretaker who inflicts punishment as a means of revenge for real or perceived abuse they received as a child at the hands of the elder.

As a person ages, his/her physical/mental capabilities lessen and he/she becomes progressively less able to reciprocate rewards. He/she is thought to lose their power base with this process. In an attempt to compensate for this, some elders consciously or unconsciously use their failing health as a means of obliging those close to them to continue providing the rewards they feel they need. However, this can generate combined feelings of guilt and resentment on the part of the caretaker and serve as an eventual breeding ground for abuse.

Applied on a larger scale, Steinmetz (1979) states that historically, any group which is perceived as politically and economically weak, as are the elderly in our society, do not receive an equal share in the allocation of resources.

Empirical support for the exchange paradigm is not at all conclusive. Pillemer and Wolfe (1986) state that while more studies are beginning to use the paradigm as a partial theoretical base in explaining elder abuse, more development and testing are needed.

### *Symbolic Interactionism*

Symbolic interactionism is based on the assumption that social interaction is a process between at least two individuals that occurs over time and consists of identifiable phases that are recurring, interrelated and loosely sequenced. It also requires constant negotiation and renegotiation to establish a "working consensus" (actually in the form of disagreement rather than agreement) about the symbolic meaning of the encounter (Pillemer and Wolfe, 1986). Extrapolating from McCall and Simmons (1966) the phases of symbolic interactionism include:

1) Cognitive phase - each individual assigns meanings to the encounter, based on cultural beliefs, past experiences, and currently salient roles. As each individual defines the situation based on perceived images of self and the other, expectancy sets are developed. An interchange follows and feedback is then received and redefinition or affirmation of perceptions follows.

2) Expressive phase - each participant displays behaviours that are consistent with the roles as they are improvised and imputed. Role synchrony occurs when each person has a similar definition of the situation and has improvised and imputed role identities that are

meshed (eg. the child who takes on the parental role and places the parent in a child role and the parent accepts this). Role asynchrony, conversely, occurs when there is a mismatching of either the definition of the situation or role identities that are assigned by each participant. An example of this would be an unresolved filial crisis where the child is unable to see the parent in any other way than in the parent role, even when the parent's ageing process renders her/him more dependent and childlike (Law and Kosberg, 1979; Block and Sinnot, 1979).

3) Evaluation process - involves consensus negotiation as participants alter their own behaviours and expectations.

Within the context of symbolic interactionism, elder abuse can be conceptualized as an inadequate or inappropriate role enactment arising from cognitive processes that alter role improvisation and imputation for both the elder and abuser (unless the elder is either cognitive or physically unable to participate in the process, in which case only the cognitive processes of the abuser are involved).

Empirical testing of this model is difficult since it deals with cognitive processes and individual symbolic meanings.

Similar to some of the earlier literature on child and spouse abuse, many of the factors identified in all three of these theoretical models have found both support and non-support in a variety of studies, which may, once again, be related to the methodologies which reflect a conceptualization of elder abuse which is predominantly reductionistic and linear.

## Addressing the Problem

### Levels of Possible Intervention

Hudson (1988) states that intervention as it relates to domestic elder abuse can occur at three levels - the micro, mezzo and macro levels.

Briefly, the mezzo and macro levels refer to education, research and policy making. With regard to education, Hudson discusses the necessity of promoting awareness of the problem to politicians, family and friends of the elderly as well as local communities. He also includes education and training programs for professionals who are directly involved with detection and intervention such as health care workers, law enforcement officers and administrators. With regard to policy making, Hudson refers to legislation which encompasses mandatory reporting and/or the development of a central registry as well as the development of support services (eg. shelters, homecare, daycare, respite services, crisis line, legal and advocacy programs). Abuse at the institutional level is also discussed.

The micro level, which is the level applying to this practicum, refers to the direct intervention with the client system.

It has only been in the last few years that attempts have been made to develop a systematic means of assessing and intervening in suspected situations of elder abuse. Once again, however, because of a lack of empirical knowledge, definitional problems, and inconsistencies with regard to legislation, there is no standardized approach being practised by those agencies and health care facilities dealing with elder abuse.



With regard to a hospital based system of assessment and intervention, a few protocols have been developed recently, mostly by those states and provinces with mandatory reporting and central registry requirements. Presently, in Manitoba, the only protocol available is a four page insert for abused or neglected elderly persons in the *Domestic Violence Protocol Manual for Social Workers in Health Facilities* (1982). However, attempts have been made by various agencies and health care facilities throughout Manitoba to develop more comprehensive protocols.

The Winnipeg Municipal Hospital is one such health care facility where, in the absence of any legislation, attempts were made to develop a protocol for screening, assessment and intervention. Draft copies of the screening and assessment tools can be found in Appendix A and B. The screening tool was developed by the committee on Elder Abuse/Neglect at the Winnipeg Municipal Hospital and the assessment tool was developed by a Masters Social Work student, Susan Allardyce, at the University of Manitoba. This particular assessment tool has an ecological orientation and as such, enables the Social Worker to view the dynamics and organize the intervention within this context. Unfortunately these tools were both in the process of being developed at the same time as the clinical portion of this practicum was taking place and consequently were not available for use during the practicum. Both tools are now in the process of being tested. In addition there has been a growing interest on the part of the provincial government which has prompted the formulation of a discussion paper from the minister responsible for senior citizens in Manitoba with province-wide consultation. The results of this will likely become known over the next year. Financing has also been made

available for the establishment of an elder abuse resource centre which recently commenced operation in Winnipeg.

### **Impact of Mandatory Reporting on Intervention**

It has been argued by Katz (1979-80) and others that mandatory reporting is undesirable because the definition of elder abuse/neglect is too broad and varied, and there are many implications for professionals in terms of legal repercussions. Also it is considered by many to be an invasion of the rights of competent elders including the right to put themselves at risk. Conversely, it is argued that crimes must not go unreported and that there is an obligation to protect the most vulnerable members of society. As well, it is suggested that mandatory reporting might take some of the burden of decision-making from individual professionals in the field (Government of Canada, 1989). This notion, however, has been questioned by Matlow and Mayer, who are members of the Beth Israel's Elder Abuse Assessment team in Massachusetts. They state that "although many of the dilemmas and ethical questions that faced social workers in the state before the advent of the reporting law continue to exist, new ones have now been added. Furthermore, with current legal, financial, and political systems changing rapidly, social workers may have difficulty adjusting to the systems confines and at the same time upholding the basic tenets of their profession." (Matlow and Mayer, 1986).

The *Discussion Paper on Elder Abuse* published by the government of Canada (1989) also cautions that suitable support systems should be in place prior to the establishment

of mandatory reporting and there should be a means for screening and assessment within the context of a inter-disciplinary team which would be responsible for assessment, reporting and review of suspected abuse/neglect cases. It is also recommended that those who would be responsible for reporting should also be immune from lawsuits. Above all, the paper emphasizes that respect for quality of life and autonomy of the elder should always be paramount. The suggestion is made for abuse/neglect to be reported through a protective social service agency rather than a law enforcement agency since this method would be seen as less punitive and more therapeutic. Emphasis is placed on the risk of damaging a working relationship through mandatory reporting.

The paper also states that there are arguments for and against protective legislation. Katz (1979) and other researchers as well as some senior groups argue that enacting protective legislation for elders promotes ageism in that it equates advanced age with incompetence with regard to making decisions for themselves. Alternately, the paper suggests that most abused/neglected elders are generally less physically, psychologically and/or cognitively competent than other seniors and are typically older and more dependent than those seniors who advocate for self-determination. While much of the literature seems to concur with the notion that the less able elderly being at greater risk, some studies do not support this finding (Pillemer and Wolfe, 1986).

Concluding remarks in the discussion paper summarize this dilemma by stating, "If we bypass their [the elders'] right to determine where they want to live and with whom, we are denying their adulthood. On the other hand, by allowing them to be coerced into remaining in a possibly fatal situation, we are partners in crime" (Government of Canada, 1989).

## **The Elder Abuse Diagnosis and Intervention Model Proposed by Tomita and Quinn**

The Tomita and Quinn Protocol was the most comprehensive assessment and intervention tool available at the time of this practicum.

It formed the base of the practicum but was given a greater ecological orientation by combining it with the ecological conceptualization of abuse/neglect proposed by J. Belskey in the child abuse literature (1980). A copy of the protocol and audit can be found in Appendix C. As described by Tomita and Quinn (1986), this model consists of a diagnostic and intervention phase and has derived its theoretical roots primarily from the traditional psychosocial approach (Sambrill, 1983; Lowry, 1957; Quinn, 1970) crisis intervention (Golan, 1978, 1979; Parod, 1971; Rappaport, 1962, 1970) and psychiatric diagnostic techniques (Follstein and McHugh, 1975; Goodwin and Guze, 1984; Kahn, Goldfarb, Pollock and Peck, 1960; Katz et al, 1963).

### ***Assessment Phase***

#### ***Diagnostic Phase I***

1. Referral - The motivation of the referral source must be determined whenever possible. If an agency is the referral source, there must be a mutual understanding of role expectations and agency mandate.

2. Preparation for initial contact - According to crisis theory, there must be a repertoire of engagement skills available to the practitioner, which serve to address the

client's need to experience a reduction in his/her distress. The language chosen by the practitioner must be appropriate to each member of the client system.

3. First contact - The main goals of the first contact are obtaining access and alleviating fear. The practitioner must not assume that he/she will be welcomed by either the victim or abuser. By alleviating fear and being perceived as helpful, the practitioner will have a better chance of enlisting the client's willingness to engage in a treatment situation. A hospital setting offers the added opportunity of greater accessibility to the elder and significant others.

### *Diagnostic Phase II*

1. Client interview - This should be done alone, as most clients will not reveal much if another person is present.

2. Caretaker interview - This should be done as soon after the elder's interview as possible.

3. Data collection - Comparisons are made between the individual assessments and discrepancies noted. A tentative diagnosis is then made of:

- no evidence for abuse/neglect
- suspicion of neglect
- suspicion of abuse
- positive for abuse/neglect

### *Intervention Phase*

According to Tomita and Quinn (1986), following the assessment, clients will fall into one of four categories:

1. capable and consenting to treatment
2. capable and non-consenting
3. incapable and consenting
4. incapable and non-consenting

The context in which the term capable is used can be equated with the legal term of competency. Initial screening for possible competence problems can be assessed by the mini-mental status exam found in Appendix C. However, more careful assessing will need to be done in many situations over a period of time and will require physician and psychiatric involvement.

In Manitoba, a person can only be deemed incompetent by the Provincial Psychiatrist who bases his assessment on the attending physician's report and a psycho-social report.

Competency remains a very complex and difficult issue as not all cases fall into the "clearly competent" and "clearly incompetent" categories. Many situations fall into a grey zone where the person is competent with some levels of problem solving and decision making but not with others (eg. cannot manage own finances but can weigh the general pros and cons of his/her living situation and make a decision about whether or not to move). However, once a person is deemed incompetent, he legally loses the right to

make decisions in all areas of his/her life. Competency is an issue which deserves closer attention but in the meantime, we as health care providers oftentimes struggle in the grey zone, of "not clearly competent or incompetent".

There are three possible courses to the intervention phase:

1. *Crisis* - Usually a one time intervention with resulting referral for short-term or long-term treatment.
2. *Short-term* - Usually 3-6 months in duration with 8-12 contacts.
3. *Long-term* - Usually lasting for two years or longer.

Since the duration of this practicum was anticipated to be 6-10 months, a brief description will follow on the short-term intervention.

### ***Short-term Treatment***

Treatment suggestions, as noted by Tomita and Quinn (1986), are the result of a review of the literature on counselling, child abuse and domestic violence in combination with direct field experiences. The guidelines are general and are not meant to represent proven methods for treating all aspects of elder abuse and neglect. The effect of separating the identified victim from the identified abuser remains an unsettled issue for child and spouse abuse and is becoming apparent now with elder abuse. Tomita and Quinn suggest that counselling techniques addressing the needs of both the elder and identified abuser should be learned. The goal of providing counselling is to stop the abuse and is based on social learning theory, which holds that behaviours are learned from one's family of origin, culture, and prior experiences. These behaviours, it is contended, can be unlearned and replaced with acceptable alternatives. It should be noted, however,

that there are certain situations where this does not apply. That is, when the psycho-pathology of the abuser is such that there is no prospect of change. However these particular situations appear to be very rare.

A. Counselling the client - The practitioner should be aware of the client's resistance to change which may be related to a sense of loyalty, guilt, shame, fear of consequences or low self-esteem. Courtesy and respect for different values, trust, privacy, confidentiality and above all, acceptance of the client's informed choices are essential to the therapeutic process.

Proposed intervention options include reality testing, assisting with re-structuring the elder's environment, utilization of educational and prevention models to develop client foresight, provision of concrete assistance services as well as indirect intervention which may consist of documentation, reporting and referral to another profession or agency.

B. Counselling the identified abuser - Emphasis is put on understanding the dynamics of the abusive situation (eg. lack of information, stress on the caretaker, cycle of family violence, degree of intentionality of acts, interactional pattern and expectations between elder and identified abuser, etc.). This helps to alleviate blame and see the abuser as a person entangled in an abusive situation. Depending on assessment, several approaches are suggested:

- In situations where the abuser is involved, a plan can be developed where repeated home or office visits can be arranged to evaluate the identified abuser's functional



capabilities, clarify role expectations, reduce conflict and assist families in communication and decision making.

- An educational plan which provides information on the elder's capabilities and limitations, the process of ageing in general and/or resource counselling regarding available support services. Phases of abuse are outlined to the identified abuser (i.e. tension building → explosion or acute abuse/neglect → loving, regret, respite phase). The practitioner explains that these phases become repetitive and eventually results in an escalation in severity and frequency.

- Resource linkage with respite services.

- Monitoring for crisis - contact people should be available to help identified abusers if they feel they are getting into trouble.

Demonstrating understanding and empathy but insisting on accountability are the primary goals of the practitioner.

C. Termination - Termination should usually be discussed in the first interview and goals of termination should be realistic (eg. gradual weaning may be necessary).

Common oversights are made during intervention and the authors point out the importance of not castigating oneself since much decision-making in the area of elder abuse is still primarily based on clinical judgement.

### **Direct Assessment and Intervention with an Ecological Approach**

"We know that to treat families we have to understand the family's ecological context, including specific psychological problems of individual members and social stresses and supports" (Straus, 1988).

Dealing with a problem in an ecosystemic context, by definition, requires that the family be seen as a co-evolutionary ecosystem located in evolutionary time space. Ecosystemics oppose the truth and dualism (i.e. right and wrong) of a reductionistic way of viewing a problematic situation (Auerswald, 1987). Rather it assumes an incongruity or lack of synchrony among those who are seeking help and requires an attitude which is not value laden on the part of the practitioner. Outcomes or goals are determined by the family member(s) themselves with the help of the practitioner. "As data accumulates, clusters of similar kinds of problem definitions form, and a spontaneous system emerges that differentiates forms of distress germane to all families - to families from differing ethno-cultural and socioeconomic environments and idiosyncratically, to families who reside in the community served by the delivery system" (Auerswald, 1987, p. 236).

Due to the complex dynamics inherent in most domestic abuse/neglect situations and also the reluctance of most elders to cut themselves off entirely from their families (or family equivalent) this practicum focused on assessment and intervention within an ecological context which included working with the elders as well as family members or significant others who had identified involvement in the abusive situation, with the permission of the elder, whenever possible.

### ***Belskey's Ecological Integration of Child Maltreatment***

When tracing the development of understanding and knowledge of child abuse, certain problems emerged which parallel problems currently being seen in the study of elder abuse. One major difficulty was that much of the research with regard to etiology was conflicting.

Jay Belskey explained this dilemma by postulating that there was not likely one single factor which would explain abuse but rather a number of factors at various levels which come together at a certain point and evolve into an abusive situation. He contended that the only way of truly understanding and increasing the predictability of child abuse is through the explicit detailing of this dynamic process.

Based on this, he delineated a conceptual framework for child abuse which integrates divergent etiological viewpoints stressing the combination of psychological disturbance in parents, abuse eliciting characteristics of children, dysfunctional patterns of family, interaction, stress inducing social forces, and abuse promoting cultural values. Abuse in this context is seen as a social-psychological phenomena which is determined by intra and interrelations between four levels of analysis defined as:

- 1) ontogenic or individual development
- 2) microsystem or family system
- 3) exosystem or community system
- 4) macrosystem or larger societal, cultural system.

Etiological factors are seen as being "nested" or embedded within one another at these four levels (Belskey, 1980).

This framework can easily be applied to elder abuse and indeed may have greater explanatory and predictive power than the individual three models described earlier by Pillemer and Wolfe (1986) since many aspects of all three models in addition to other factors can be seen within Belskey's four levels of analyses.

In an attempt to illustrate this dynamic process the following example was formulated by this student for presentation to the Elder Abuse Committee at the Winnipeg Municipal Hospital:

*A middle-aged woman who was physically abused by her father (otogenic level) managed to raise her own children without abuse because of a reasonably stable economic and emotional environment (microsystem level), involvement with community support resources such as a parent's group and various recreational groups for herself, her husband and children (exosystem level). All of this occurred during the 1980's when society had been experiencing a heightened awareness and unacceptance of child abuse which prompted the development of programs and resources at all three levels to counteract its occurrence (macrosystem). However, the woman's husband dies in his mid forties and the family's economic and emotional security becomes severely threatened (microsystem). At the same time, her father, has been having some difficulty managing in the community, offers to move into her home and pay her a monthly amount sufficient to maintain the family in the home. She agrees because she needs the money but has ambivalent feelings about taking care of her father. In addition to needing*

*the money, she does feel sorry for him and guilty about the idea of not trying to help him. However she also feels resentful and angry about the way he treated her when she was a child and in need of his support. Living apart, they have maintained a civil relationship. Now they are in day to day contact with each other and he attempts to establish the same rules they lived by when she was a child. However, she rebels against his efforts to exercise control and the tension escalates within the newly formed family (or microsystem). At the same time home care is contacted (exosystem) but has only limited resources due to government cutbacks which have occurred because other social programs have been deemed more of a priority since greater value has been attached to target groups other than the elderly (macrosystem).*

The potential now exists for the evolution of an abusive or neglectful situation, not because of any one factor but because of the way in which many factors in each system level have come together at a particular point in time.

This situation is only one example which attempts to illustrate the interactive nature of abuse and at this point in time we can only speculate as to the possible explanatory power of any particular combination. Extensive testing would need to be done once the various combinations were offered as hypothesis.

### Summary

This literature review demonstrates that the study of elder abuse is still developmentally in its infancy. Definitional problems, conflicting research and a paucity of consistent and comprehensive guidelines for assessment and intervention characterize the literature at this point in time.

However, many of these problems, which at one point were identified as difficulties with the studies of both child and spouse abuse, can be ameliorated when framed in an ecological context, as exemplified by Belskey.

Consequently, this practicum, which focuses on the micro level of intervention (Hudson, 1988) will utilize an existing protocol (Tomita and Quinn, 1986) for assessment and intervention and expand upon it, using the four levels of analysis proposed by Belskey during the assessment and intervention phases.

The student acknowledges that this only represents a first step in attempting to gain a more comprehensive understanding of the problem and provide a variety of points of intervention. The challenge of developing testing methods which evaluate the explanatory and predictive power of various combinations of factors within and between each level of analysis is left to the researchers.

## **Design of the Practicum**

### **The Setting**

The setting for this practicum study was the Winnipeg Municipal Hospital which is a 340 bed geriatric rehabilitation and extended care facility including the King Edward, Princess Elizabeth, King George and Day Hospitals.

There is an inpatient and outpatient component which is serviced by the physician in charge as well as other health care professionals including nursing, occupational therapy, physiotherapy, speech therapy, pastoral care, recreational therapy, home care, dietary and social work.

The student was well oriented to this setting, having been a social worker at the Winnipeg Municipal Hospital for nearly eight years.

### **Clients**

The clients included inpatients from the King George, Princess Elizabeth and King Edward Hospitals as well as outpatients from the Day Hospital over the age of 60 years.

The definitions and indicators given earlier, served as general guidelines in determining the existence of suspected abuse/neglect. Based upon these guidelines, referrals were made to this student by any of the aforementioned disciplines with the permission of the attending physician. Those situations which had no family or

equivalent family context (eg. one time assault, robbery by a stranger) were not included since the focus of the practicum was domestic or family abuse/neglect.

Eight situations were identified as positive for abuse/ neglect over the eleven month period in which this practicum took place. Some clients required ongoing treatment following the practicum and these were referred to the appropriate sources.

### **Intervention**

There were four main factors which guided the intervention:

1. Social work is a voluntary, secondary service in this medical setting. People do not expect and in some cases, do not want to be involved in an in-depth psychosocial assessment and therapy.

2. There is no legal mandate as there is with child and spouse abuse, to investigate and work with situations which have been identified as suspected abuse/neglect. The only two exceptions to this are "spouse abuse grown old", where elder abuse is seen as a subset of general spouse abuse and situations where a person is considered incompetent and in need of legal guardianship.

3. The "secrecy" element discussed earlier makes it difficult to engage the identified victim, let alone the identified abuser. In an attempt to facilitate the engagement process,



this student found it useful to reframe elder abuse/ neglect in the context of "stressful situations which result in unmet care needs".

4. We don't know enough about elder abuse to proceed with any certainty that we are doing what is best. The only definitive premises used to guide our actions at this point are "Do no harm" and "choose the least restrictive alternative".

As discussed, intervention with patients and whenever possible, their family or equivalent family included an assessment, intervention and termination phase based on an ecological systems model.

The process of these phases can be seen in the flow chart presented in Appendix D(Fulmer and O'Malley, 1987).

### *Assessment phase*

As mentioned, the assessment was comprised of parts of the Tomita and Quinn assessment model (1986) and additional questions pertaining to all four levels of analysis as proposed by Belskey (1982). Such questions were designed to elicit information which would enable exploration of the issues discussed in the literature review with regard to the various theoretical speculations (eg. cycle of violence, role incongruencies, control issues, loyalty, etc.).

This assessment was kept by the student and a more concise and limited assessment format currently in use by the Department of Social Work was placed on the patient's

chart. In addition, progress notations based upon departmental standards were recorded in the patient's chart.

Results of the mini-mental status exam, usually completed by occupational therapy, were included in the more comprehensive assessment along with collateral information from other disciplines (eg. results of physical examination). Whenever a clinical depression was suspected, a referral was made to the appropriate source for further assessment and treatment.

It should be noted that in some situations, assessment data continued to be accumulated over the entire time in which this student was working with the client system. As suggested by Tomita and Quinn (1986), priority was given to alleviating fear and anxiety and increasing the perception of being helpful over the need to accumulate assessment data during the first few interviews. If it was thought that questions would compromise the engagement process, they were deferred until a later time when the rapport and trust between the client system and worker was amenable to further questioning. However, sufficient assessment information was usually compiled within a few sessions which would enable a diagnosis of:

1. no evidence for abuse/neglect,
2. suspicion of abuse/neglect and need for further assessment, and
3. positive for abuse/neglect.

Following this, competency was explored. There were some situations which were clear initially and remained clear. However there were others which only became clear with time as discussed below.

### *Intervention phase*

The formulation of an intervention plan was based upon which category the patient was thought to be in at any given point in time:

1. capable and consenting to treatment,
2. capable and non-consenting,
3. incapable and consenting, and
4. incapable and non-consenting.

Four situations fell into category one with one patient consenting to her own involvement but not her family's. One patient was thought to be borderline in terms of competency and was placed in category one because of the guiding principle of following the least restrictive alternative. One situation fell into category three initially, and moved to category one at a later date. Three situations fell into category four but an intervention plan was formulated because one or more family members consented to involvement with the student.

The intervention plans formulated in each situation were diverse and are explored in more detail in the next chapter. However, certain general principles and steps were applied to all of the situations:

1. The student introduced herself as a Graduate Student Social Worker who was interested in working with patients and families who were experiencing stress such that there was difficulty in meeting the elder's care needs.
2. A non-judgemental, supportive atmosphere in which the client system could reveal and discuss the occurrence of abuse/ neglect was provided.

3. Ventilation of feelings by the client system was encouraged.
4. Communication patterns which evolved into abusive/ neglectful situations were identified and discussed.
5. Education was provided which was appropriate to the situation (eg. ageing process, escalating nature of abuse/neglect, life cycle issues, etc.).
6. Options for setting goals aimed at changing abusive/ neglectful situations were explored. This aspect of intervention was particularly difficult since not all persons within the client system agreed with the manner in which the patterns required change. In fact, some members felt there was no need for change at all. In these situations, priority was given to those individuals who were committed to ameliorating the abuse situation, which interestingly enough, was not always the elder.

### ***Termination phase***

Although Tomita and Quinn (1986) suggest that termination be discussed in the first interview, this was not done since engagement frequently required 2-3 sessions and certain situations remained somewhat tenuous in their commitment throughout the course of the practicum (eg. some individuals would only commit to one meeting at a time). Consequently termination was usually introduced when the established goals were close to being met.

Once the goals were met, two situations were referred to the community worker for follow-up, as is the policy once the patient is discharged. Five situations, where the goals had been met required that the patient remain on an outpatient or inpatient program with follow-up by the attending social worker. One patient died during the course of the

practicum and one patient discharged herself against medical advise on the initiative of her son. Community follow-up was required since this family was considered at risk.

### **Evaluation**

There were two parts to the evaluation design:

*1. Evaluation of this student's skill development.*

*2. Evaluation of the intervention's impact on the client system.*

*1. Evaluation of skill development* - Since this was a practicum study, the main emphasis of evaluation was on this student's skill development.

Due to the sensitive nature of the study, a tape recorder was only used with one family where permission was granted. The other cases were discussed with the advisor with the use of a student diary. In all eight situations, the quality assurance form for the Tomita and Quinn protocol (Tomita and Quinn, 1986) was utilized. This audit was developed by Tomita, Clark, Williams and Rabbitt (1982) and can be found in Appendix G.

*2. Evaluation of intervention effects on the client system* - The only standardized scale used was the consumer satisfaction scale found in Appendix E. Due to the significant communication difficulties of many of the patients, standardized tests were not

considered to be appropriate. These difficulties were due to illiteracy, trauma and or the disease process. The reason for non-use with the families was due to the sensitive and oftentimes tenuous nature of engagement.

The three main methods of evaluating the effectiveness of the intervention were:

1. A diary which outlined the interview process and the establishment and attainment of goals.

2. Eco-maps which were used pre and post intervention. Pre intervention represented the time immediately preceding hospital admission and post intervention represented the interview which took place 6 weeks following case termination.

Eco-maps offered a quick means of visually evaluating outcomes and measuring change by comparing the pre-intervention ecomap with the post-intervention ecomap of each family system (Laird and Hartman, 1978). A copy of Laird and Hartman's ecomap can be found in Appendix F.

3. Whenever possible, a client satisfaction questionnaire was used, although the usefulness of such a tool was recognized as having limitations due to the social desirability factor.

## **The Practicum Experience**

### **Overview**

During the practicum period, this student became involved in eight situations which had either been assessed as suspicious or positive for abuse/neglect during the assessment phase (described on p. 48). There were several other situations which had been screened as possible abuse/neglect but these were either found to be negative with further assessment or the patients discharged themselves from the program shortly after admission.

The degree of involvement varied with each situation. Following is a breakdown of each client system according to age, sex, referral source and place, risk indicators identified, assessment of type of abuse/neglect, identity of family members seen and number of interviews as well as outcome at the time of a 6 week follow-up. All of the families resided locally with the exception of Mrs. E's daughter who lived in another province. Seven were caucasian and one family was native. In terms of socio-economic status, four situations could be described as middle class, middle class being defined as having additional income to the old age security pension. The other four patients were solely reliant on old age security with little or no additional savings or income from other sources.

Just prior to hospitalization, three patients were living with their children, four were living with spouses (one of whom had a grandson who lived across the street and stayed with the family at least 4 days a week), and one patient lived alone.

TABLE 1

Breakdown of Client Group

<u>Age</u>	<u>Sex</u>	<u>Referral source and place</u>	<u>Risk indicators identified upon referral</u>	<u>Assessment of Type of Abuse/Neglect</u>	<u>Identity of family members seen &amp; no. of interviews</u>	<u>Outcome at case termination (at 6 wk. follow-up interview)</u>
A 80	F	physician in Geriatric Medicine inpatient	malnutrition; emaciation; poor hygiene and clothing; and pt. not allowed out of bedroom; pt. showing apathy re decision making; pt. very weepy and anxious; no money for expenses	physical/psycho-social neglect; financial abuse	pt. - 16 sessions - alone dtr. - 1 phone conversation pt. & dtr. not seen together	- no evidence of physical/psycho-social neglect; financial neglect continuing - monitoring system in place
B 71	F	ward social worker in discussions with nursing from General Medicine inpatient	malnutrition; mismanagement of pts. medication; observed shouting between pt. & dtr.; burns to pts. hair, hands and clothing	physical/psycho-social abuse and neglect, financial abuse	pt. - 5 sessions - alone dtr. - 8 sessions - alone pt. & dtr. - 5 sessions pt., dtr, & pts. sister - 2 sessions pt., dtr. & dtrs. fiancé - 1 session	- no evidence of physical/psycho-social abuse and neglect or financial abuse - monitoring system in place



<u>Age</u>	<u>Sex</u>	<u>Referral source and place</u>	<u>Risk indicators identified upon referral</u>	<u>Assessment of Type of Abuse/Neglect</u>	<u>members seen &amp; no. of interviews</u>	<u>termination (at 6 wk. follow-up interview)</u>
C 80	M	ward social worker in general medicine	threats of abandonment of pt. by grandson; grandson admitted to hitting pt. when frustrated; observed high stress levels between pt. & wife & pt. & grandson	physical/psycho-social abuse	pt. - 2 sessions - alone wife - 6 sessions - alone wife & grandson - 4 sessions pt., wife, grandson & grandson's wife - 3 sessions	- signs of escalation which may lead to physical/psycho-social abuse - Family not agreeable to treatment, but monitoring system in place
D 67	F	nursing and physiotherapy in general medicine inpatient	observed "rough handling" of pt. by son; smell of alcohol on son; lack of supervision & safety requirements on the part of son	physical abuse/neglect	pt. - 4 sessions - alone with interpreter son - 5 sessions - alone pt. & son - 1 session	- evidence that physical abuse/neglect may be occurring - Family not agreeable to treatment - monitoring system in place

<u>Age</u>	<u>Sex</u>	<u>Referral source and place</u>	<u>Risk indicators identified upon referral</u>	<u>Assessment of Type of Abuse/Neglect</u>	<u>Identity of family members seen &amp; no. of interviews</u>	<u>Outcome at case termination (at 6 wk. follow-up interview)</u>
E 82	F	ward social worker in discussion with patient - dtr. General medicine inpatient	Call to Social Worker from pts. dtr. expressing concern. In the beginning there were no other indicators present. Several wks. after admission other indicators emerged (as described under Family "E")	physical abuse/neglect psycho-social abuse/ neglect, financial abuse	pt. - 2 sessions - alone husband - 6 sessions - alone dtr. - 7 long distance calls - 1 session in person	- no evidence of physical abuse/ neglect; psycho- social abuse/neglect or financial abuse - monitoring system in place
F 74	F	nursing from Respiratory unit inpatient	pt. ambivalent about returning home (unlike past behavior); pt. expressing anger re theft of rings and money by dtr.	physical abuse/neglec financial abuse, psycho-social abuse/ neglect	pt. - 12 sessions - alone husband - 2 sessions - alone pt. & husband - 5 sessions	- patient deceased
3 85	F	physician from Day Hospital	pt. directly expressing abuse by her husband	physical psycho- social & financial abuse	pt. - 14 sessions - alone husband & other family never seen	- no evidence of physical abuse or financial abuse - amelioration of psycho-social abuse - monitoring system in place

<u>Age</u>	<u>Sex</u>	<u>Referral source and place</u>	<u>Risk indicators identified upon referral</u>	<u>Assessment of Type of Abuse/Neglect</u>	<u>Identity of family members seen &amp; no. of interviews</u>	<u>Outcome at case termination (at 6 wk. follow-up interview)</u>
H 78	F	nursing and occupational therapy from Day Hospital	pt. directly expressing abuse by her son and daughter-in-law	physical, psycho-social & financial abuse	pt. - 9 sessions - alone son - 1 phone conversation family never seen together	- no evidence of physical, psycho-social or financial abuse - monitoring system in place

**FAMILY CASE STUDIES**

## FAMILY CASE STUDIES

### Family "A"

#### *Referral Information:*

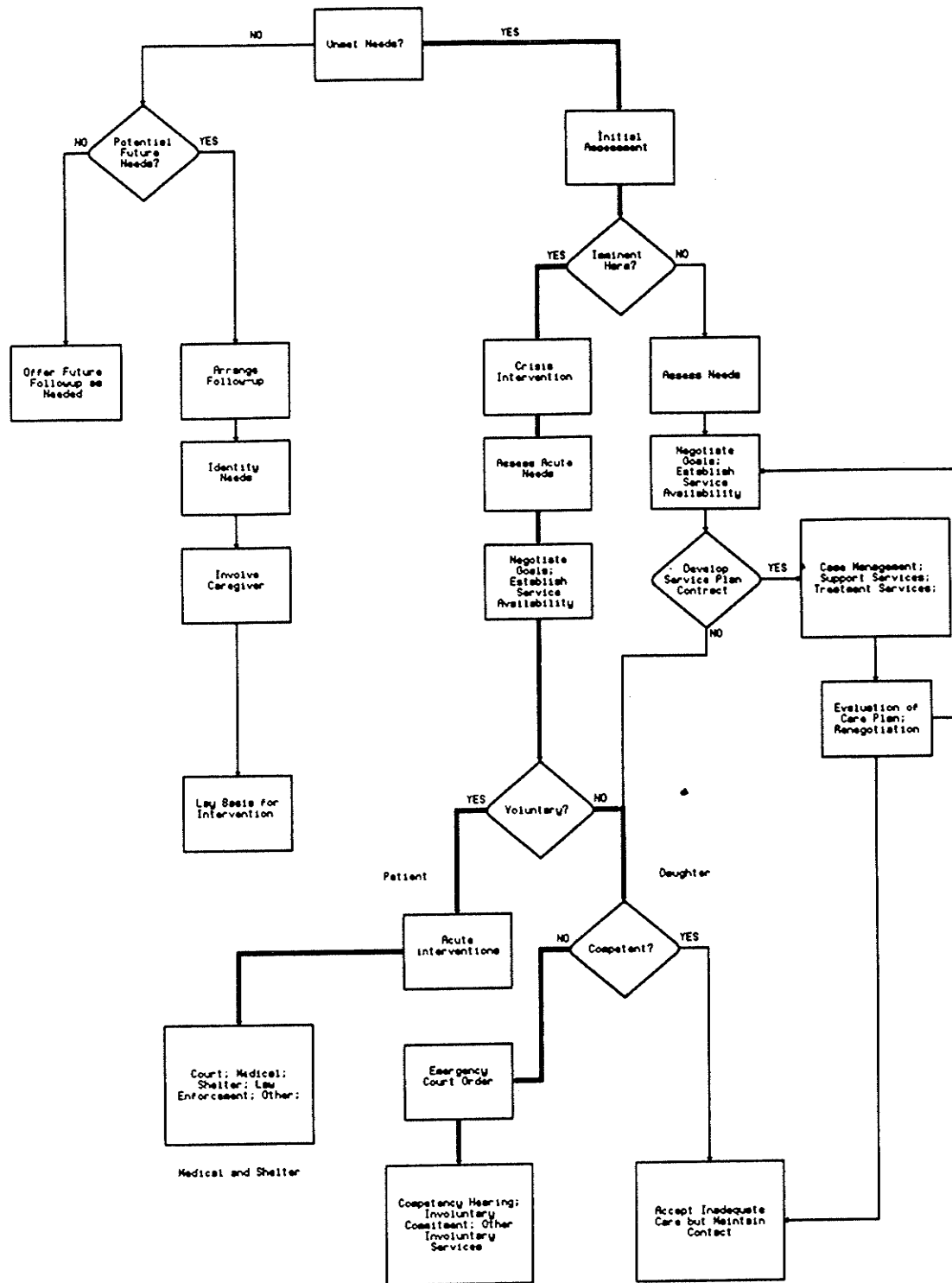
An inpatient referral was made to this student by the attending physician in September 1988 for suspected physical and psycho-social neglect with possible financial abuse as well.

The reason for Mrs. A's hospital admission was listed as "back pain, emaciation and anxious depression". Two previous inpatient referrals to Social Work were noted in June 1985 and September 1986 for assessment of the home situation due to high stress levels observed between the patient and her daughter. Both of these admissions were precipitated by falls resulting in a fractured hip and femur, respectively.

The course of family A's involvement with this student is illustrated in the flow chart and detailed under the headings of assessment, intervention and evaluation phases, all of which took place in the months between September 1988 and June 1989.

Involvement primarily included Mrs. A although there was some contact with her brother and sister-in-law. Attempts were made to engage her daughter but there was only one brief telephone contact between this student and Mrs. A's daughter.

# Figure 1: Family "A"



***Assessment Phase:***

*Patient's perspective* - Having been born and raised in Winnipeg with one older brother, Mrs. A denied any history of abuse in her family of origin. She also denied abuse within her marriage or toward her only daughter who at the time of the assessment was 55 years old, living with her and was diagnosed as a schizophrenic. Mr. A died in 1981 and Mrs. A reported that it was at this point the stress between she and her daughter began to escalate.

Until this admission, Mrs. A believed she could handle the situation but the following recent events had changed her mind:

- The daughter discontinued her medication and began experiencing delusions, hallucinations and suicidal thoughts.

- The daughter's auditory hallucinations dictated certain rituals. These included no touching between mother and daughter, no use of toilets or taps except for obsessive cleansing of the daughter's hands (urine and faeces remained on the floor). Mrs. A was not permitted to leave her room, cook or eat. Contact with the outside world was not allowed except when permission was granted by the voices.

*Daughter's perspective* - Attempts to contact the daughter were unsuccessful since she would not open the door or answer the phone (except on the signal that her mother was calling). On one occasion the daughter contacted the student by phone and effusively described her frustration and exhaustion which she attributed to the demands of her mother and "others" the voices). Realizing the tenuous nature of the conversation, attempts were made to provide empathy

as well as the opportunity to elaborate on her stress, but nonetheless, engagement was unsuccessful. Following her intense ventilation, the daughter quickly terminated the phone call.

*Collateral information* - Mrs. A's brother and sister-in-law became concerned when communication to them was cut off by the daughter and consequently contacted the Friends of the Schizophrenic Society. At the same time, the family doctor who was familiar with the family dynamics, became concerned and initiated admission arrangements for Mrs. A.

*Student's perspective* - The assessment provided a positive diagnosis for abuse/neglect and initial engagement was successful with part of the client system, namely Mrs. A who appeared to be in a greater state of crisis than noted in previous admissions. However, in interviewing Mrs. A, there was also the presence of a strong bond of family loyalty and a great deal of guilt at being, as she described "an ineffective parent". It was therefore anticipated that after the initial disclosure and with some time away from the situation, Mrs. A would begin to experience a sense of betrayal to her daughter and attempt to disengage from the intervention process. This hypothesis was actually tested out when the ward physician took a concerned, protective approach toward Mrs. A while admonishing the daughter for her treatment of Mrs. A. Mrs. A responded by defending her daughter and subsequently avoiding contact with the doctor.

It was therefore necessary for Mrs. A to perceive the student as wanting to be helpful to both Mrs. A and her daughter and at the same time support Mrs. A's expressions of fear and anger toward her daughter.



Based on this assessment, Mrs. A had two main goals. The first was to ensure her own health and sense of well being and the second was to maintain a relationship with her daughter and promote the daughter's well-being. She had come to the point of realizing that neither would be accomplished by giving up all control and power to the daughter. The daughter's judgement was impaired by a disease process which was ultimately threatening the well-being of both women.

The student's goal was to help Mrs. A explore methods by which she could achieve her goals. In the process, Mrs. A would need to feel empowered with regard to decision making and parenting.

***Intervention Phase:***

Mrs. A. clearly fell into the category of capable and consenting to treatment. A mini-mental status exam was not required although she was seen by a physician for treatment of depression during the course of the intervention which included:

1. Provision of shelter in hospital beyond completion of her physical treatment.
2. Opportunity for ventilation of Mrs. A's fear and anger toward her daughter and her deceased husband.
3. Facilitation of Mrs. A's insight into the destructive nature of the dynamics between she and her daughter and the escalation process.
4. Establishment of specific aspects of their communication which she wanted to change. Mrs. A felt that the relationship would always be tumultuous

but she wanted the life-threatening events to cease. Also, she did not want to pursue the financial aspect of abuse.

5. Exploration of methods by which Mrs. A's goals could be achieved. Through a reframing process, Mrs. A eventually concluded that she would be more helpful to her daughter and herself by going against her daughter's wishes and soliciting psychiatric assistance for the daughter. With the assistance of this student and the physician, Mrs. A completed a list of her daughter's behaviour which was then forwarded to the Provincial Psychiatrist for consideration of an involuntary psychiatric assessment. She also advised her daughter that she would be discharged from hospital to a guest home until the psychiatrist considered it advisable for her to return home. Over the next 3 - 4 months, the daughter was seen by a psychiatrist but continued to make threats and pleas which in turn made Mrs. A question her decisions. However, despite her periodic ambivalences she continued to follow through with her chosen plan of action.

6. Development of a support network which included Mrs. A's brother and sister-in-law, the guest home proprietor, peer support through the Friends of the Schizophrenic Society and home care involvement.

***Evaluation Phase:***

Instruments used in determining the effectiveness of the intervention were eco-maps pre and post intervention and the completion of a client satisfaction questionnaire at a six week follow-up visit with Mrs. A.

The eco-maps (figure 2 and 3) illustrate changes at a variety of levels. At the exosystem level, there was a significant increase in social supports which was

considered to be particularly important due to the fact that Mrs. A intended to eventually return to a situation which would always be precarious. It was hoped that an ongoing monitoring system would be able to pick up on early signs of an escalation process and intervene before it became too dangerous. At the micro system level, there were changes in the mother-daughter relationship such that the tension was decreased and the life-threatening acts eliminated. At Mrs. A's insistence the financial aspects were not addressed. These relationship changes occurred once Mrs. A made some changes at the otogenic level, increasing her self-esteem and sense of control. There was a marked improvement in Mrs. A's physical and psychological frailty as noted by all staff.

The consumer satisfaction questionnaire completed by Mrs. A reflected a high degree of satisfaction with the service provided. She expressed the wish, however, that the options available were not so limited and painful.





**Family "B"*****Referral Information:***

An inpatient referral was made to this student by the ward social worker following a discussion with nursing in November 1988 for suspected physical abuse and neglect due to poor health status (poor nutritional status, mismanagement of medication to control seizures) and high stress levels observed between the patient and her youngest daughter (crying and yelling at one another). Burns to clothing, hair and hands were also noted by nursing.

The reason for Mrs. B's hospital admission was listed as "total left hip replacement, history of alcohol abuse with signs of Korsakoff's dementia".

The course of family B's involvement with this student is illustrated in the flow chart and detailed under the headings of assessment, intervention and evaluation phases, all of which took place in the eight month period between November 1988 and July 1989.

Involvement primarily included Mrs. B and her youngest daughter (separately and together), some contact with Mrs. B's sister and Mrs. B's daughter's fiancé.



***Assessment Phase:***

*Patient's perspective* - Mrs. B was born and raised in rural Manitoba along with her younger sister. She denied any history of abuse/neglect in her family of origin. However, during episodes of disorientation, she was observed to be pleading with her mother and father to stop hurting her. She also denied abuse/neglect from either of her two husbands who had predeceased her, or toward any of her three children. Mrs. B denied any problems in her relationship with her youngest daughter, adamantly stating that she wanted to leave the hospital as soon as possible and return home to live with the daughter.

*Daughter's perspective* - The youngest daughter, aged 25, presented as very anxious, stressed and eager to discuss her situation. She admitted to having been neglected and hit by her mother as a child. More recently she stated that the tension between she and her mother had escalated to the point of mutual verbal abuse and some hitting and pushing. Apparently on one occasion, the daughter had misdirected her anger toward the family cat in a physically abusive manner. After this episode she realized that the situation between she and her mother was becoming increasingly more destructive. She then attempted to de-escalate the emotional outbursts by leaving the home for short periods of time. However, because of Mrs. B's careless smoking habits, and propensity to mismanage her medications, she would either burn herself or suffer injuries during seizures while the daughter was away. The daughter felt trapped in a situation with no apparent resolve. If she stayed with her mother, she might seriously abuse her. If she left her mother alone, her mother might seriously injure herself.



The daughter also stated that Mrs. B's relationship with all her children had been characterized by conflict due to the alcohol abuse and the aggressive behaviour which accompanied it. In 1982 her two eldest children initiated proceedings for an order of supervision which was granted. Mrs. B then requested the assistance of her youngest daughter, who was eighteen at the time, in rescinding the order and providing part-time care to Mrs. B. In return, Mrs. B agreed to stop drinking and provide free room and board to the daughter in her home. Since the daughter needed help financially and because she felt sorry for her mother, she agreed. While the relationship was volatile, the daughter did not consider it to be abusive until recently with the decline of Mrs. B's physical and cognitive abilities. Apparently arguments would ensue regarding proper management of medication, smoking practices and a host of other issues. Further strain was added when the daughter became engaged.

*Collateral information* - Mrs. B's sister attended two sessions with the daughter in an attempt to provide support and to assist the daughter in seeing that she was overextending herself for her mother at the expense of her own well-being and happiness. The sister considered that Mrs. B was demanding and unrealistic in her expectations of her daughter. She also felt that Mrs. B used guilt to manipulate the daughter into neglecting her own needs in order to meet Mrs. B's needs.

In addition, the ward staff observed angry verbal outbursts between Mrs. B and her daughter during most visits.

*Student's perspective* - The assessment provided a positive diagnosis for abuse and neglect and engagement was successful with part of the client system, namely Mrs. B's daughter. Severe memory and orientation problems as well as cognitive deficits made the engagement of Mrs. B in an intervention plan an impossible task.

Several elements appeared to contribute to the evolution of abuse/neglect in this situation. These included transgenerational patterns of violence and neglect, Mrs. B's declining physical and cognitive abilities resulting in her increased dependency on her daughter during a time when the daughter was attempting to separate from her family of origin, and a limited understanding of disease and the aging process on the part of the daughter.

The daughter's goal was to prevent the situation from becoming worse and ensure the well-being of both women. However, she was convinced that the well-being of one of them would need to be sacrificed for the enhancement of the other's well-being.

The student's goal was to assist the daughter in finding some compromise to meeting her own needs as well as her mothers.

***Intervention Phase:***

Mrs. B clearly fell into the category of incapable and non-consenting to treatment. Her mini-mental status score was low and during her hospitalization an order of supervision was issued and the Public Trustee appointed as her guardian.

Intervention with Mrs. B was limited. She was seen regularly by this student, provided with support, apprised of changing events and when appropriate, her involvement was solicited in some aspects of decision making. She could only relate in a concrete manner and was unable to appreciate details. However much of her fear and anger could be dissipated when she perceived a situation to have an amicable ambience, even if it was only a temporary experience due to her memory problems. Consequently every attempt was made to relieve her anxiety by providing concrete and comforting experiences. For example, meetings were arranged between the public trustee representative and Mrs. B in order that a relationship be established. Also, Mrs. B was taken to several personal care homes by her daughter to meet the staff and see the rooms. Her reaction was monitored and served as a guide for the daughter in her decision regarding the choice of home.

Intervention with the daughter was more involved and included:

1. Provision of shelter for Mrs. B - several discussions were held with the attending physician who initially planned to discharge Mrs. B back home since this was what she repeatedly requested. These discussions included the daughter, Mrs. B's sister, nursing and therapy staff as well as the home care co-ordinator and this student. Once the physician realized the high risk nature of the situation he agreed to keep Mrs. B in hospital until an appropriate plan could be formulated.
2. The opportunity for ventilation was provided to Mrs. B's daughter who initially could see no resolve to her situation.

3. The focus of subsequent sessions became the facilitation of insight into the mutual web of dependency established between Mrs. B and her daughter as well as developmental issues, the aging and disease process and the escalating nature of abuse.

4. The establishment of short and long term plans was attempted by Mrs. B's daughter. The short term plan involved Mrs. B returning to live with her daughter and sister for 1 or 2 years during which time an application for nursing home would be processed. Home care support would also be provided during this time. Once Mrs. B was placed in nursing home the daughter would follow through with the long term plan of marrying her fiancé.

5. Re-evaluation of this plan took place when Mrs. B's sister decided that she could not be involved in providing care due to her own health problems and Mrs. B refused to consider home care help and nursing home placement. During several very painful and distressing sessions, the daughter decided to turn the responsibility of guardianship over to the Public Trustee and marry her fiancé who had recently been offered a job out of province.

6. Since this re-evaluation took place toward the end of the practicum, a referral was made to the Interfaith Pastoral Care Institute for ongoing support and counselling to assist Mrs. B's daughter in coming to terms with her decision.

***Evaluation Phase:***

Instruments used in determining the effectiveness of the intervention were eco-maps pre and post intervention and the completion of a client satisfaction questionnaire at a six week follow-up session with Mrs. B's daughter.

Observations by ward staff regarding the changed interaction between Mrs. B and her daughter were also considered to be a relevant form of evaluation.

The eco-maps (figures 5 & 6) illustrate major changes to the family's entire ecological system such that all physical and psycho-social acts of abuse/neglect were eliminated. Significant changes at the otogenic level were noted as a result of the daughter's increased insight into the pattern of communication between she and her mother, life cycle issues as well as the aging and disease process. Reverberations of this could be seen at the microsystem level since the daughter's approach to her mother became more calm and understanding and this resulted in a notable de-escalation of anger between the women during hospital visits. At the exosystem level, the isolation of both women was alleviated with input from hospital staff, the Interfaith Pastoral Institute, a visiting chaplain student and the Public Trustee. In addition, Mrs. B's other children began visiting more regularly.

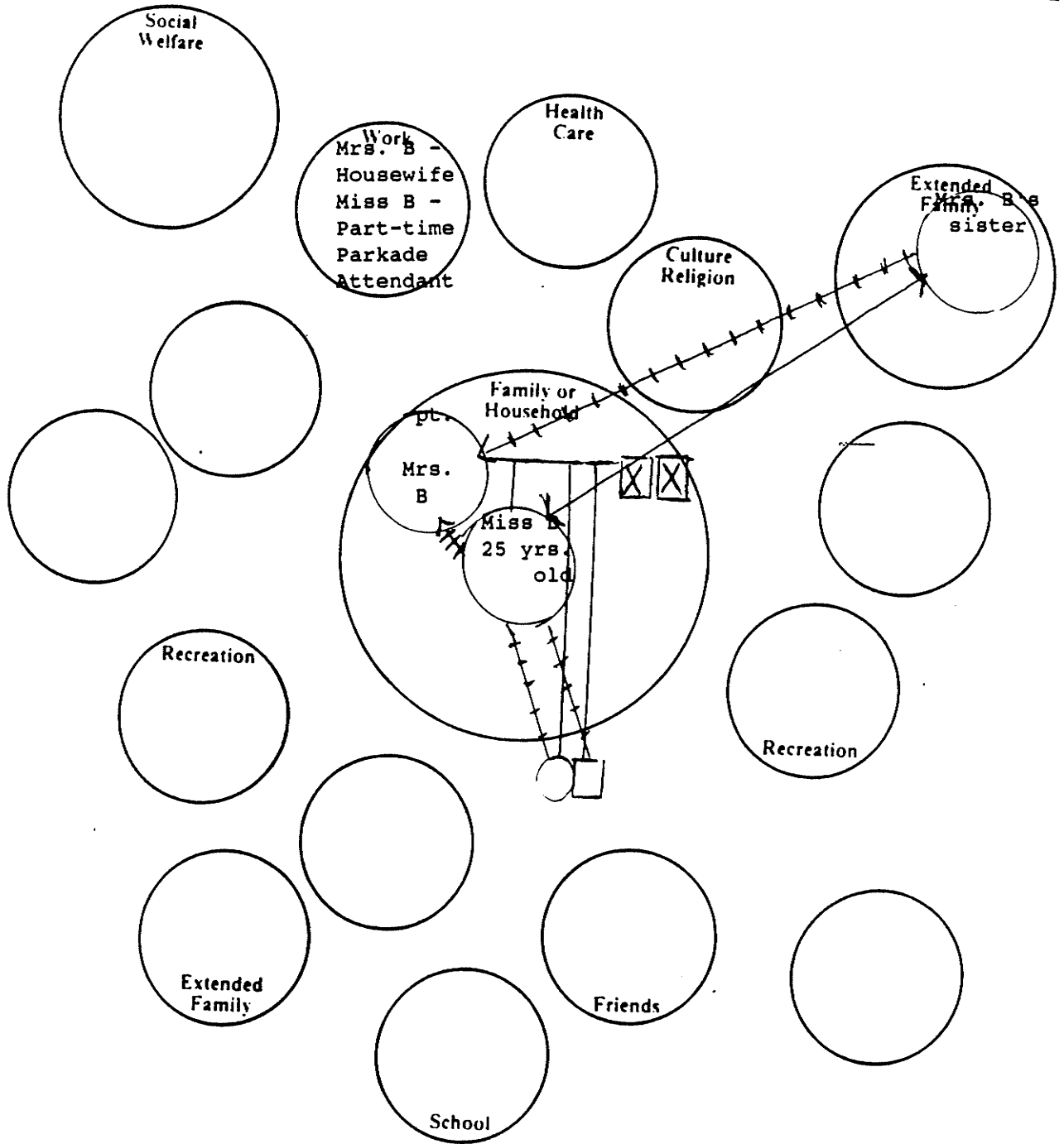
The consumer satisfaction questionnaire which was completed by the daughter reflected a high degree of satisfaction with the service provided. Additional comments included her appreciation at being treated with respect and concern while discussing some very uncomfortable and unpleasant issues.

# Eco-Map

Figure 5

Family "B"

Name Nov. 89  
Date pre-intervention



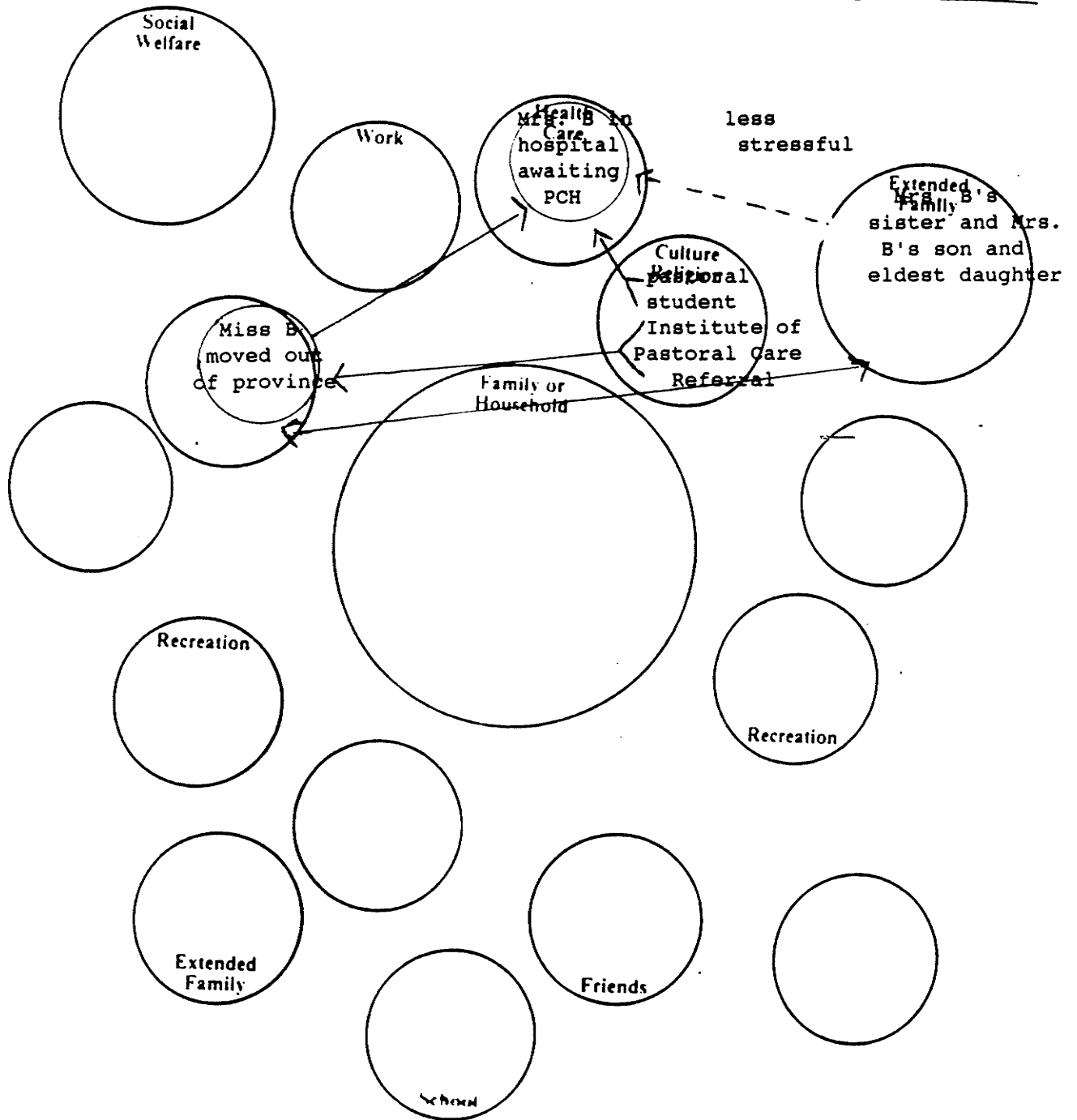
Fill in connections where they exist.  
 Indicate nature of connections with a descriptive word or by drawing different kinds of lines:  
 \_\_\_\_\_ for strong. - - - - - for tenuous. + + + + + for stressful.  
 Draw arrows along lines to signify flow of energy, resources, etc. → → →  
 Identify significant people and fill in empty circles as needed.

Eco-Map

Figure 6

Family "B"

Name July 90  
Date post-intervention



Fill in connections where they exist.  
 Indicate nature of connections with a descriptive word or by use of different kinds of lines:  
 \_\_\_\_\_ for strong, - - - - - for tenuous, + + + + + for stressful  
 Draw arrows along lines to signify flow of energy, resources, etc. → → →  
 Identify significant people and fill in empty circles as needed

**Family "C"*****Referral Information:***

An inpatient referral was made to this student by the ward social worker in December 1988 for physical abuse and neglect. During a routine social work assessment with the family, the grandson told the social worker that he sometimes hit his grandfather when he became frustrated or angry.

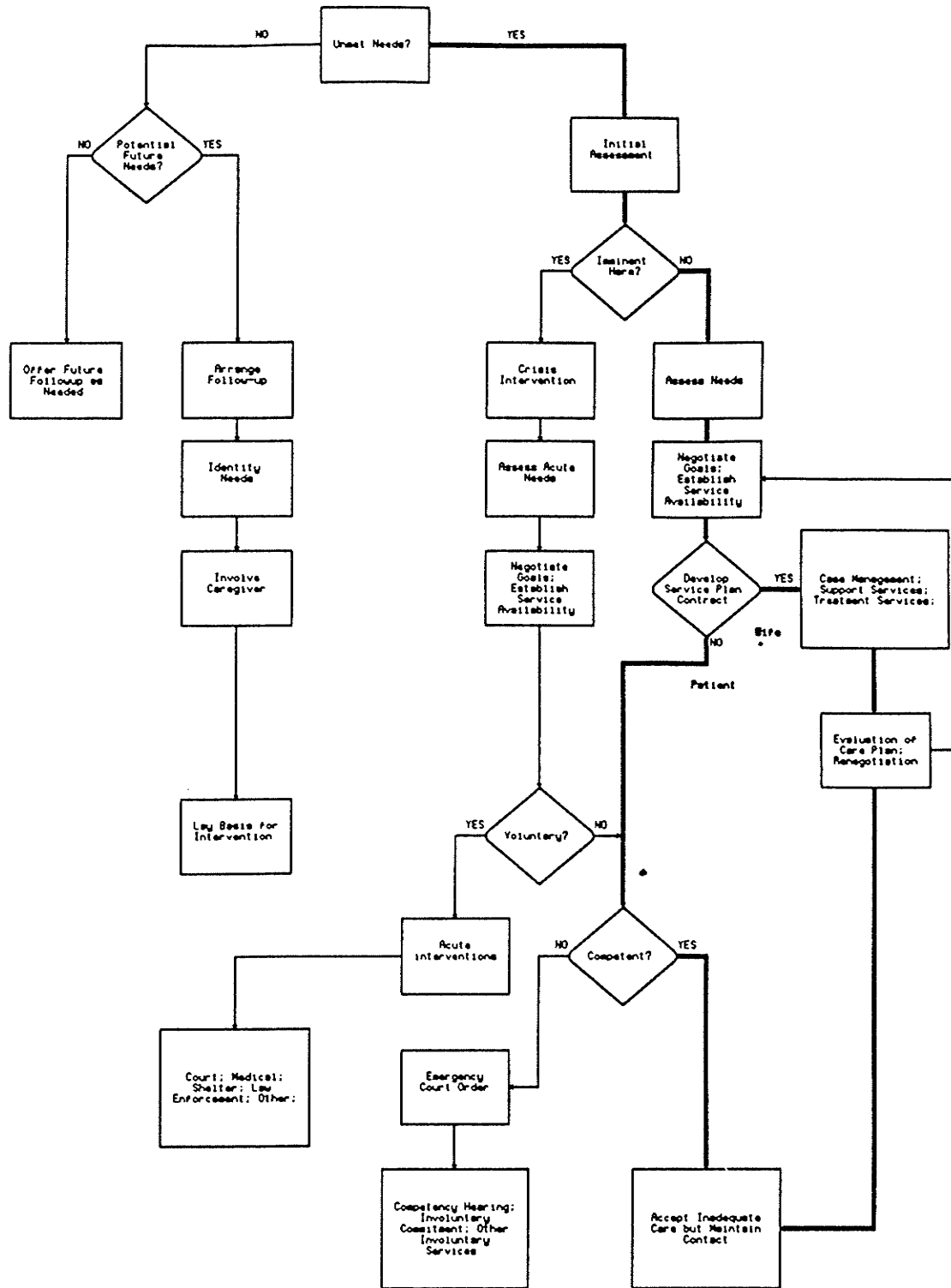
The reason for Mr. C's hospital admission was listed as "collapsed lung, anaemia and long standing history of ethanol abuse". During his hospital stay, Mr. C also suffered a minor C.V.A., commonly known as a transient ischemic attack or T.I.A.

The course of family C's involvement with this student is illustrated in the flow chart and detailed under the headings of assessment, intervention and evaluation phases, all of which took place in the six month period from December 1988 to June 1989.

Involvement primarily included Mr. C's wife, although Mr. C consented to some involvement toward the end as did the grandson.



Figure 7: Family "C"



***Assessment Phase:***

*Patient's perspective* - It was difficult to obtain a history from Mr. C due to a severe hearing impairment and memory problems.

Mr. C was born and raised in Winnipeg. He had two daughters and one son from a previous marriage with whom there had been minimal contact over the years. The present Mrs. C and patient had two daughters and also raised the son of the youngest daughter. Mr. C stated that he had been retired for about 20 years from a labourer's position at a factory.

Mr. C denied any problems with alcohol or stress within the family and minimized the grandson's admission that he hit Mr. C when he became frustrated or angry. Mr. C's only concern was that his wife might not want him home again, emphasizing that she could be very difficult at times for no particular reason.

*Mrs. C's perspective* - Initially Mrs. C presented as very stressed and eager to discuss the problems in the family. She stated that her husband had been an alcoholic since the beginning of their relationship and that he had physically abused her and the children on several occasions while intoxicated. She had initiated a legal separation several times but never followed through because of religious convictions and a sense of family loyalty. After her initial disclosure, she became less emphatic, stating that the drinking was no longer a major problem because he simply passed out now rather than becoming aggressive. She agreed that the drinking was actually serving a de-escalating function at this point. She

did, however, continue to express concern regarding a possible discharge home.

Her reasons were:

- Their 2 room shack had no working plumbing and was in deplorable condition.

- Her own declining health compromised her ability to meet his care needs.

- Taking care of Mr. C would jeopardize her ability to care for other family members such as the grandson who was of borderline intelligence and given to emotional rages when put under stress. The grandson was married with no children and lived across the street from Mr. and Mrs. C. Since he did not have a job, he spent a great deal of time in the C's home. Mrs. C also provided childcare for her daughter from Tuesday night until Friday night every week. With the amount of supervision and care Mr. C required, she was concerned that she would have to give up this commitment which she stated was her "only joy in life".

*Collateral information* - Following his initial admission of hitting Mr. C, the grandson later minimized the behaviour by stating that it only happened once. The family denied involvement with any other social agency. Consequently there was no collateral information from community sources.

*Student's perspective* - The assessment provided a positive diagnosis for abuse within the family and engagement was initially successful with part of the client system, namely Mrs. C.

Family "C" seemed to have a long standing history of unresolved marital and family discord typified by acts of psycho-social and physical acts of neglect

and abuse. It appeared that Mrs. C regarded Mr. C's hospitalization as a "legitimate" opportunity to separate, the failing health of both individuals being an "acceptable" reason for a separation. As Mr. C's physical condition improved in hospital, Mrs. C's physical health declined and at one point she was nearly hospitalized.

Mrs. C's goal was to reduce her own anxiety which clearly escalated as the prospect of Mrs. C's discharge back to the community became a reality.

The student's goal was to facilitate insight into Mrs. C's behaviour which appeared to be that of a well engrained pattern of victimization and helplessness. Attempts would be made to empower Mrs. C in order that she could gain some control over her own health and decision-making with regard to the her own and the family's future. Once Mrs. C was in a position to make some decisions, the student would attempt to engage Mr. C, Mrs. C, the grandson and his wife as a family unit.

***Intervention Phase:***

Mr. C was assessed by the physician as borderline in terms of competency given a fairly low score on the mini-mental status exam. However, in keeping with the philosophy of "least restrictive alternative", he was deemed competent to make his own decisions regarding intervention and acceptance of the treatment he was receiving by his grandson.

Since Mrs. C was the only family member agreeable to intervention, weekly sessions were initially set up with her and the following plan was formulated:

1. Provision of shelter for Mr. C in hospital beyond the stay required for his physical treatment while Mrs. C attempted to make decisions regarding the extent to which she felt she could be involved in Mr. C's care. The physician agreed to keep Mr. C in hospital once he understood the high risk nature of a discharge into a family situation which was already experiencing difficulty in coping.

2. The opportunity for ventilation was provided to Mrs. C whose initial sense of helplessness was manifested in persistent attempts to solicit decision making from the student regarding her situation.

3. Subsequent sessions focused on the facilitation of insight into Mrs. C's pattern of helplessness and victimization. Details regarding her family of origin were explored as well as events in her marriage.

Despite her escalating health problems (asthma, arthritis and heart problems), Mrs. C attended the weekly sessions regularly and eventually began to see the relationship between her health problems and sense of powerlessness. Shortly thereafter her health began to improve and she became ready to explore alternatives and choices available to her.

4. Mrs. C decided to provide care to her husband under the following conditions:

- the home would be sold and the couple would move to a senior citizens' apartment
- Home Care and Day Care would be provided in order that Mrs. C continue with her babysitting arrangements with her daughter

- Mrs. C would discuss these conditions with her husband. If he did not agree, she would make plans for a move which would not include him.

Initially Mr. C refused to agree to her conditions. However, once she began making plans for herself, he changed his mind and agreed to her terms.

5. Assistance was provided by this student with the relocating arrangements as well as other practical matters such as a hearing and sight assessment for Mr. C. Weekend leaves of absence were arranged to assess the amount of home care required as well as to test out the new living arrangements.

6. A family meeting was held to discuss:

- the impact the new living arrangements had on the family stress levels.

It was anticipated that a more appropriate environment and establishment of a support network (ie. Home Care, Day Centre) would contribute to the alleviation of some of the stress. It was also anticipated that the distance between the C's and the grandson would result in a little more independence for both families and hopefully some additional reduction of stress.

- the establishment of a protection plan should the stress levels begin to escalate again.

While Mr. C continued to express dissatisfaction with the apartment, the other family members agreed that the situation had improved. All family members, including Mr. C were accepting of Home Care and Day Care once a week for Mr. C. At this point the family did not feel it necessary to discuss a protection plan. Attempts were made by the student to assist the family in visualizing possible scenarios based on past events. The response was

minimization and denial by all family members. Another opportunity for engagement on this issue presented itself at the 6 week followup and will be discussed below.

***Evaluation Phase:***

Instruments used in determining the effectiveness of the intervention were eco-maps pre and post intervention and the completion of a client satisfaction questionnaire at a six week follow-up session with Mr. and Mrs. C, the grandson and his wife.

The eco-maps (Figures 8 & 9) illustrate that the changes which took place were limited primarily to the exosystem with the move to a less stressful environment and the acceptance of home-care. Any changes Mrs. C began to make in her way of relating to her husband and family were temporary and the families interactional pattern returned to status quo quickly after the move.

All family members completed the client satisfaction questionnaire. While it had limited usefulness in terms of evaluation because of Mrs. C's confusion and the cover-up being practised by the other family members, it provided an opportunity for the student to once again try and engage the family. While completing the form the grandson became angry with Mr. C's misinterpretation of the questions, Mrs. C attempted to calm the grandson, and Mr. C became angry with his wife and started swinging his cane. The grandson's wife quietly slipped into another room. These dynamics were reflected back to the family but each member denied having any concerns and declined the offer to discuss a protection plan or be referred for counselling. The V.O.N. were apprised of the

situation and agreed to monitor.







**Family "D"*****Referral Information:***

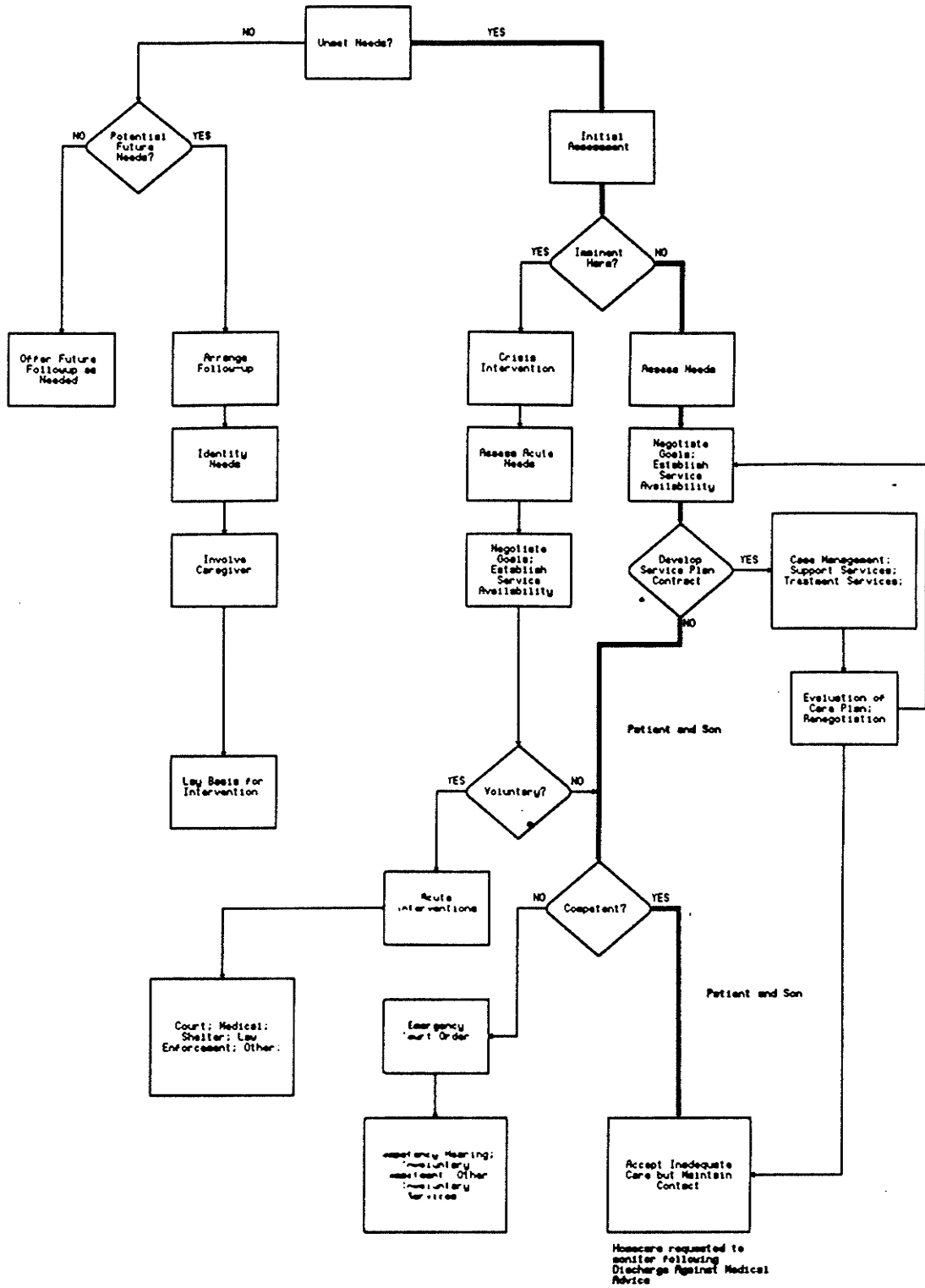
An inpatient referral was made to this student by nursing and physiotherapy in October 1988 for suspected physical abuse and neglect. The head nurse and the physiotherapist had observed "rough handling" of the patient by her son (who was in his late 40's) while he was assisting her with exercises and activities of daily living. They had also detected the smell of alcohol on the son during visits.

The reason for Mrs. D's hospital admission was listed as "left C.V.A. resulting in a right hemiplegia, emotional lability, and severe dysphasia with word comprehension and word finding difficulties (also an unreliable "yes" "no" response)".

The course of family D's involvement with this student is illustrated in the flow chart and detailed under the headings of assessment, intervention and evaluation phases, all of which took place during the seven month period from October 1988 to May 1989.

Involvement included Mrs. D and her son separately with the exception of one occasion when they were seen together. Engagement attempts were not made with Mr. D who had been disengaged from the family for many years despite the fact that he lived in the upper part of their duplex. He did not visit with Mrs. D during her hospitalization.

Figure 10: Family "D"



***Assessment Phase:***

*Patient's perspective* - Due to severe speech deficits it was not possible to illicit background information or thoughts/feelings from Mrs. D. A Polish interpreter and a speech therapist attempted to assist with the assessment of Mrs. D but with minimal success. It was therefore necessary to rely on staff observations in order to gain some insight into Mrs. D's perspective.

Mrs. D remained weepy, anxious and clearly frustrated with her limitations throughout her stay. She did however seem calmer and in better spirits when she left hospital for leaves of absence and she was able to communicate her strong desire to return home on a consistent basis.

*Son's perspective* - According to the son, Mrs. D immigrated to Canada from Poland when she was twelve years old. She worked in a factory until her marriage. Mr. and Mrs. D had only one son who had always resided in the family home. Mr. D and Mrs. D decided to separate informally about 15 years ago. Mr. D moved upstairs to their duplex and apparently there had been virtually no communication between Mr. D and his wife and son over the past 15 years.

The son presented as very stressed, anxious and guarded with all staff members. He did, however, confide that he left work as a computer consultant because of a "nervous breakdown" at the time of his mother's stroke. He was clearly having difficulty caring for himself as evidenced by his dishevelled and unkempt appearance, loss of weight, and very anxious and fatigued presentation. Later in Mrs. D's stay, staff began to smell alcohol on his breath during visits and

on a few occasions he seemed to be quite intoxicated. His denial of the situation remained as a coping mechanism throughout Mrs. D's stay. He believed that she would get better if she was pushed past her pain threshold and she appeared to be contributing to this belief as evidenced by staff during therapy classes and on the ward. Regardless of the education provided, he continued to handle Mrs. D roughly when providing physical assistance. He also insisted on having her perform painful exercises which were explained to him as being counter-therapeutic by the therapist on several occasions. Mr. D was observed to be encouraging him in this direction as well.

*Collateral information* - The family doctor was asked to provide further information. He stated that Mrs. D had been a patient for several years but he didn't know her well. It seemed that she and her son remained isolated from any kind of formal or informal community support system.

*Student's perspective* - The assessment provided a positive diagnosis for neglect and abuse although an intent to inflict pain out of resentment or anger did not seem evident. There appeared to be a belief system present of "no pain no gain". Engagement in terms of establishing a commitment for intervention was not successful with Mrs. D or her son although there was ongoing contact at the initiation of the student. Consequently, no goals were set, although the goal of engagement remained a priority for the student. An intervention plan based on this goal was formulated by the student and supported by the health care team.

***Intervention Phase:***

Assessment of capability was difficult because of Mrs. D's speech problem. However the family physician assessed her as competent to make decisions regarding choice of relationships and discharge. This meant that she was competent to accept care which was considered inadequate. Therefore Mrs. D fell into the category of capable and non-consenting to treatment. The student and all team members continued to monitor for signs that Mrs. D was afraid of her son or skeptical about leaves of absence. However no signs to this affect were noted during her stay.

Attempts were made by the student to engage the son in the following manner:

1. The opportunity was provided for the son to ventilate and discuss his concerns regarding the care of his mother. Although he admitted to feeling overwhelmed with the prospect of caring for his mother, he continued to take her on regular leaves of absence and refused assistance from home care.

2. Education was provided regarding stroke rehabilitation by all team members. However this had no effect. The son continued to practice his own style of therapy which his mother seemed to condone and he continued to believe that she would "return to normal" with the "right kind of rehabilitation program".

3. When a lump on Mrs. D's breast proved to be malignant, supportive counselling was offered to assist in making a decision regarding surgery. This was refused.

4. When Mrs. D's safety became compromised because of the son's drinking and driving to and from leaves of absence, the son was questioned by the head nurse. The result was a discharge against medical advise. Mrs. D simply did not return from a leave one day.

5. Home Care was contacted and advised that the situation was regarded as high risk. They agreed to assess. A few months later this student received a call from a social worker employed by a local Day Hospital who was preparing for an assessment interview with Mrs. D and her son. Apparently the homecare nurse was eventually permitted to visit the D's home and was successful in convincing them to be assessed by this particular Day Hospital program. The nurse specifically requested social work involvement and encouraged the social worker to contact this student for background information.

***Evaluation Phase:***

The only evaluative instrument used in the D's situation was the eco-map (Figures 11 & 12) which illustrated that the only change noted was at the exosystem level. The D's had accepted some initial involvement with a community support and although this was a tenuous relationship, it was seen as another opportunity for possible engagement.

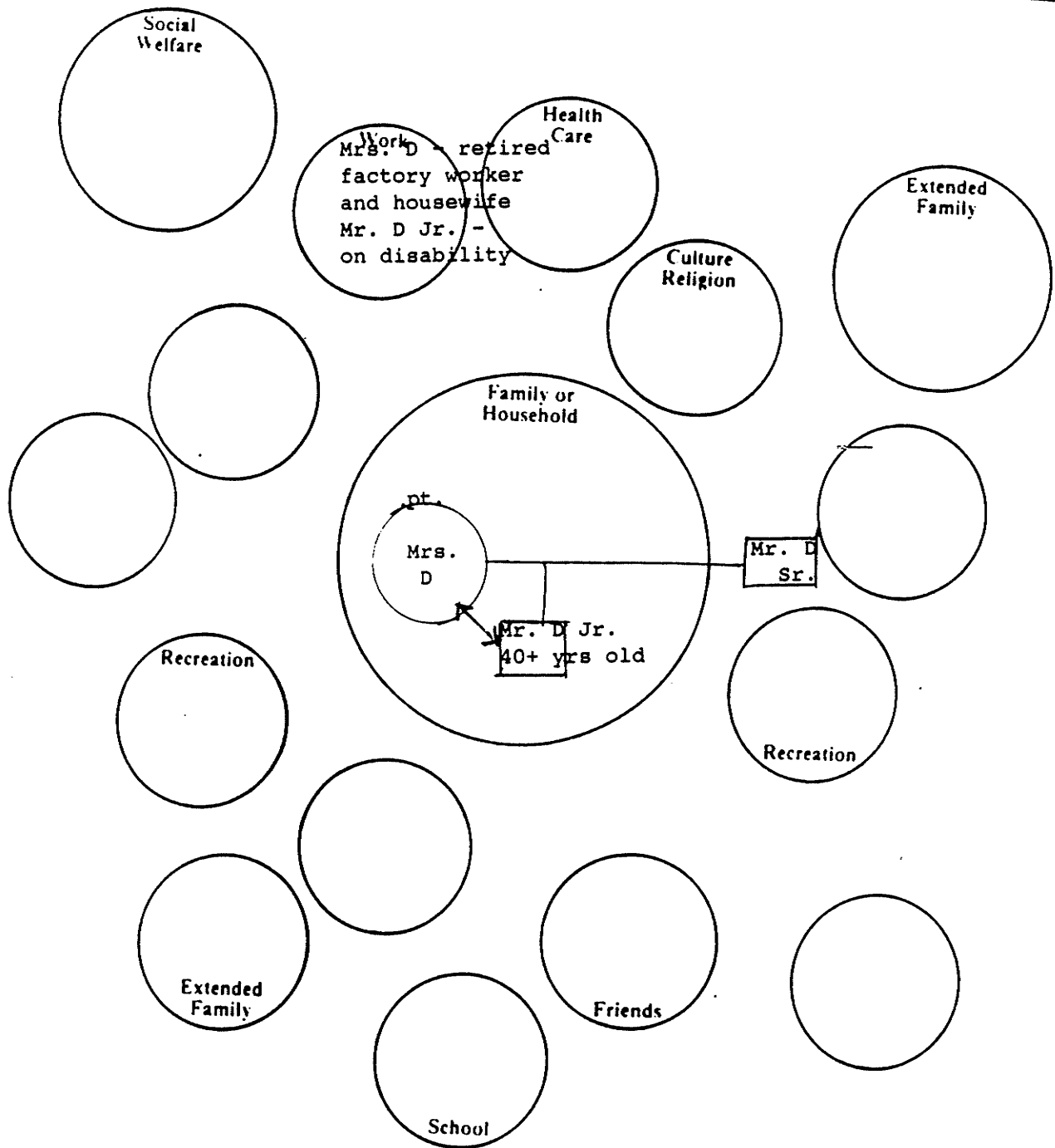


# Eco-Map

Figure 11

Family "D"

Name May 89  
Date pre-intervention



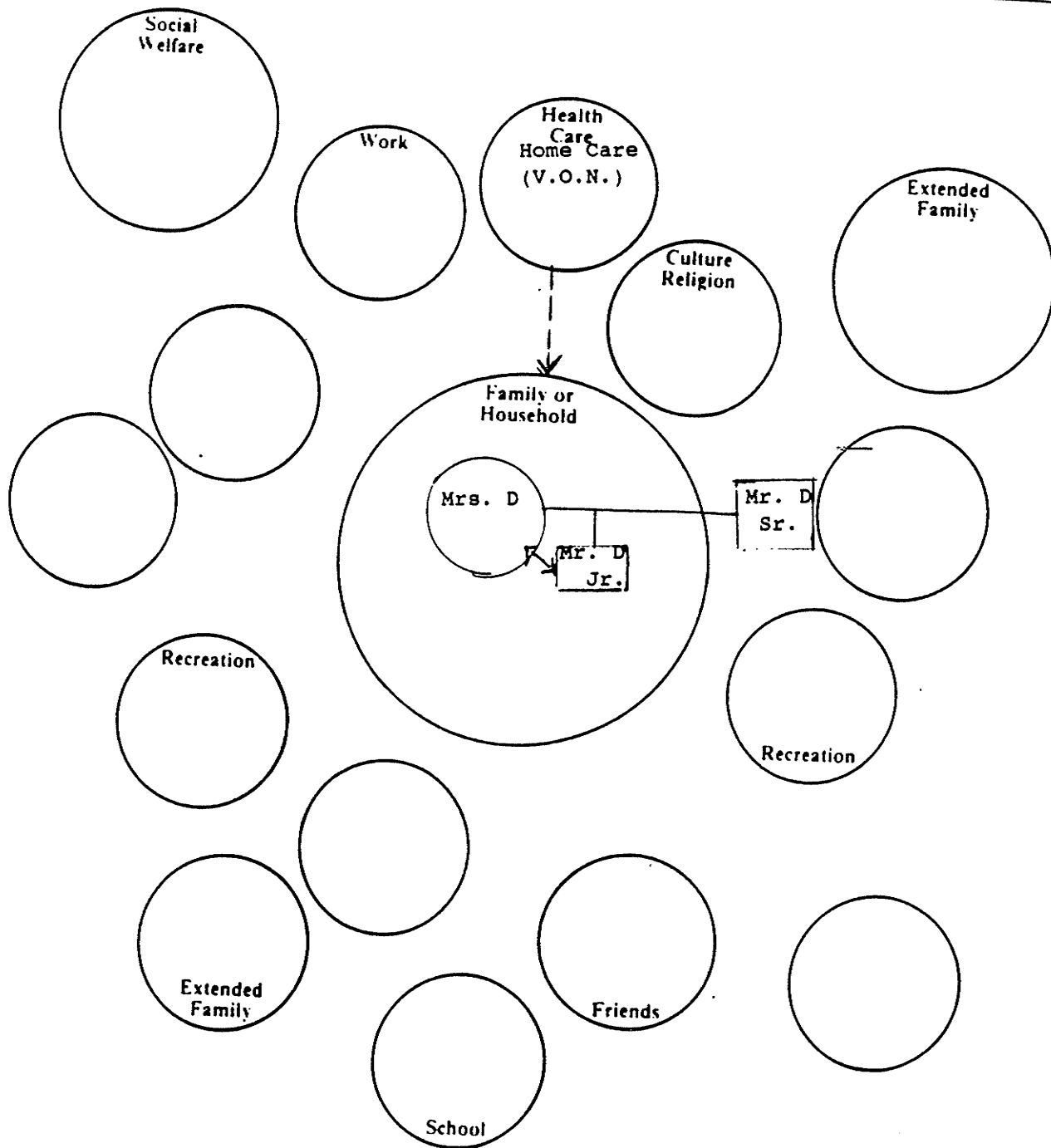
Fill in connections where they exist.  
Indicate nature of connections with a descriptive word or by drawing different kinds of lines:  
———— for strong, - - - - - for tenuous, + + + + + for stressful.  
Draw arrows along lines to signify flow of energy, resources, etc. → → →  
Identify significant people and fill in empty circles as needed.

# Eco-Map

Family "D"

Figure 12

Name May 89  
Date Post-intervention



Fill in connections where they exist.  
Indicate nature of connections with a descriptive word or by drawing different kinds of lines:  
\_\_\_\_\_ for strong. ----- for tenuous. ++++++ for stressful.  
Draw arrows along lines to signify flow of energy, resources, etc. → → →  
Identify significant people and fill in empty circles as needed.

**Family "E"*****Referral Information:***

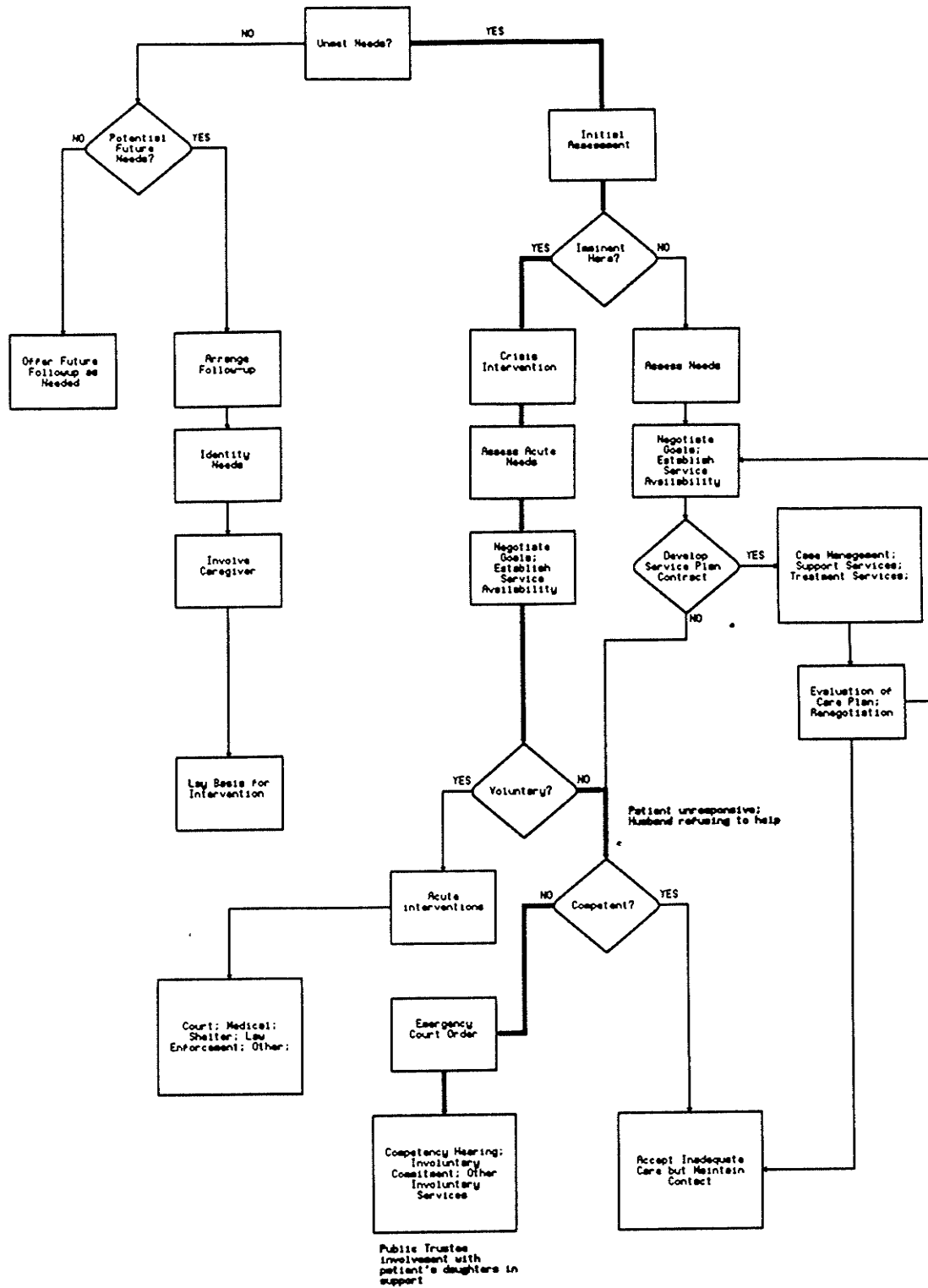
An inpatient referral was made to this student by the ward social worker in October 1988 for possible physical abuse, neglect; psycho-social abuse/neglect and financial abuse. The ward social worker had received a phone call from the patient's daughter, who lived out of province, expressing concern over Mr. E's ability to provide care to his wife.

The reason for Mrs. E's hospital admission was listed as "Alzheimer's disease and a fractured hip". The daughter suspected that Mr. E was responsible for Mrs. E's fracture although was not able to prove it since she was not at the home when the fall occurred.

The course of family E's involvement with this student is illustrated in the flow chart and detailed under the headings of assessment, intervention and evaluation phases, all of which took place during the ten month period from October 1988 to August 1989.

Involvement primarily included Mrs. E's husband and daughter in separate contacts. The daughter acted as spokesperson for herself and her sister who also lived out of province. Mrs. E was seen twice by the student.

# Figure 13: Family "E"



***Assessment Phase:***

*Patient's perspective* - Mrs. E was completely unresponsive during both visits with the student. When she was first admitted she relied on total care from staff including feeding. However after several months in hospital she began to assist with her feeding and at times would give non-verbal gestures to indicate her needs. Staff observations of the interaction between she and her husband became very important in interpreting her perspective. Mrs. E was observed to consistently turn her head away and close her eyes when her husband would visit.

*Husband's perspective* - Mr. E initially presented as a very affable man who was concerned about his wife. On several occasions he stated that he wanted her to return home following hospitalization and that he was prepared to care for her. He denied any stress associated with her care. With further questioning regarding her care needs, hostile undertones began to emerge until Mr. E stated angrily and unequivocally that Mrs. E was his wife and she would return home with him. He stated further that she had been completely well prior to hospitalization and that the physicians were responsible for her present problems. He advised that once she was able to walk he would take her home and administer a medication regime which he had read about in the Enquirer. Part of his plan involved the discontinuance of her present prescriptions, some of which included life-saving medication.

*Daughter's perspective* - The eldest daughter who lived out of province provided the greatest detail during the assessment.

Mrs. E was born in Winnipeg, married Mr. E in her late twenties and had two daughters. Abuse was apparently not a problem in Mrs. E's family of origin. Apparently Mr. E's father was a prison guard however and practised corporal punishment at home as well as at work. One of Mr. E's sisters committed suicide as a young woman.

The daughter further confided that Mr. E had struck and frequently threatened and intimidated his wife and 2 daughters with acts of violence and death. The police had intervened on several occasions but charges were not laid. The daughter considered that her mother's sense of family loyalty and her belief that she could "handle" Mr. E were the reasons for staying in the marriage. She also said there was "another side" to Mr. E which attracted Mrs. E. Apparently he could also be very kind, gentle, vulnerable and affectionate.

During the years that Mrs. E was physically well, the daughter respected her mother's desire that there be no interference but now that Mrs. E required total care, the daughter felt an obligation to protect her. She also felt a strong obligation to protect her father from himself. She saw her father as having two distinct personalities, one of which she suspected had suicidal and homicidal potential. She did not want to intervene aggressively on behalf of her mother because of fear of her father and also because she saw herself as the only person who could monitor his situation. She felt it would be in everyone's best interests to have the Public Trustee acting on her mother's behalf. This would allow her to be in a position of maintaining cordial contact with her father, and at the same time, her mother's welfare would be ensured by an experienced, objective, and

legally-sanctioned organization. When asked about other supports, she stated that her father had never maintained a friendship with anyone and he had successfully managed to isolate himself and his family from community contacts over the years.

*Collateral Information* - During Mrs. E's stay in hospital, Mr. E was admitted to an acute care facility on two occasions, with the diagnosis "emaciation, drug and alcohol overdose". He discharged himself both times, refusing any home care help. A psychiatric assessment was requested on the second admission following a discussion between this student and the home care coordinator at the acute care facility. However Mr. E left before arrangements could be made.

Also, during Mrs. E's stay and following Mr. E's first discharge from hospital, Mr. E was found trying to suffocate and choke his wife during visits. He stated that he was frustrated with her unresponsiveness to him and was trying to get her attention. Visits were subsequently supervised and threats of eviction from hospital were issued should Mr. E attempt to harm Mrs. E again. Mr. E did not appear to comprehend the gravity of his actions and angrily accused the staff of trying to interfere between him and his wife.

*Student's perspective* - This assessment clearly provided a positive diagnosis for abuse and neglect with one daughter becoming actively involved in formulating an intervention plan. The other daughter, who also lived out-of-province, supported the action taken.

Given the family history, Mrs. E's vulnerable condition and the dynamics observed between Mr. and Mrs. E, it was deemed appropriate to implement a highly protectionist plan. However, attempts were still made to involve Mr. E in the plan and an adversarial position was taken only as a last resort.

***Intervention Phase:***

Mrs. E clearly fell into the category of non-capable and non-consenting to treatment. C.T. Scans revealed significant brain atrophy.

The physician in charge considered himself to be in a dilemma since Mr. E presented so well initially and was so intent on having his wife return home. However, once the social assessment was complete and nursing provided an incident report on the two abusive incidents, he agreed not to discharge Mrs. E back to her home. The intervention began with the least adversarial and progressively moved to the most adversarial and restrictive position.

1. Attempts were made to engage Mr. E, with the hope of having him become involved in an intervention plan which would change the abusive relationship which seemed to have characterized his 40+ years of marriage. The team agreed that a non-threatening approach was required so as not to incur Mr. E's anger which he could take out on his wife. The daughters were in agreement. Attempts were made to facilitate insight into Mr. E's understanding of his wife's condition. Attempts were also made to provide an environment whereby Mr. E could talk about the grief and stress typically experienced by Alzheimer families. However, these attempts were unsuccessful. Mr. E remained convinced that Mrs. E would return to her previous level of functioning, and he adamantly stated that



there was no stress associated with her care. Further exploration of her specific care needs engendered a great deal of hostility in Mr. E (eg. commenting on Mrs. E's incontinence and the required frequency of changes, and then asking Mr. E how he managed with this at home).

2. Since Mr. E believed that his wife would walk again with daily therapy, despite contrary reports given to him by the physician and therapists, a bargain was struck between Mr. E and the team. Mrs. E would receive daily therapy for 6 wks. If she achieved her former status and expressed the desire to return home she would be discharged. If she did not, Mr. E would sign nursing home papers and use her cheque for per diem payments. It was during this six week time period that the choking and suffocating incidents took place.

3. At the end of 6 weeks there was no change in Mrs. E's status. Therefore another meeting was held during which Mr. E denied making any such agreement.

4. Mr. E was advised that an order of supervision would be requested. Initially he stated he would obtain legal services to fight the order. However, he had difficulty obtaining legal representation, and eventually decided not to follow through with this.

5. Arrangements were made for the daughter to meet the Public Trustee officer responsible for Mrs. E and plan toward nursing home placement together.

6. This case was transferred back to the ward social worker who agreed to prepare a report for the nursing home staff once the choice of home was known.

***Evaluation Phase:***

Instruments used in determining the effectiveness of the intervention were eco-maps pre and post intervention and the completion of a client satisfaction questionnaire by the daughter.

The eco-maps (Figures 14 & 15) illustrate changes to the exosystem which affected the micro-system to the extent that all abuse and neglect of Mrs. E ceased. However Mr. E remained a threat to himself.

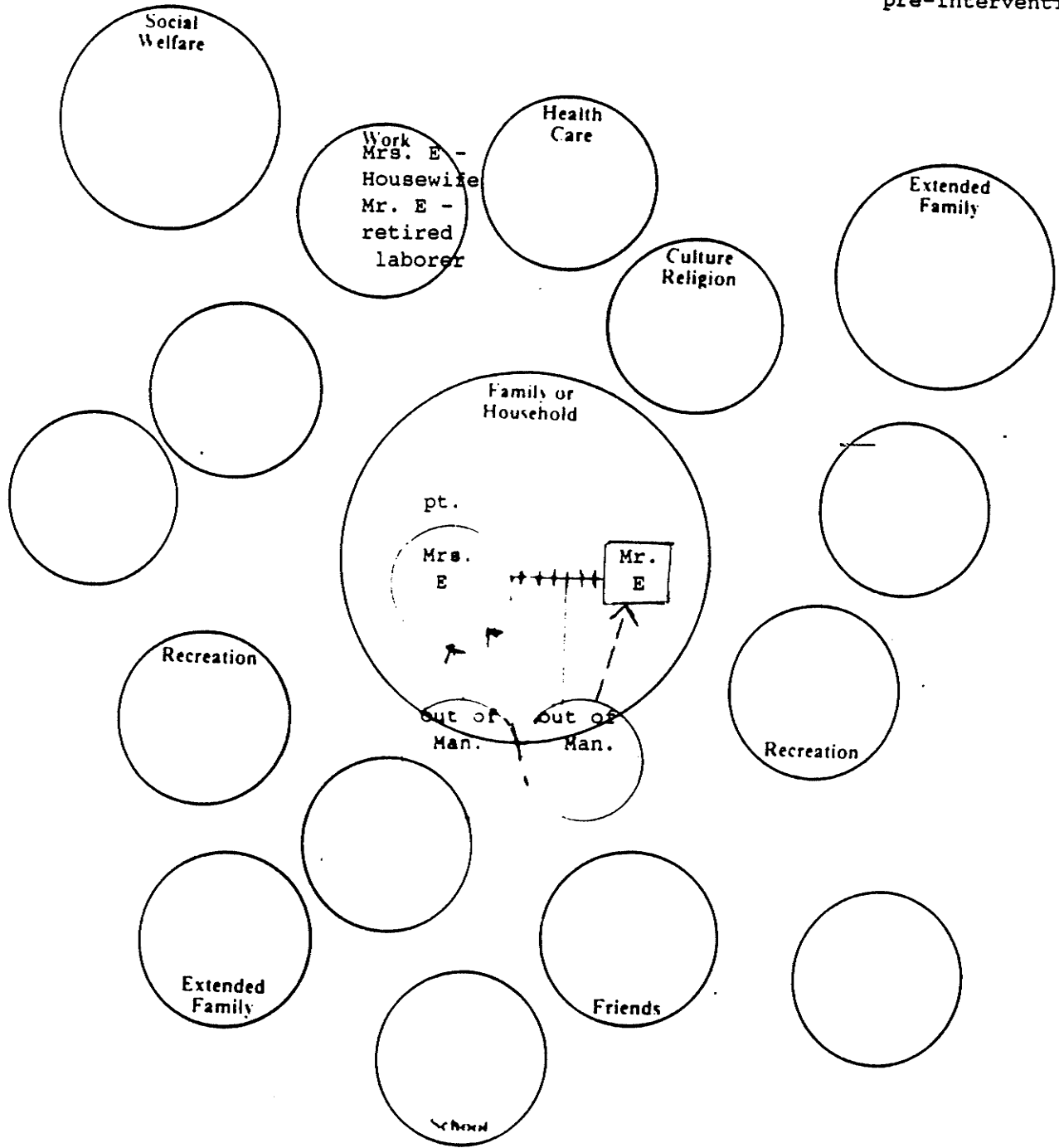
The client satisfaction questionnaire reflected the daughter's satisfaction with the service provided.

# Eco-Map

Figure 14

Family "E"

Name \_\_\_\_\_  
Date October 88  
Date pre-intervention



Fill in connections where they exist.  
Indicate nature of connections with a descriptive word or by drawing two kinds of lines:  
\_\_\_\_\_ for strong, - - - - - for tenuous + + + + + for dotted  
Draw arrows along lines to signify flow of energy, resources  
Identify significant people and fill in empty circles as needed

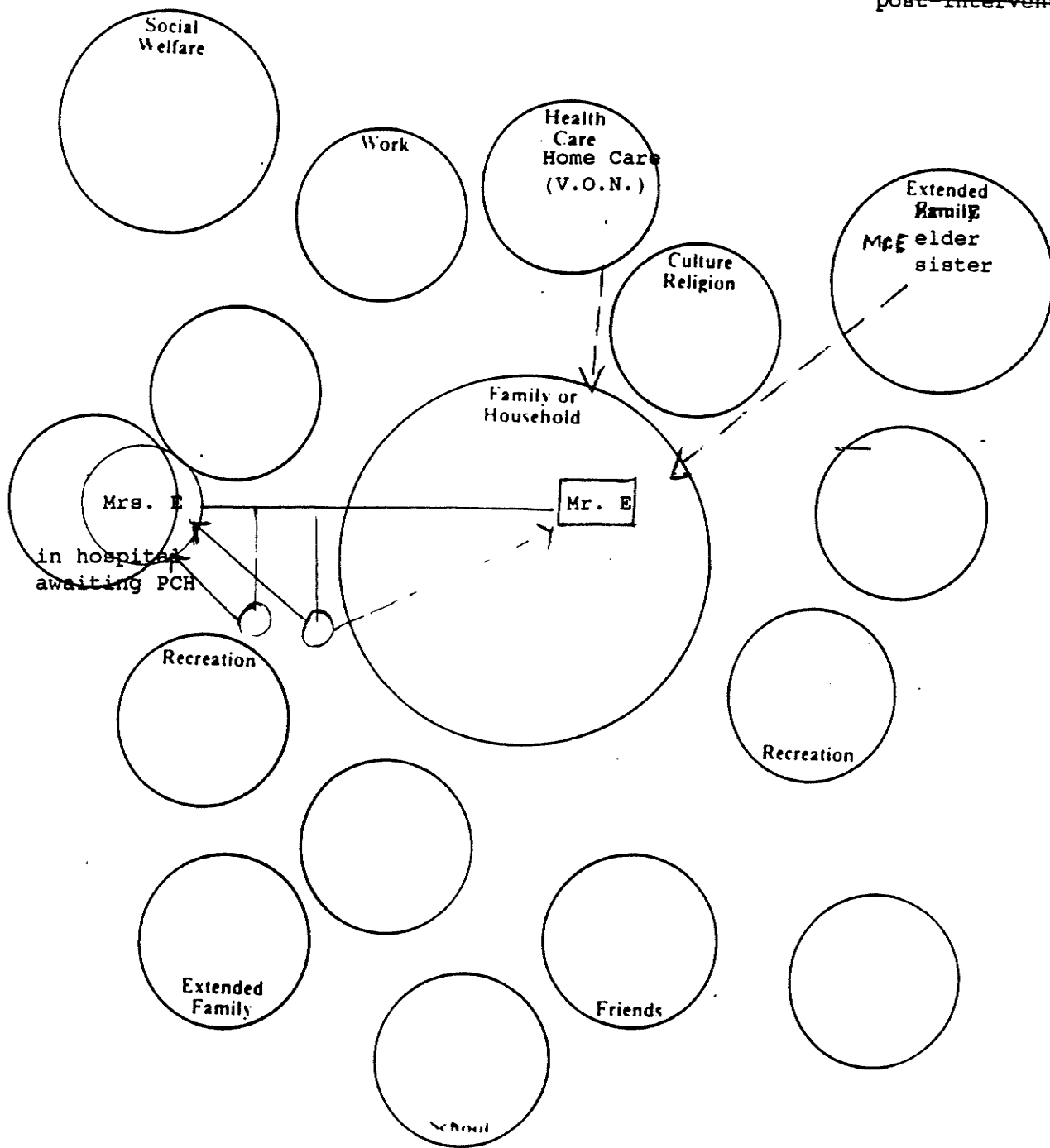
Eco-Map

Figure 15

Family "E"

Name \_\_\_\_\_ August 88

Date \_\_\_\_\_ post-intervention



Fill in connections where they exist.  
 Indicate nature of connections with a descriptive word or symbol. Use different kinds of lines:  
 \_\_\_\_\_ for strong, - - - - - for tenuous, ······ for tenuous  
 Draw arrows along lines to signify flow of energy, resources  
 Identify significant people and fill in empty circles as needed

**Family "F"*****Referral Information:***

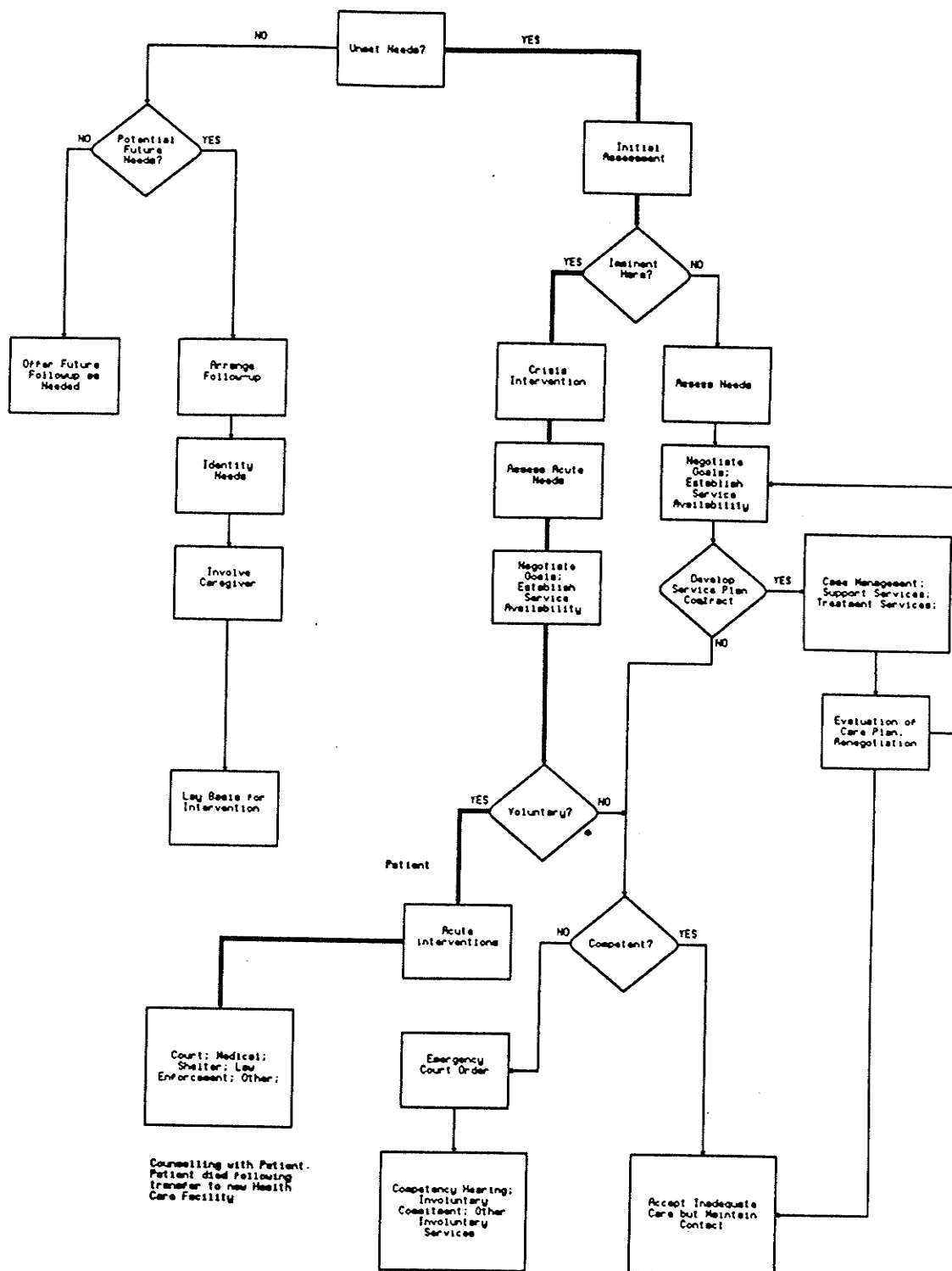
An inpatient referral was made to this student by nursing in September 1988 for suspected physical abuse/neglect; psycho-social abuse/neglect and financial abuse.

The reason for Mrs. F's hospital admission was listed as "Diabetes mellitus, diabetic peripheral neuropathy, chronic obstructive pulmonary disease, chronic heart failure and fractured hip and colles from a fall. Mrs. F was dependent on 24 hour oxygen. The head nurse, who knew Mrs. F from previous admissions, observed her to be more despondent than usual and uncharacteristically ambivalent about returning home to her husband. Upon further questioning she admitted to physical and emotional maltreatment from her husband. She also stated that her daughter had stolen rings and some money.

The course of family F's involvement with this student is illustrated in the flow chart and detailed under the headings of assessment, intervention and evaluation phases, all of which took place during the six month period from September 1988 to March 1989.

Involvement was primarily with Mrs. F, although her husband was seen alone twice and with Mrs. F five times.

Figure 16: Family "F"



***Assessment Phase:***

*Patient's perspective* - Born on a reservation, Mrs. F completed her high school education in a boarding school which was operated by Roman Catholic nuns. She denied any history of abuse within her family of origin but admitted to being severely beaten and terrorized by her first husband who was an alcoholic. Apparently she lost three babies because of beatings during pregnancies. Mrs. F raised two foster children on her own. Apparently the eldest daughter had always been very close to Mrs. F while the other daughter was described by Mrs. F as unpredictable and untrustworthy. The most recent problem with the youngest daughter involved a set of rings and some money which the daughter took at the time of Mrs. F's hospitalization and did not return, even after Mrs. F's request for her to do so. Mrs. F stated that this was a pattern and she did not want to pursue the matter further. She would simply cut off communication with her daughter for an indefinite period of time. Her main concern centred around her present common-law husband of 30 years. Mrs. F reported that he had started hitting her, throwing objects at her and threatened further violence when under the influence of alcohol. He also left her alone in the home for long periods of time, without access to food, medication or the practical assistance she required for her activities of daily living. Home Care had also been refused admission by Mr. F on occasion. Mrs. F attributed her recent fracture indirectly to Mr. F since he had left the home for several days and she was unable to ambulate safely on her own. Apparently he had been with his girlfriend at the time of Mrs. F's fall.

*Mr. F's perspective* - Mr. F was still legally married to another woman while living common-law with Mrs. F and had an ongoing affair with yet another woman. He agreed that the home situation was stressful and he admitted to issuing threats and on occasion throwing objects. He denied hitting Mrs. F. He expressed no regret with his actions, stating that Mrs. F was too demanding and had unrealistic expectations of him. In spite of their problems, he stated that he loved and needed Mrs. F and hoped that she would return home soon.

*Collateral information* - Home Care and the head nurse had been familiar with Mr. and Mrs. F for many years. They were aware of Mr. F's drinking problem and stated that he could be verbally aggressive at times. They also stated that Mr. and Mrs. F fought regularly but until recently did not consider that Mrs. F was in any danger. However with her recent decline in health, they noticed that Mrs. F seemed more vulnerable and expressed greater ambivalences about remaining with her husband.

*Student's perspective* - The assessment provided a positive diagnosis for abuse/neglect and engagement was successful with Mrs. F. Attempts were made to engage Mr. F several times but these were not successful, although he would see this student when asked. Mrs. F was a very articulate woman who appeared to have a great deal of insight into herself and her situation. She was concerned that her present situation was evolving into one similar to her first marriage. She believed that the time had come for Mr. F and her to consider living apart since he could not cope with her growing dependency. However Mr. F attempted to



persuade her to return home on several occasions and this created strong ambivalences for Mrs. F throughout her stay.

Since Mrs. F was already suffering from many losses, it was important that she remain in a position to make her own decisions. At times this was difficult because of her frailty and the staff's desire to protect her from a situation which was known to be high-risk.

*Intervention Phase:*

Mrs. F clearly fell into the category of capable and consenting to treatment. It did, however take a few sessions before she became engaged. Initially she was distant and skeptical about social work involvement but eventually she became committed to the formulation of an intervention plan which included:

1. Provision of shelter in hospital until her medical status stabilized and appropriate discharge plans could be formulated.
2. During her stay, a close friend, her first husband (with whom she had maintained a friendship) and her sister died. Grief work also became part of the intervention.
3. Opportunity for ventilation regarding her distant and recent past. Mrs. F had a great deal of insight into her pattern of being drawn to abusive situations. She was well aware that her situation with Mr. F would get worse. However, she was suffering many losses and was not ready to give up her role as the strong, emotional supporter to Mr. F. In addition there was a strong sense of family loyalty influenced by her culture. Consequently, she wavered in her

decision to live apart from Mr. F even though she, herself, felt ready to accept institutional living because of her health care needs.

4. Eventually Mrs. F decided to apply to a chronic care respiratory ward in another hospital and at the same time try a leave of absence. The leave ended prematurely when the situation broke down and Mrs. F called the hospital, asking to return before the weekend was over. While frightened by the events that took place during the leave, she had also confirmed in her own mind that she and Mr. F would be better off living apart. However, Mr. F disagreed, and continued to put pressure on Mrs. F to return home. Firm in her decision but weakened by physical problems she asked the Dr. to help her explain to her husband that she would be going to the respiratory ward even if Mr. F terminated the relationship which he had threatened to do on several occasions. While he was angered by her decision, Mr. F did tell her that he would not discontinue seeing her.

Sadly, Mrs. F died shortly after her transfer to the new facility.

***Evaluation Phase:***

The only evaluative instrument used was the eco-map pre and post intervention, (post intervention representing a report from the new facility at 3 weeks following the transfer since Mrs. F died prior to the 6 week follow-up visit).

The eco-maps (figures 17 & 18) illustrate changes at the microsystem and exosystem levels which were generated by changes to Mrs. F's otogenic level. Despite her increased dependency which was accompanied by a decreasing self-esteem, she was able to risk losing a relationship with her husband in order

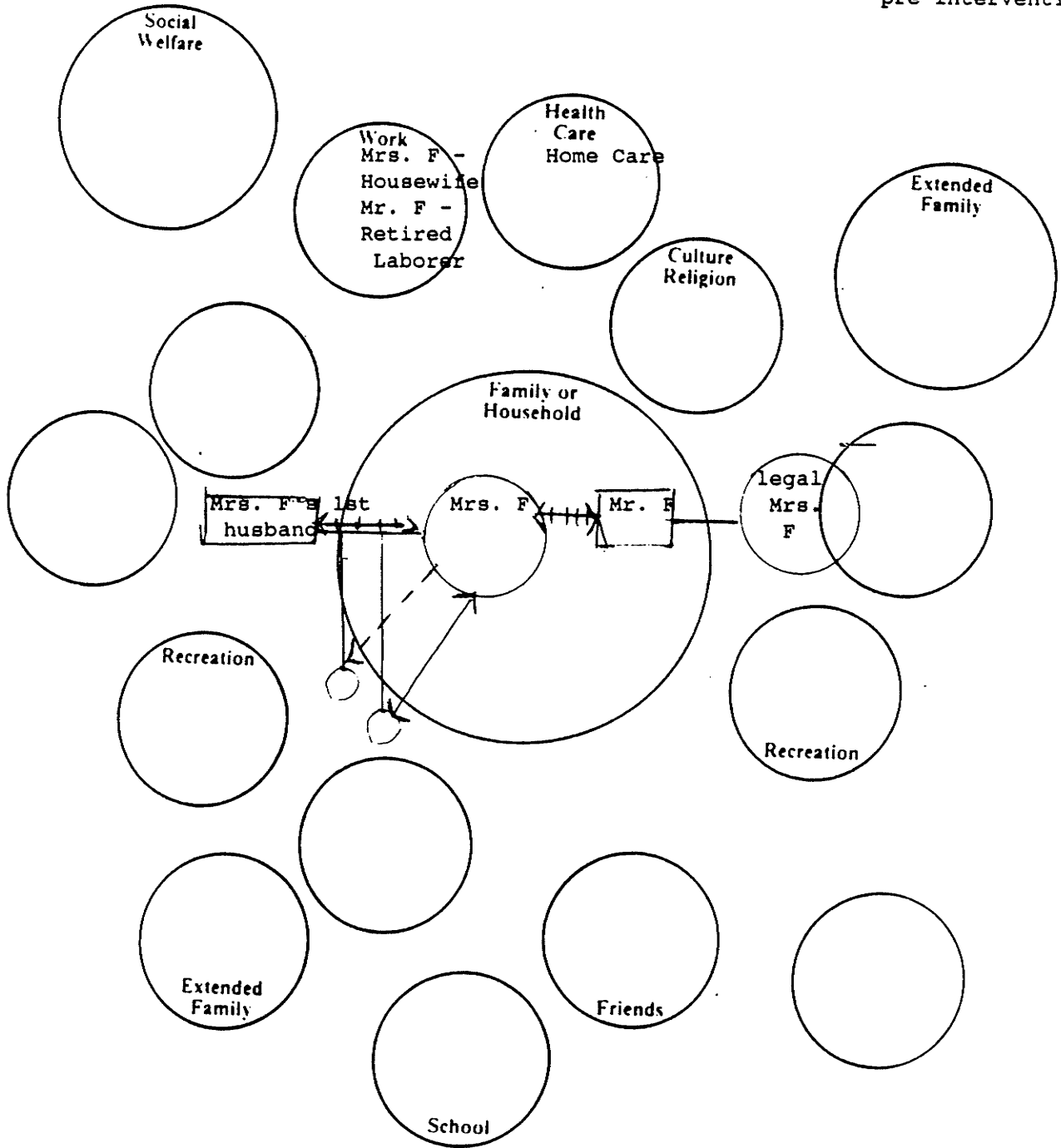
to enhance her chances at self-preservation and establish a quality existence for herself for the time she had left. The key to this intervention was that Mrs. F was in charge of the decision making throughout, despite her weakened physical state. This not only assisted in improving a waning self-esteem but, considering the outcome, no one was left behind to deal with the guilt that surely would have emerged if Mrs. F had been directed or pressured to accept institutional care over returning home.

# Eco-Map

Figure 17

Family "F"

Name \_\_\_\_\_  
 Date Sept. 88  
pre-intervention



Fill in connections where they exist.  
 Indicate nature of connections with a descriptive word or by drawing different kinds of lines:  
 \_\_\_\_\_ for strong, - - - - - for tenuous, + + + + + for stressful.  
 Draw arrows along lines to signify flow of energy, resources, etc. → → →  
 Identify significant people and fill in empty circles as needed.

# Eco-Map

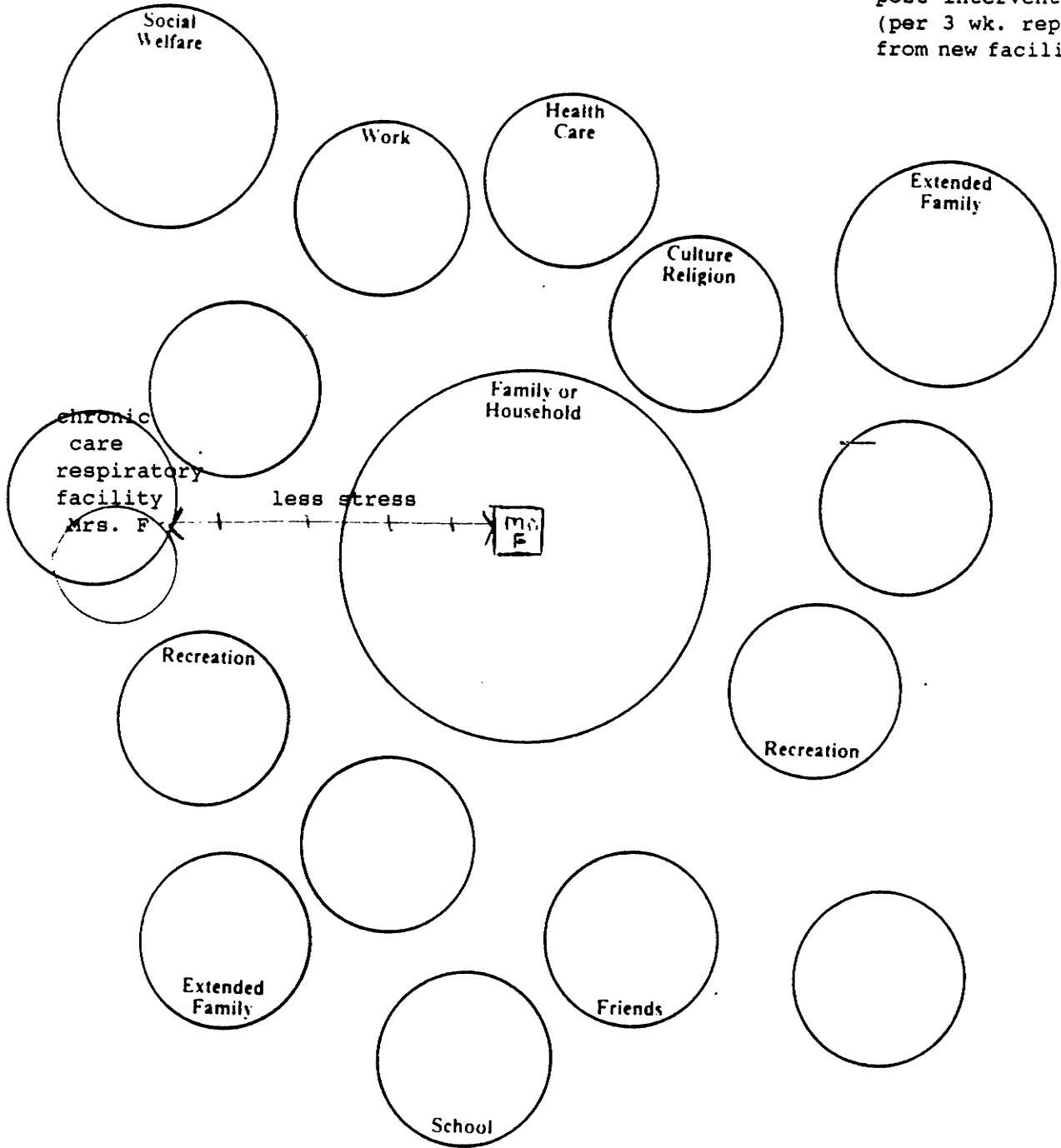
Figure 18

Family "F"

Name \_\_\_\_\_

March 89

Date post-intervention  
(per 3 wk. report  
from new facility)



Fill in connections where they exist.  
Indicate nature of connections with a descriptive word or by drawing different kinds of lines:  
\_\_\_\_\_ for strong. ----- for tenuous ++++++ for stressful.  
Draw arrows along lines to signify flow of energy, resources, etc. ->->->  
Identify significant people and fill in empty circles as needed.

**Family "G"*****Referral Information:***

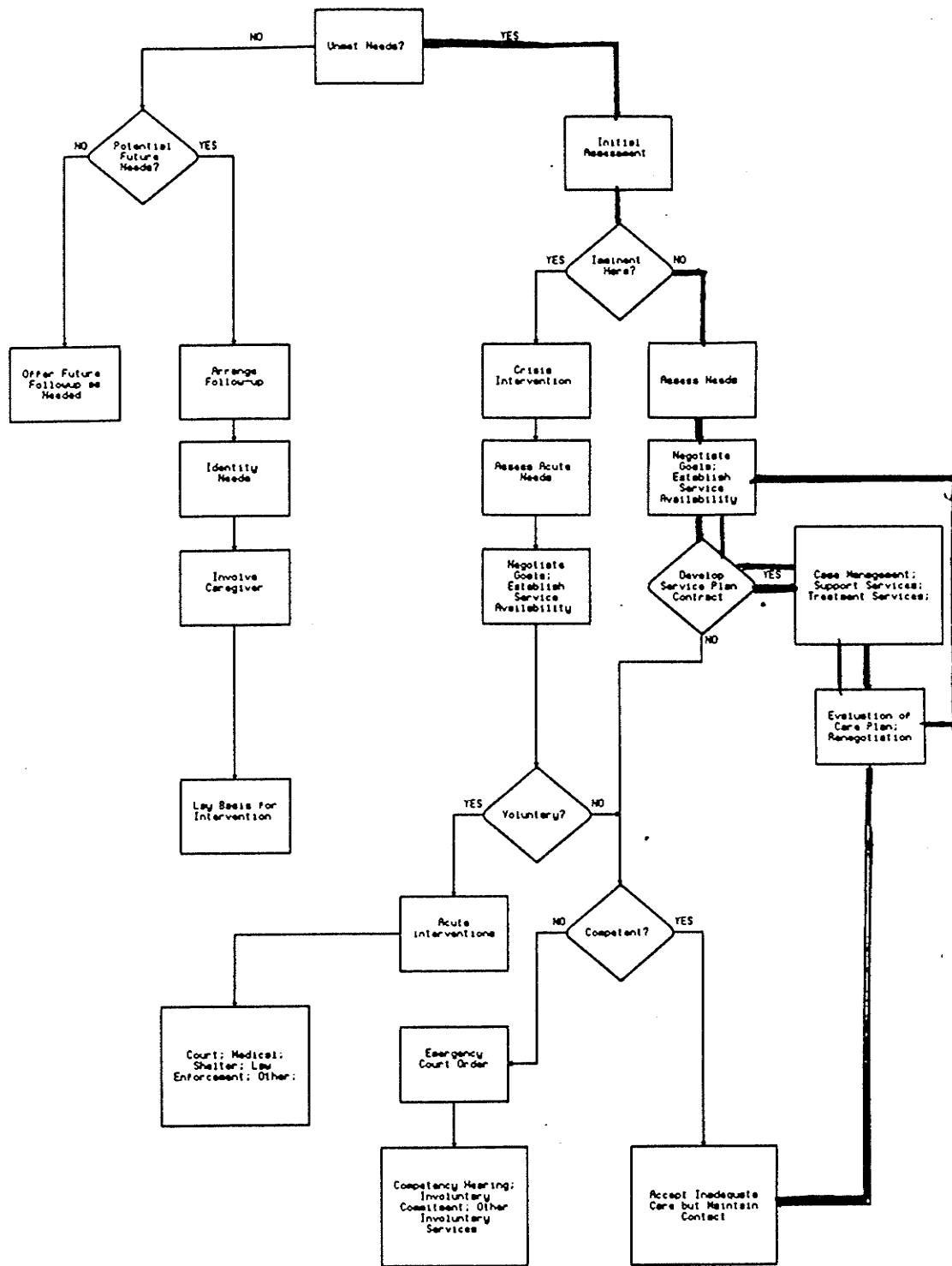
An outpatient referral was made to this student by a physician in March 1989 for physical and psycho-social abuse per Mrs. G's admission that her husband had been striking and intimidating her during the entire sixty-two years of their marriage.

The reason for Mrs. G's referral to the Day Hospital program was listed as rehabilitation and social support. Her medical history included arthritis, diverticular disease; hypertension, ulcer surgery, hip surgery, shoulder surgery due to fracture, fractured ribs, fractured coccyx, bilateral carpal tunnel syndrome and Menière's syndrome. It was learned in the first interview that Mrs. G's history of fractures was due to severe beatings by her husband.

The course of family G's involvement with this student is illustrated in the flow chart and detailed under the headings of assessment, intervention and evaluation phases, all of which took place during the 5 month time period from March 1989 to August 1989.

At Mrs. G's request, involvement with the student only included herself.

# Figure 19: Family "G"



***Assessment Phase:***

*Patient's perspective* - Mrs. G was born to a French-Canadian family and raised on a farm. She was married in her late teens and had 13 children.

She admitted to being physically and verbally abused by her father but denied sexual abuse. She also stated that she was responsible for exhausting and sometimes demeaning tasks for her mother as well as nuns in a nearby convent as a young child (eg. - heavy household cleaning, washing out menstrual rags). She believed that she would be rewarded in heaven because of the difficulties she experienced as a child and later as an adult when she was beaten and raped by her husband. It seems that Mr. G was an alcoholic and while under the influence of alcohol would hit Mrs. G and the children to the point of causing bruises, lacerations and fractures. Mrs. G suspected that Mr. G had sexual relations with their daughters and she knew for certain that he had numerous affairs with mutual friends and relatives during their marriage.

Mrs. G considered that in recent years the situation had improved since Mr. G no longer drank, was physically weakened by arthritis and the aging process and no longer had sexual desires. Throughout her marriage, Mrs. G had confided in many people regarding her situation and was encouraged to leave. This included several nuns and the parish priest. Apparently she left for short periods of time but always returned because of a sense of loyalty to God and her family.

*Collateral information* - The home care nurse who visited Mr. and Mrs. G did not consider that physical abuse had been a problem in the last 4 - 5 years.



Apparently Mr. G did admit that it had been a problem for about 50 years because of his drinking. The nurse stated that both Mr. and Mrs. G would yell and threaten each other on an ongoing basis and at times Mr. G appeared to be on the verge of hitting Mrs. G.

*Student's perspective* - This assessment provided a positive diagnosis for abuse/neglect of a woman with a well-engrained pattern of victimization. Engagement was immediately successful with Mrs. G who readily discussed her history as she had done many times in the past. However after the initial ventilation her attendance at Day Hospital became erratic and she avoided contact with the student.

When questioned about this, Mrs. G admitted that this was a pattern established with all people who offered support over the years. Whenever she could no longer handle her situation with her husband, she would enlist the help of someone to listen, empathize and assist in helping her to leave. However she would either leave for only a short while or would decide not to leave at all. The result was embarrassment and shame at not leaving such a deplorable situation and also for having "let down" the helping person. The long term result of this had been the establishment of a belief that she really enjoyed being abused which in turn created further feelings of self-hate and contempt. This dynamic, coupled with the well established belief that the more she suffered the greater her rewards would be in heaven, made for a very challenging intervention. To complicate the situation further, Mrs. G would not allow Mr. G to be involved in the intervention.

***Intervention Phase:***

Mrs. G fell into the category of competent and consenting to treatment although testing revealed memory problems and difficulties with her ability to abstract. This, unfortunately limited certain intervention efforts which would have incorporated cognitive restructuring as part of the plan. Nonetheless the following plan was formulated:

1. There were several team discussions regarding Mrs. G. It was decided that the team would support Mrs. G during her ventilation of anger toward her husband and normalize the ambivalences which followed. The goal was to counteract any perceived messages that she was unworthy herself and even deserving of abuse if she continued to return to an abusive situation.

2. Attendance at Day Hospital for an indefinite period was seen as an end in itself. It served as a buffer between Mr. and Mrs. G and it gave Mrs. G permission to enjoy herself twice a week which didn't seriously jeopardize her belief that she must suffer in order to be rewarded later.

3. The student made Mrs. G aware that assistance would be provided should she decide to leave. However the assumption was made that she would remain and intervention would focus on (a) the development of a protection plan with which she could live, (b) working on self-esteem issues. The later area was less successful because of Mrs. G's memory problems and difficulty in abstracting.

***Evaluation Phase:***

Evaluative instruments used in terms of determining the effectiveness of the intervention included the eco-map pre and post intervention and observations by Day Hospital and home care personnel. Mrs. G did not complete the client satisfaction questionnaire since she had difficulty understanding it.

The eco-maps (figures 20 & 21) illustrate changes at all three levels.

The relationship between Mrs. G and Day Hospital gained in strength such that her attendance became regular. This resulted in a reduction in tension between Mr. and Mrs. G and Mrs. G began to allow herself some pleasure and enjoyment at the Day Hospital.

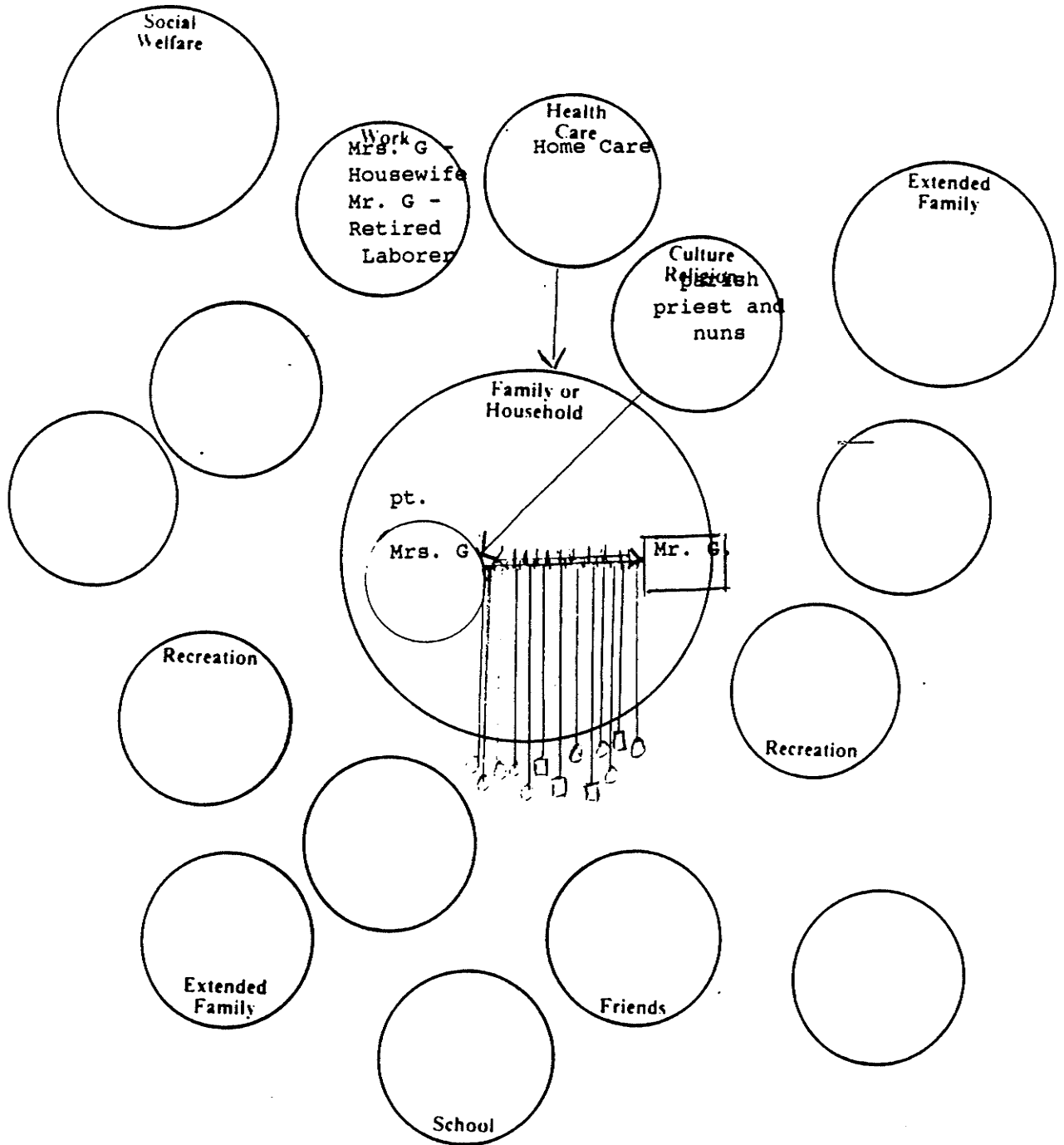
The home care nurse observed that Mrs. G's affect and dress remained depressed five days a week but on the Day Hospital days her mood was elevated and she gave a great deal of attention to improving her appearance.

# Eco-Map

Figure 20

Family "G"

Name March 89  
Date pre-intervention



Fill in connections where they exist.  
Indicate nature of connections with a descriptive word or by drawing different kinds of lines:  
———— for strong. ----- for tenuous. ++++++ for stressful.  
Draw arrows along lines to signify flow of energy, resources, etc. ————  
Identify significant people and fill in empty circles as needed.

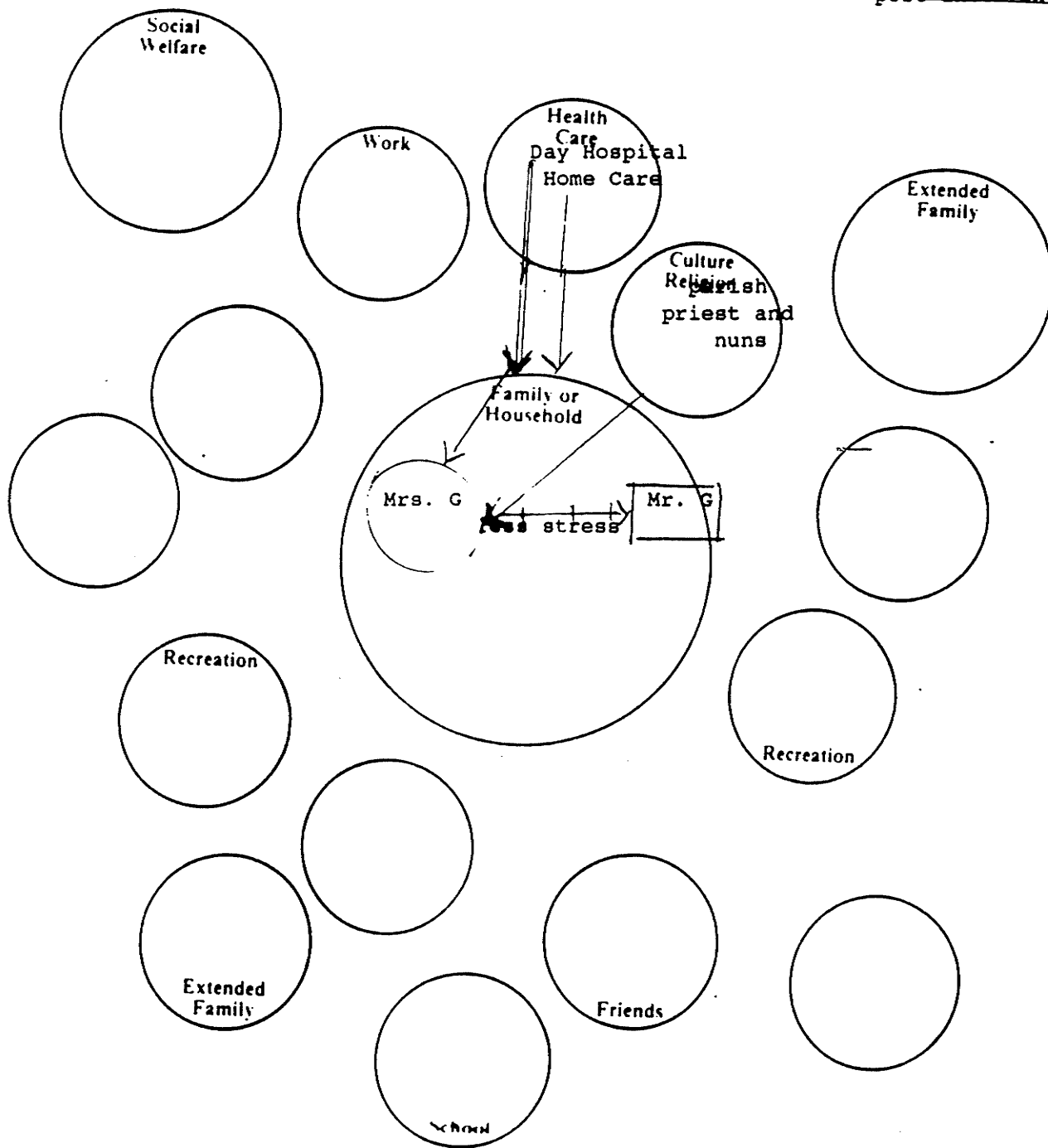
# Eco-Map

Figure 21

Family "G"

Name August 89

Date post-intervention



Fill in connections where they exist.

Indicate nature of connections with a descriptive word or by type of line: \_\_\_\_\_ for strong, - - - - - for tenuous, + - - - - for stressful

Draw arrows along lines to signify flow of energy, resources, etc.

Identify significant people and fill in empty circles as needed

**Family "H"*****Referral Information:***

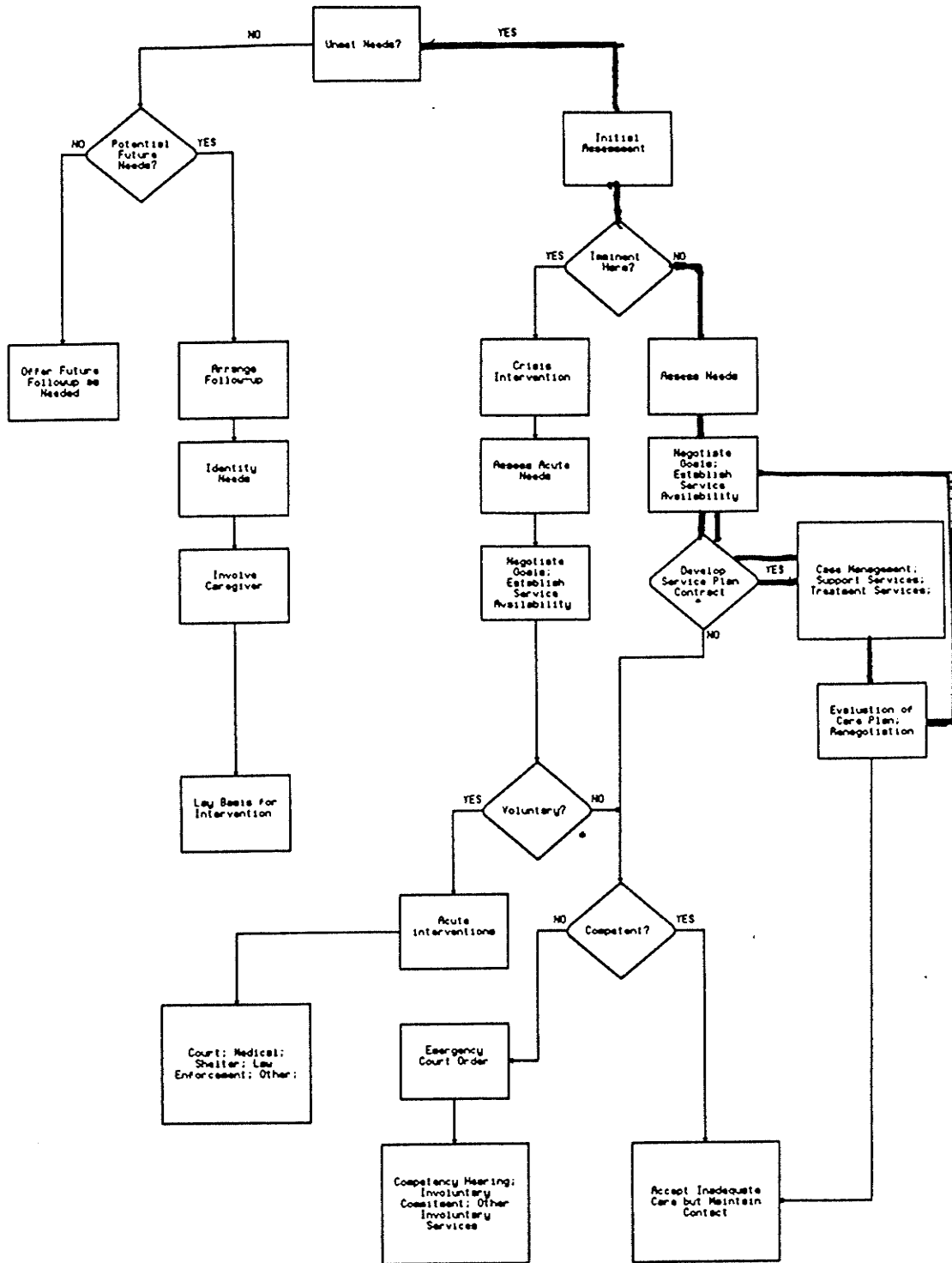
An outpatient referral was made to this student by nursing and an occupational therapist in April 1989 for suspected psycho-social and financial abuse per Mrs. H's expressed concern that she didn't know where her money was going under the management of her son. She also talked openly about conflict between her and her son regarding her future planning.

Mrs. H was referred to the Day Hospital program from the inpatient interdisciplinary team for rehabilitation and social support. Her medical history included a diagnosis of Alzheimer's type dementia, high blood pressure and a fractured hip. As an inpatient, Mrs. H had been referred to social work because she had been registering the same complaints. However, after seeing the son, the worker was not able to determine whether abuse was occurring or if Mrs. H's concerns were an expression of her confused and disorientated status. The worker did indicate that further assessment was warranted.

The course of family H's involvement with this student is illustrated in the flow chart and detailed under the headings of assessment intervention and evaluation phases, all of which took place during the four month period from April 1989 to August 1989.

Involvement included Mrs. H and her son separately. Failed attempts were made to see Mrs. H and her son together and efforts to see the grandson were also not successful due to his heavy travel schedule.

Figure 22: Family "H"



*Assessment Phase:*

*Patient's perspective* - Mrs. H was born in the Ukraine and immigrated to Canada during her teens. She had no formal education and worked in a sewing factory until her marriage. Mr. and Mrs. H had 1 son. Mr. H died about 20 - 25 years ago. Mrs. H maintained regular contact with her son and his three children over the years. She also had regular contact with the son's first wife but did not approve of his second wife. She blamed her hospitalization on the second wife, stating that the wife had hit Mrs. H in the head while Mrs. H was standing at a bus stop. She was also convinced that the second wife was influencing her son in a manner that was jeopardizing Mrs. H's money and independence. The son was managing Mrs. H's money with a joint power of attorney with a grandson and only giving her small amounts. He was also planning to sell her duplex and move her into a senior citizens apartment to which she was adamantly opposed.

*Son's perspective* - Mr. H presented in a very curt, authoritarian manner. He discussed the many stresses he was experiencing which included a mother-in-law on the emergency nursing home list, a demanding position with a well established business and visiting and shopping for his mother once a week as well as managing her finances. Due to the grandson's heavy travel schedule, Mr. H was managing Mrs. H's finances exclusively at this point. He expressed concern about his mother's judgement, memory and her overall safety while living alone in her home.

*Collateral information* - The home care nurse reported that Mrs. H was doing well at that point with weekly home care help but that any further decline



would likely compromise her ability to remain on her own. However, medical reports suggested that there was no indication that a decline was immediately forthcoming. In fact, Mrs. H's condition had improved to her pre-surgery status. Memory problems and occasional disorientation were still evident but not to the extent that they existed following her hip surgery.

*Student's perspective* - The assessment provided a positive diagnosis for abuse but intentionality become an important factor in determining an intervention approach. It was considered possible that the motivation behind the acts of denying Mrs. H adequate accessibility to her finances and right to self-determination were of an overly protective nature on the part of an efficient, overburdened and obsessive son. The result was an escalating power struggle between Mrs. H and her son. In an attempt to gain greater control of the situation the son had recently enlisted the services of a lawyer in application for an order giving the son rights of private Committeeship. This would give him the power to administer her finances against her wishes which would also enable him to pressure her into a move to a senior citizen's apartment. The lawyer had requested two reports from physicians attesting to her incompetency. Initially the Day Hospital physician agreed to supply such a report but revised that decision after hearing the report from home care and reviewing an occupational therapy report which demonstrated an improved score on her mini-mental status exam and general observations of overall cognitive improvement.

*Intervention Phase:*

Mrs. H's competency was unclear. She had exhibited signs of paranoia and significant disorientation which would clearly jeopardize her safety. She was also diagnosed with a disease which had a known process of chronic and progressive decline. However, improvements were noted over a period of time to the extent that her competency became more questionable. The home care report and a home visit by the occupational therapist and student all attested to a reasonable degree of safety and this prompted a determination of the least restrictive alternative which was to deem her competent to make decisions for herself.

Consequently the student's intervention plan included the engagement of Mrs. H, the son and the grandson (the only family member who Mrs. H trusted) with the goal of facilitating some problem-solving. Mrs. H was agreeable. However the son was not able to attend the first home visit and the grandson was out of town. In a lengthy phone conversation with the son, the student attempted the following intervention:

1. Provided the opportunity for ventilation since it was anticipated that the son would be angry when he learned that the Day Hospital physician would not declare Mrs. H incompetent.

2. Facilitation of insight into the escalating situation between Mrs. H and her son by partializing his stress and reframing his mother's "stubbornness" by discussing the fears associated with loss of physical and mental capabilities.

Role reversal scenarios were used since the opportunity presented itself and appeared to be successful. The end result was a significant diffusion in the son's emotional wrath, his agreement not to pursue the committee and as well he decided not to pressure Mrs. H into a move since he himself agreed that she appeared to be safe in her environment for the moment.

3. This situation was still regarded as precarious and was therefore referred to the Day Hospital Social Worker for ongoing assessment and support. While there was no evidence of misappropriation of funds during this practicum, it was considered appropriate to assess this area further as well.

***Evaluation Phase:***

The only evaluative instrument used in terms of determining the effectiveness of the intervention was the eco-map (Figures 23 & 24), since Mrs. H was not able to complete a client satisfaction questionnaire.

The significance of the intervention efforts in this situation, is actually demonstrated by the fact that there was no apparent change noted pre and post intervention. Prior to hospitalization Mrs. H had been completely independent. However, during her hospitalization, attempts were made by her son to change her independent status to one of greater dependency, an occurrence which could be perceived as abusive in the sense that her right to self-determination and dignity were being threatened. The intervention efforts were aimed at sustaining and prolonging as much of Mrs. H's pre-hospital status as possible.





## **Evaluation of Learning Objectives**

As stated earlier, the objectives of this practicum were to gain a more comprehensive understanding of elder abuse through a review of the literature, provide an assessment and intervention in situations identified as abusive/neglectful, evaluate the impact of the intervention on the client system and as well evaluate the student's skill development. An additional component of the practicum was to provide education to hospital team members and participate on hospital committees concerned with elder abuse.

The extent to which these objectives were met is explored in this section as well as the student's general learning and recommendations arising from the practicum.

### **Literature Review**

The studying, organizing and integrating of relevant literature presented a definite challenge to this student. In addition to a review of the limited literature on elder abuse, the student found it necessary to explore some of the literature on child and spouse abuse. Although it is still unknown as to whether the findings from some of the spouse and/or child abuse studies can be generalized to the elderly population, it did enable the student to develop a more comprehensive assessment and intervention protocol than was available in the area of elder abuse/neglect at the time the practicum took place.

### **Model of Assessment and Intervention**

As a social worker in a hospital setting prior to the practicum, this student had not been exposed to the type of unconscionably brutal situations occasionally reported by the media which appeared to occur within a clearly defined victim-perpetrator context. Rather, the student's experience had been that the phenomena of elder abuse/neglect most often evolved from a diverse and complex set of interactional dynamics. The development of a model for assessment and intervention was guided by this experience in addition to the knowledge gained through a review of the literature.

This model, which was a combination of the Tomita and Quinn protocol (1986) and Belsky model (1982), was considered to be a good beginning attempt at the development of an assessment and intervention protocol in a geriatric rehabilitation and extended care hospital setting even for the most brutal of situations such as the one described in the "Family E" case study.

The assessment process would have been improved if the Allardyce assessment tool (1990) found in Appendix B had been developed prior to the practicum. While the assessment used by this student captured most of the dynamics that the Allardyce tool is designed to elicit, the highly organized and comprehensive nature of the Allardyce tool would have contributed much greater efficiency to this student's assessment process.

The intervention process was not unlike any other social work intervention with the establishment of goals designed to change certain aspects of the clients'



situation. The only additional component to the utilization of the generic skills of crisis management, knowledge in the areas of aging, illness and disability and depression in the elderly was the provision of education regarding the nature of abuse and information regarding the resources available to assist persons caught in an abusive/neglectful situation.

### **Evaluation of Services to Clients**

The designing of an evaluation process presented major difficulties to this student. The first problem was a lack of questionnaires relating to the subject matter. The second problem was the fact that most of the population were partially or totally illiterate due to trauma, disease and/or limited formal education. Another obstacle was the tenuous nature of engagement which quite likely would have been further threatened with the use of questionnaires. Consequently the only questionnaire which was used was a short, generalized consumer satisfaction questionnaire which can be found in Appendix E. Six completed questionnaires were returned and their responses are compiled in Appendix E. Only two of the patients were able to complete the questionnaire. The other four were completed by those significant others who were involved in the intervention.

Eco-maps were also used, pre and post intervention. Pre-intervention represents the period of time immediately preceding hospitalization and post intervention represents the 6 week follow-up interview. Although the eco-map

does not depict the changes occurring at the otogenic level, it does effectively demonstrate changes at the microsystem and exosystem levels.

Observation of staff members was also considered to be a very useful means of evaluation.

### **Evaluation of Student's Skill Development**

The student's skills were assessed and developed through the use of:

A) A diary comprised of process recordings which were reviewed regularly by the student and advisor. Most of the learning focused on methods designed to improve the skills of engagement, assessment and intervention with single subjects and families.

Various methods of engaging a reticent and sometimes hostile client population in a secondary setting were explored and practised. In general, a benign and client centred approach designed to elicit concerns of each member of the client system regarding their current situation was considered to be the best method for initial engagement.

Assessment was considered an ongoing process, essential to the development of a realistic and appropriate intervention plan. The acquisition of as much information and as many perspectives within the client's ecological sphere was considered to be critical to the development of a comprehensive assessment. As the practicum progressed, the student became more skilled at screening and sifting through great amounts of information and using only that which was relevant to the achievement of the established goals.

Most interventions involved the opening up of communication and assisting with problem solving through the use of education, reframing, partializing, normalizing and goal setting. In depth family therapy was not considered a focus for this practicum. However, if the need and willingness for family therapy had arisen, a referral would have been made to an appropriate service.

The setting of goals was a challenging aspect for this student since it raised the ethical issue of whether or not we as professionals have the right to supersede the goals of the client as is the case with child protection services or do we abide by the client's goals as in spouse abuse situations. Compounding this ethical dilemma further was the fact that five of the eight patients had varying degrees of questionable competency. In an attempt to resolve this dilemma the student made certain judgement decisions:

1. In those situations where the patients were clearly competent, the student only acted as a facilitator to the client system as they established goals they felt were appropriate, even if those goals were not the same as the student's desired goals (e.g., Mrs. A deciding not to pursue financial abuse). Underlying this decision was the belief that imposed goals or the application of undue pressure on a competent adult to formulate goals they themselves do not want will likely result in the client finding a way to subvert the intervention or disengage from the clinician. On occasion the student attempted to influence the goal setting process by offering alternatives or exploring through questions, the client's belief system. However, it was always made clear that the student's input was only to offer the client as many options as possible. The choices and decisions were the client's

responsibility and would be accepted by the clinician even if the clinician had concerns that they may not necessarily be in the client's best interests. Confidence in this practice was strengthened further by Mrs. F's situation. Some well-meaning and concerned staff were tempted to put pressure on Mrs. F to choose institutional care over returning home. Because of her weakened condition, Mrs. F would have undoubtedly succumbed to the pressure. However staff resisted the temptation to protect Mrs. F and instead offered her much encouragement and support in making her own decision. After some emotional struggle, which included a leave of absence at home, Mrs. F decided to choose institutional care. However, shortly after the move, she died. It is not known for certain whether the move to an unfamiliar environment and the use of different therapeutic techniques had some responsibility in hastening her death. Had Mrs. F not struggled to reach the decision herself, not only would staff have felt a great deal of sadness around the loss of Mrs. F, but quite likely some guilt as well.

2. In those situations where the patients competency was in question, attempts were made to engage those persons in the client system who were involved with the abuse/neglect and gain a commitment for their involvement in the formulation of an intervention plan aimed at ameliorating or eliminating the abuse/neglect. This approach was successful in all but two situations one of which never achieved successful engagement (family D) and another where, as a last resort, an intervention plan was imposed on the client system (family E).

B) The Quality Assurance Form for the Elder Abuse and Neglect Protocol was used with each family. It is an audit form designed for use with the Tomita and Quinn protocol (1986). Responses relating to all eight situations were tabulated and can be found in appendix G. The audit form was useful in evaluating standards pertaining to the Tomita and Quinn Protocol but there was no similar method of evaluating standards pertaining to Belskey's model.

### **Educative and Committee Membership Role**

The student worked with four inter-disciplinary teams during the course of the practicum. Since there was hospital wide interest in the subject of elder abuse, the student's learning experiences were well received by all team members. There were regular, in depth team discussions with the mutual formulation of goals and role expectations. An inter-disciplinary team approach to elder abuse/neglect such as the one this student enjoyed was deemed critical for a comprehensive assessment and successful formulation and implementation of an intervention plan.

This student also became an active member the hospital committee on elder abuse which was given the task of developing a philosophical approach to the problem and a screening, assessment and intervention protocol. This was an invaluable learning experience for the student who actively struggled along with a variety of other disciplines to establish a consistent and standardized approach to the problem of elder abuse/neglect. Staff from medicine, nursing, pastoral care, therapy disciplines, and social work all brought their own personnel and

professional values and ethics to this forum and much work was done to establish an approach which was acceptable to all disciplines. The committee was at the point of testing the screening and assessment tools at the time the practicum was nearing completion. They continue to meet on a regular basis to date.

The student only attended two meetings of a city-wide inter-hospital committee on elder abuse/neglect whose objective was to solicit funding for a teaching module which was to be developed and used for hospital staff working with abuse. The inception of this committee commenced at the end of the practicum and another social worker from the hospital subsequently took the place of the student.

### **General Learning**

This practicum study focused on a small number of individuals who represented only part of the elder abuse/neglect population, namely those disabled or unwell elderly having inpatient or outpatient status in a geriatric extended care and rehabilitation facility. Consequently some of the student's findings may not be applicable to the total population.

However, germane to all aspects of work in the field of elder abuse, is the presence of many conflicting ethical issues resulting in the need for a wide range of clinical skills.

Fundamental to the technical skills required is an ability to work in a concerned yet objective manner in an area which, by its very nature, engenders

a high degree of emotionality, at a very personal level. While effective clinical practice involves a recognition of one's personal biases, this appears particularly critical in the area of abuse/neglect. Anger, frustration, the need to protect and/or admonish are all feelings which every clinician needs to come to terms with at a personal level in order to work effectively with individuals involved in an abusive/neglectful situation. This student considers that a commitment to this process of personal learning and growth is essential to the process of learning and growth at a professional level.

As mentioned by Hudson (1988), intervention in the area of elder abuse/neglect can occur at three main levels. While this practicum study focused primarily on the micro level of analysis which involves direct clinical intervention, there was unquestionable influence from the mezzo and macro levels which essentially involves education and research and policy making. Following is a summary of the students findings:

*Micro level* - Clinical access to all eight situations was greatly enhanced by the physical setting and the context which was established.

The setting provided two main advantages. First of all, elders were admitted as either inpatients or outpatients for medical purposes, a socially acceptable reason for which to seek help and one which evokes no particular defensiveness or resistance. Secondly, the setting provided greater environmental control than would otherwise be afforded in an acute care hospital or shelter where people are expected to stay for short periods of time or most certainly in the community where support services are limited and health care workers can easily

be denied access to private residences. Inpatients routinely stay for several months or longer and Day Hospital patients are frequently seen two days per week, thereby enhancing access to the elder. In addition, family or significant others are encouraged and in some cases expected to participate in the elder's treatment program and/or discharge planning which maximizes access to those individuals who may be involved in the abusive/neglectful situation.

There was however one difficulty encountered with this medically focused setting. Elders and their significant others expected communication to centre around medical and physically therapeutic treatment of the elders medical problems and it was sometimes very difficult for the student to change their focus to one involving interrelationships.

In terms of context, it seemed that access was greatly enhanced by utilizing an ecological approach to the problem. It enabled the student to gain a comprehensive view of each family situation and it offered a variety of possibilities for points of intervention relevant to each families needs. As mentioned before, it is extremely difficult to gain access into these situations due to the secrecy, bonds of loyalty, fear, shame, lack of awareness and in some situations because of competency problems. An ecological approach embodies an holistic and non-inflammatory approach by its very nature and this served to enhance the chances of engagement with a population which for the most part is known to be very resistant.

Another aspect which was considered an essential to the process of screening, assessment and intervention was the utilization of an interdisciplinary



team which in most cases consisted of physicians, nursing, occupational therapy, physiotherapy, recreational therapy, speech therapy, dietary, pastoral care, as well as social work in an ancillary role. Most of these health care workers see patients individually and frequently with their significant others on a daily basis or at least several times a week. Their opportunity to detect situations of abuse/neglect is oftentimes greater than that of the social worker, particularly in settings where social work is an ancillary service and involvement occurs upon referral.

In addition, while all team members have their own discipline specific intervention, a consistent overall approach regarding abuse/neglect reduces confusion and resistance within the client system and enhances the opportunity for change in a positive direction. The movement noted in each of the eight situations in this practicum would not have been possible without the input of the interdisciplinary teams with whom the student worked.

Conflict which naturally arises when team members bring their own personnel and professional set of ethics and philosophical beliefs to the interdisciplinary forum, was, for the most part, not used in a competitive manner as team members effectively met the challenge of problem-solving in the best interests of the client system. Different approaches were tried and assessed in their merit, rather than personalized. However even the most cohesive teams can have difficulties with problem solving related to assessment and intervention from time to time and it has been the experience of the Beth Israel Hospital Assessment Team in Boston that an appointed team mediator is useful in facilitating a constructive approach to team problem-solving.

Specific to the social work intervention, there was much general learning, some of which is yet to be understood and articulated upon future reflections.

The two main aspects of learning which are significant for the student at this point include an improved awareness of client readiness and the degree to which protectionism and free choice is exercised in any given situation.

In terms of readiness it took for the most part, a great deal of time for disclosure and in many cases, clients reconsidered their commitment to intervention at various points in time. Not only was a genuine acceptance of this on the part of the student considered to be important, but the need to normalize this pattern at the outset of every intervention was also deemed important in terms of "doing no harm". The client must be free to change goals or even discontinue intervention as their needs dictate and to do so in a climate of non-condemnation. Should this approach not be practised, there is the risk that the client may receive messages from the clinician which compound pre-existing problems of self esteem. Feelings of guilt, inadequacy, embarrassment and even the belief that they were deserving of abuse can occur when a client reconsiders some of the changes to which they initially committed themselves. By normalizing the ambivalences at the outset and demonstrating flexibility, the clinician increases the likelihood of having some degree of change take place or at least reengagement at a time when the client is more ready. More importantly, the clinician exercises the principle of doing no harm, something we all aspire to but may inadvertently not practice.

In terms of balancing free choice and protectionism, it was realized that no definitive position could be taken, since each situation was unique and required

varying degrees of both. However, a method evolved during the study which assisted in enhancing the clinical judgement which was exercised. A thorough assessment of every situation was completed and the principle of utilizing as little protectionism as possible was adopted. Attempts were made to employ the least restrictive alternative and encourage as much free choice as possible even with situations where competency was an issue.

*Mezzo and macro levels* - During the course of the practicum, it became evident that the efficiency and effectiveness of the clinical interventions were to be significantly influenced by the current state of professional and public knowledge, governmental involvement and research.

At the start of the practicum, there were very few efforts being directed toward promoting public awareness and increasing professional knowledge in the area of elder abuse. However, over the next eleven months, many programs were developed which were aimed at increasing awareness and understanding, both locally and nationally. This resulted in a noticeable change in attitude both on the part of professionals and the general public as well. At a professional level, there was an increasing interest and desire to learn more about elder abuse/neglect. At a public level, more people began expressing concern regarding their own situation or someone they knew.

Toward the end of the practicum, there was more significant movement on the part of the provincial government to address the area of legislation and more funding was made available for community resources such as the Elder Abuse Resource Centre. Notwithstanding these progressive developments, however, it

was clear that there remained an urgent need for immediate attention to this area in order that clinical interventions be enhanced, supported and maintained. This practicum yielded a critical need for the development of more specific guidelines to serve professionals; professional training programs; increased respite, home care and day care services; legal and advocacy programs; family counselling services for the elderly and significant others; shelters which accommodate the needs of elderly men and women and seniors housing without lengthy waiting lists for interim or long-term residency.

Based on the aforementioned findings, a list of recommendations follows.

### **Recommendations arising from the Practicum**

1. That intervention take place at all system levels - the micro, mezzo and macro levels (Hudson, 1986) in order that the problem be dealt with comprehensively.
2. That the issue of mandatory reporting be fully explored by government both locally and nationally utilizing input from programs with experience in this area such as the Beth Israel Hospital Assessment Team in Boston and those Provinces with mandantory reporting requirements.

3. That resources be available to meet the needs which have been identified through this and other studies such as crisis lines; counselling; shelters; housing; home care, day care and respite services; legal and advocacy programs.

4. That consideration be given to establishing a shelter in a setting such as the one in which this practicum took place. The physical setting, the time frame allowed for effective intervention, the inter-disciplinary approach were all features which contributed greatly to the overall effectiveness of intervention in the eight situations described.

5. That a standardized protocol be developed for use in health care settings and that the protocol include screening, assessment, intervention and evaluation tools. This protocol would be subject to periodic evaluation and refinement.

6. That a short, easily completed screening checklist be completed on elders entering a health care setting along with the general admission assessment. The checklist presently being tested at the Winnipeg Municipal Hospital in Winnipeg is considered to be useful in terms of targeting potential abuse/neglect situations early in the patient's program, thereby averting a crisis at the time of discharge or later in the community.

7. That an inter-disciplinary approach to assessment, intervention and evaluation be practised in health care settings dealing with elder abuse/neglect and that professional training in the area and team building seminars be included as part of the inter-disciplinary teams development. Another method for enhancing the growth and development of teamwork might be to have an experienced mediator present at team meetings to assist with problem-solving as the team negotiates an approach to case management as well as assessment and intervention.

8. That the client exercise as much free choice as possible and that the concepts of the "least restrictive alternative" and "do no harm" guide any intervention until such time as more specific guidelines are developed and tested.

9. That assessment and intervention be flexible, broad and based in an ecological perspective. An assessment tool such as the Allardyce Tool is recommended since it is designed not only to elicit a comprehensive assessment and give a focus for intervention but because of its research potential as well.

10. That researchers attempt to further study the issue of elder abuse within an ecological context such that the interrelationships between and among factors or constructs within all four levels (otogenic, microsystem, exosystem and macrosystem) are analyzed. This would require the systematic study of a series of research projects each incorporating a manageable number of possible ecological relationships.

11. And finally, that more in-depth practicum studies be developed in a variety of community and health care settings. Specific studies designed to examine single issues such as the significance of loyalty in elder abuse/neglect situations or general studies such as this one are all necessary for the ongoing collection of knowledge to be used in an area which is predicted to become more problematic with the years.

## References

- Allardyce, S. (1991). Elder Abuse Intake and Assessment Form. Manuscript in preparation.
- Anderson, C. L. (1981). Abuse and neglect among the elderly. *Journal of Gerontological Nursing*, 7(2), 77-85.
- Attkissan, C. and Zwick, R. (1982). CSI: Psychometric properties and relations in service utilization and psychotherapy outcome. *Evaluation and Program Planning*, 5, 233-237.
- Auerswald, E. (1987). Epistemological confusion in family therapy and research. *Family Process*, 26, 317-330.
- Beck, C. and Phillips, L. (1984). The unseen abuse: Why financial maltreatment of the elderly goes unrecognized. *Journal of Gerontological Nursing*, 10(12), 26-30.
- Belsky, J. (1980). Child Maltreatment: An ecological integration. *American Psychologist*, 35(4), 320-335.
- Beth Israel Hospital Assessment Team. (1986). Practice concepts: An elder abuse assessment team in an acute hospital setting. *The Gerontologist*, 26(2), 115-118.
- Block, J., King, M., and McGrath, G. (1985). *Elderly victims of physical presenting in hospital: A Canadian study*. (Adapted from a presentation at the XIII meeting of the International Association on Gerontology). Vancouver, B.C.



- Block, M. R., and Sinnott, J. D. (1979). *The battered elder syndrome: An exploratory study*. College Park, MD: University of Maryland Press.
- Brekke, J. (1987). Detecting wife and child abuse in clinical settings. *Social Casework: Journal of Contemporary Social Work*, 332-338.
- Brofenbrenner, V. (1979). *The ecology of human development*. Cambridge, Mass: Harvard University Press.
- Cohen, P. (1984). Violence in the family: An act of loyalty?. *Psychotherapy*, 21, 249-253
- Douglass, R. (1983). Opportunities for prevention of domestic neglect and abuse of the elderly. *Aging and Prevention*, 135-149.
- Douglass, R. (1983). Domestic neglect and abuse of the elderly: Implications for research and service. *Family Relations*, 32, 395-402.
- Douglass, R., Hickey, T. and Noel, C. (1980). *A study of the elderly and other vulnerable adults*. Ann Arbor, MI: University of Michigan Institute of Gerontology.
- Edwards, C. (1985). *Elder abuse: The hidden phenomena*. (Prepared for the Provincial conference on elder abuse). Vancouver, B.C.
- Elder, G. (1977). Family history and the life course. *Journal of Family History*, 2, 279-304.
- Flanzer, J. (1982). The many faces of family violence. Springfield, Ill: Charles C. Thomas.
- Floyd, J. (1981). Collecting data on abuse of the elderly. *Journal of Gerontological Nursing*, 10(12), 11-15.

- Forward, S. (1986). *Men who hate women and women who love them*. New York, NY: Bantam.
- Fulmer, T. and O'Malley, T. (1987). *Inadequate care of the elderly: A health care perspective on abuse and neglect*. New York: Springer Publishing.
- Gelles, R. and Strauss, M. A. (1979). Determinants of violence in the family: Toward a theoretical integration. In W. R. Burr et. al., (Eds.), *Contemporary Theories about the Family*. Vol. 1. New York, NY: Free Press.
- Gil, D. G. (1970). *Violence against children*. Cambridge, Mass: Harvard University Press.
- Giordano, N. and Giordano, J. (1986). Elder abuse: A review of Health and Welfare Canada. In *Abuse and neglect of the elderly*. Ottawa: National Clearing House on Family Violence.
- Government of Canada. Working Together. 1989 National Forum on Family Violence, June 18 - 21, 1989. Discussion Paper: Elder Abuse.
- Government of Manitoba. (1989). Elder abuse in Manitoba: A discussion paper from the Minister Responsible for Senior Citizens. Winnipeg: Government of Manitoba.
- Hill, C. (1984). Caring for an elderly relative. *Canada's Mental Health*, March, 13-14.
- Hudson, J. E. (1988). Elder abuse: An overview. In B. Schlesinger and R. Schlesinger (Eds.), *Abuse of the elderly*. Toronto, Ont.: University of Toronto Press.
- Katz, K. D. (1979). Elder Abuse. *Journal of Family Law*, 18, 695-722.

- Kosberg, J. (1983). *Abuse and maltreatment of the elderly: Causes and Interventions*. Boston, Mass.: John Wright P.S.B. Inc.
- Krugman, S., Bograd, M. and Shapiro, R. (1986). Solutions to spouse abuse. *Networker*, May-June, 40-66.
- Laird, J., and Hartman, A. (1983). *Family Centred Social Work Practice*. New York: Free Press.
- Larson, D., Atkisson, C., Hargraves, W., and Nguyent, T. (1979). Assessment of client/patient satisfaction: Development of a general scale. *Journal of Evaluation and Program Planning*, 2, 197-207.
- Lau, E. and Kosberg, J. (1979). Abuse of the elderly by informal caregivers. *Aging*, 11-15.
- Meier, J. H. (1985). Definition, dynamics and prevalence of assault against children: A multifactorial model. In J. H. Meier, (Ed.), *Assault against children*. San Diego, CA: College Hill Press.
- McCall, G. and Simmons, J. (1966). *Identities and interactions*. New York, NY: Free Press.
- McNair, D., Lorr, M. and Droppleman, L. (1979). *P.O.M.S.: Profile of mood states*. San Diego, CA: Edits.
- Matlaw, J. and Mayer, J. (1986). Elder abuse: Ethical and Practical Dilemmas for Social Work. National Association of Social Workers Inc. *Health and Social Work (the Journal)*.
- National Council of Organizations for Children and Youth. (1976). *America's Children*. Washington, D.C.

- O'Malley, T. A., Everett, D. E., O'Malley, H. C. and Campion, E. W. (1983). Identifying and preventing family mediated abuse and neglect of elderly persons. *Annals of Internal Medicine*, 98, 998-1005.
- Pedrick-Cornell, P. and Gelles, R. (1981). *Elder abuse: The status of current knowledge*. Providence, R.I.: Brown University Press.
- Pillemer, K. and Finkelhor, D. (1988). Causes of elder abuse: Caregiver stress versus problem relatives. *American Journal of Orthopsychiatry*, 59, 179-187.
- Pillemer, K. and Wolfe, R. (1986). *Elder abuse: Conflict in the family*. Dover, Mass.: Auburn House Publishing Co.
- Phillips, L. R. (1980). *Family relations between two samples of family of elderly individuals* (Ph.D. dissertation). Arizona: University of Arizona.
- Podnieks, E., Pillemer, K., Nicholson, J., Shillington, T. and Frizzell, A. (1989). *National Survey on Abuse of the Elderly in Canada: Preliminary Findings*. Toronto: Ryerson Polytechnical Institute.
- Rathbone-McCuan, E. (1980). Elderly victims of family violence and neglect. *Social Casework*, May, 296-304.
- Ray, M. (1982). *The abused partner: An analysis of domestic battering*. New York, N.Y.: Van Nostrand Reinhold.
- Rounds, L. (1984). Environmental factors precipitate abuse. *Journal of Gerontological Nursing*, 10(8), 41-42.
- Schlesinger, B. and Schlesinger, R. (1988). Abuse of the elderly: Knowns and unknowns. In B. Schlesinger and R. Schlesinger (Eds.), *Abuse of the elderly*. Toronto, ON: University of Toronto Press.

- Schlesinger, B. and Schlesinger, R. (Eds.). (1988). *Abuse of the elderly*. Toronto, ON: University of Toronto Press.
- Shell, D. (1982). *Protection of the elderly: A study of elder abuse*. Winnipeg, MB: Manitoba Council on Aging.
- Sgroi, S. M. (1982). *Handbook of clinical intervention in child sexual abuse*. Lexington, MA: Lexington Books/D.C. Heath and Co.
- Steinmetz, S. K. (1977). *The cycle of violence: Assertive, aggressive and abusive family interaction*. New York, NY: Praeger.
- Steinmetz, S. K. (1978). Battered parents. *Society*, July-August, 24-27.
- Steur, J. and Austin, E. (1980). Family abuse of the elderly. *Journal of the American Geriatrics Society*, 28(8), 372-376.
- Straus, M. (Ed.). (1988). *Abuse and victimization across the life span*. Baltimore, MD.: Johns Hopkins Press.
- Straus, M. A. (1979). Family patterns and child abuse in a nationally representative American sample. *Child Abuse and Neglect*, 3, 213-225.
- Straus, M. A. (1980). Stress and physical child abuse. *Child Abuse and Neglect*, 4, 75-88.
- Straus, M. A., Gelles, R. J., and Steinmetz, S. K. (1980). *Behind closed doors: Violence in the American family*. Garden City, NJ: Doubleday.
- Tomita, S., Clark, H., Williams, V. and Rabbitt, J. (1981). *Detection of elder abuse and neglect in a medical setting*. (Printed from a presentation at the First National Conference on Abuse of Older Persons). San Francisco, CA: University of San Francisco.

- Tomita, S. and Quinn, M. (1986). *Elder abuse and neglect: Causes, diagnosis and intervention strategies*. New York, NY.: Springer.
- Whiting, B. and Whiting, J. *Children of six cultures*. Cambridge, Mass: Harvard University Press.
- Williams, G. (1983). Child Abuse. In Walker, E. and Roberts, M., (Eds.), *Handbook of clinical child psychology*. New York, NY: Wiley.
- Wodarski, J. (1987). *An examination of spouse abuse: Practise issues for the profession*. Athens, GA: University of Georgia.
- Young, M. (1977). *Lonely parents: Observations by public health nurses of alienation in child abuse*. July, 1977.

**APPENDIX A**

**Winnipeg Municipal Hospital Screening Tool**

APPENDIX A

INTERDISCIPLINARY SCREENING CHECKLIST FOR IDENTIFYING POTENTIALLY AT RISK PATIENTS

This checklist can be completed by any or all members of the Health Care Team. Please indicate discipline involved in comment section.

	<u>YES</u>	<u>NO</u>	<u>COMMENTS/SIGNATURE</u>	<u>DATE</u>
I			Are there any unusual physical features noted on the physical assessment. (i.e., untreated bed sores or fractures, bruises, scratches, person is unkempt)?	
II			Do any of the responses made by the patient or observed by the staff re the patient's attitude towards their family suggest the need for further exploration (i.e., reluctance to talk openly; waits for caregiver to respond, avoids physical or verbal contact with care giver)?	
III			Does the behavioral response of the patient suggest that they are feeling helpless resigned, sad, listless (not illness related) lack of self worth, fearful, passive, angry or aggressive? (please circle)	
IV			Has the family and/or caregiver verbalized feelings of stress over their caregiving (i.e., feels forced into caregiving role, isolated with no supports)?	
V			Are the family/caregiver's behavioral responses to patient and/or staff inappropriate to the situation (i.e., lacks information/ understanding of patient's needs, responds with defensiveness when questioned; excessively under or over concerned, acts aggressive/ insults/harasses patient or staff)?	
VI			Does the patient and/or family state, or, is there observed violent behavior, substance abuse, financial mismanagement or other mistreatments?	

DISPOSITION: Referred to Social Work for assessment (circle)      YES      NO

Patient's Name \_\_\_\_\_

Hospital Number \_\_\_\_\_

Date Completed \_\_\_\_\_



**APPENDIX B**

Allardyce Assessment Tool

APPENDIX B

ELDER ABUSE INTAKE AND ASSESSMENT FORM

DATE:

COMPLETED BY:

COMPLETED WITH:

IF OTHER THAN ELDER, IDENTIFY PARTICIPANT'S RELATIONSHIP TO ELDER:

<p>TO BE COMPLETED AT CLOSURE</p> <p><u>Abuse:</u> Suspected _____ Confirmed _____ Not Present _____</p> <p><u>Police Charges:</u> Yes _____ No _____</p>
---

GENERAL LIFESTYLE ISSUES

ACCESS TO AND USE OF FORMAL SUPPORTS

	Almost Always	Very Fre- quently	Fre- quently	Infre- quently	Never	Not Assessed	Not App- ropriate
1. Receives range of medical services when appropriate or requested, eg. eye doctor, dentist, specialist(s), etc.	1	2	3	4	5	N/A	N/APP
2. Has transportation to health services.	1	2	3	4	5	N/A	N/APP
3. Is able to appropriately describe the purpose and function of each medication taken.	1	2	3	4	5	N/A	N/APP
4. Caregiver is able to appropriately describe the purpose and function of each medication administered.	1	2	3	4	5	N/A	N/APP
5. Receives Home Care, Meals on Wheels, and other types of assistance if needed.	1	2	3	4	5	N/A	N/APP
6. Has been admitted to hospital on a respite basis when required.	1	2	3	4	5	N/A	N/APP

COMMENTS:

LIVING ARRANGEMENTS

	Almost Always	Very Fre- quently	Fre- quently	Infre- quently	Never	Not Assessed	Not App- ropriate
7. Environment is safe, eg. home safety measures are adequate, fear of crime is not expressed, etc.	1	2	3	4	5	N/A	N/APP
8. Has access to a telephone.	1	2	3	4	5	N/A	N/APP
9. Has appropriate mobility within the home, eg. wheelchair, bedroom on the main floor of the home, etc.	1	2	3	4	5	N/A	N/APP
10. Environment is conducive to physical well-being, eg. absence of health hazards such as insects, faulty wiring, lack of hearing, etc.	1	2	3	4	5	N/A	N/APP
11. Has access to TV, radio and other types of visual/audio stimulation.	1	2	3	4	5	N/A	N/APP
12. Suitable standard of cleanliness is maintained in the home, eg. regular changes of linen and bedding, etc.	1	2	3	4	5	N/A	N/APP

COMMENTS:

GENERAL WELL-BEING

13. Feels isolated, eg. not included in family mealtimes, kept in a bedroom apart from the family, etc.	5	4	3	2	1	N/A	N/APP
14. Expresses discomfort at not obtaining enough/obtaining too much sleep.	5	4	3	2	1	N/A	N/APP
15. Outlines positive, nurturing aspects of living in present environment. (DETAILS)	1	2	3	4	5	N/A	N/APP

COMMENTS:

FINANCESPERSONAL FINANCIAL DECISION MAKING

	Almost Always	Very Frequently	Frequently	Infrequently	Never	Not Assessed	Not Appropriate
1. Maintains control over personal finances, eg. bank deposits, withdrawals, etc., and/or provides specific instructions for family/friends	1	2	3	4	5	N/A	N/APP
2. Purchases appropriate clothing size, seasons of the year, etc. or provides specific instructions regarding purchasing.	1	2	3	4	5	N/A	N/APP
3. Has sufficient funds for amusements/social outings.	1	2	3	4	5	N/A	N/APP
4. Has appropriate A.D.L. supports.	1	2	3	4	5	N/A	N/APP

COMMENTS:

FAMILY FINANCIAL DECISION MAKING

5. Chooses to contribute monies to household expenses, eg. rent, utilities, groceries, etc.	1	2	3	4	5	N/A	N/APP
6. Chooses to contribute towards major home repairs.	1	2	3	4	5	N/A	N/APP
7. Has some input into household budgeting.	1	2	3	4	5	N/A	N/APP
8. Feels there is enough money to meet the needs of everyone in the family (if not, explain).	1	2	3	4	5	N/A	N/APP

	Almost Always	Very Fre- quently	Fre- quently	Infre- quently	Never	Not Assessed	Not App- ropriate
9. Feels money is not managed appropriately by family members, eg. too much money is spent on alcohol, etc.	5	4	3	2	1	N/A	N/APP
10. Maintains control over personal property, eg. disposal of any properties and/or belongings was done in accordance with person's wishes.	1	2	3	4	5	N/A	N/APP
11. Feels coerced into giving gifts of money, belongings, or property to adult children and/or grandchildren. (DETAIL)	5	4	3	2	1	N/A	N/APP

COMMENTS:

SOCIAL SUPPORTS (EXCLUDING FAMILY)

ACTIVITIES

1. Is satisfied with level of participation in recreation, fitness, club and/or religious activities. (DETAIL)	1	2	3	4	5	N/A	N/APP
2. Describes a typical day which includes activities that were enjoyed. (DETAIL)	1	2	3	4	5	N/A	N/APP

COMMENTS:

SOCIAL NETWORK

3. Isolated from friends and neighbours.	5	4	3	2	1	N/A	N/APP
4. Is satisfied with the extent of contact with friends.	1	2	3	4	5	N/A	N/APP

	Almost Always	Very Frequently	Frequently	Infrequently	Never	Not Assessed	Not Appropriate
5. Enjoys activities that they do together. (DETAIL)	1	2	3	4	5	N/A	N/APP
6. Is able to access friends without assistance.	1	2	3	4	5	N/A	N/APP
7. Has certain friends who are particularly helpful and caring. (DETAIL)	1	2	3	4	5	N/A	N/APP

COMMENTS:

#### PERSONAL HISTORY

##### CHILDHOOD

1. Felt that parental anger resulted in excessive and/or inappropriate discipline, eg. beatings, belittling, etc.	5	4	3	2	1	N/A	N/APP
2. States was abused by parents as a child, eg. physically, sexually and/or psychologically. (DETAIL)	5	4	3	2	1	N/A	N/APP
3. Alcohol/drug abuse was prevalent in the family.	5	4	3	2	1	N/A	N/APP

COMMENTS:

##### ADULTHOOD

4. Family/friends outside the nuclear family were available for support as needed.	1	2	3	4	5	N/A	N/APP
5. Observed own or spouse's parents being abused. (DETAIL)	5	4	3	2	1	N/A	N/APP

	Almost Always	Very Frequently	Frequently	Infrequently	Never	Not Assessed	Not Appropriate
6. Abused own or spouse's parents. (DETAIL)	5	4	3	2	1	N/A	N/APP
7. Felt that anger was displayed inappropriately in household. (DETAIL)	5	4	3	2	1	N/A	N/APP
8. Observed abuse of spouse and/or children. (DETAIL)	5	4	3	2	1	N/A	N/APP
9. Abused spouse and/or children. (DETAIL)	5	4	3	2	1	N/A	N/APP
10. Was abused by spouse and/or children. (DETAIL)	5	4	3	2	1	N/A	N/APP
11. Alcohol/drug abuse was prevalent in the family.	5	4	3	2	1	N/A	N/APP

## COMMENTS:

FAMILYCOMMUNICATION

1. Receives visits from/visits extended family members.	1	2	3	4	5	N/A	N/APP
2. Feels listened to and understood by family, eg. is comfortable expressing needs to family, etc. (DETAIL)	1	2	3	4	5	N/A	N/APP
3. Ignores/denies that there are problems/issues within the home, eg. substance abuse, etc. (DETAIL)	5	4	3	2	1	N/A	N/APP

	Almost Always	Very Frequently	Frequently	Infrequently	Never	Not Assessed	Not Appropriate
4. Becomes withdrawn/fearful when talking about family members, eg. expresses fear of reprisal or abandonment when discussing family members.	5	4	3	2	1	N/A	N/APP
5. Becomes overly aggressive when talking about family members, eg. raises tone of voice, belittles family members, etc.	5	4	3	2	1	N/A	N/APP

COMMENTS:

AFFECTIVE RELATIONSHIPS

6. States aspects of family life that are considered important by the person <u>and states that these are experienced.</u> (DETAIL)	1	2	3	4	5	N/A	N/APP
7. Describes alliances within the family that are potentially harmful to the person, eg. members talking behind back, taking money for substance abuse, etc. (DETAIL)	5	4	3	2	1	N/A	N/APP
8. Appears overly protective of family members, eg. perceives outside "threats" to family such as visits from Child and Family Services, Police, etc.	5	4	3	2	1	N/A	N/APP
9. Blames self for existing problems in the family.	5	4	3	2	1	N/A	N/APP

COMMENTS:



BEHAVIOUR/CONTROL ISSUES

	Almost Always	Very Fre- quently	Fre- quently	Infre- quently	Never	Not Assessed	Not App- ropriate
10. Feels that expressed anger becomes uncontrolled and leads to violent behaviour within family members. (DETAIL)	5	4	3	2	1	N/A	N/APP
11. Feels family has appropriate ways of dealing with stressful family situations, eg. adult child does not lash out physically at spouse in response to situation of unemployment, etc. (DETAIL)	1	2	3	4	5	N/A	N/APP
12. Ignores or is unaware of children'/families' stressful situations, eg. unemployment, separation, etc.	5	4	3	2	1	N/A	N/APP
13. States there is substance abuse within the family. (DETAIL)	5	4	3	2	1	N/A	N/APP
14. Feels power in the family is consistently held by one person, eg. one person is most likely to make major decisions, etc. (DETAIL)	1	2	3	5	5	N/A	N/APP
15. Assumes helpless/dependent stance as assertiveness is responded to with violence, eg. elder feels unable to affect power imbalances within the family. (DETAIL)	5	4	3	2	1	N/A	N/APP
16. States specific abuse received from family members. (DETAIL)	5	4	3	2	1	N/A	N/APP
17. Habit disorders are observed, eg. thumbsucking, rocking, etc.	5	4	3	2	1	N/A	N/APP

COMMENTS:

ROLES

	Almost Always	Very Frequently	Frequently	Infrequently	Never	Not Assessed	Not Appropriate
18. Feels he/she has a meaningful role in family, eg. gives emotional support when required to adult children, etc. (DETAIL)	1	2	3	4	5	N/A	N/APP
19. Feels unreasonable expectations of the person's capabilities are held by the caregiver, eg. when person is used as a housekeeper or babysitter against his/her wishes.	5	4	3	2	1	N/A	N/APP
20. Unreasonable expectations of the caregiver's capabilities are held by the person, eg. person expects caregiver to stay home with him/her and not go out to visit friends, etc. as this is equated with desertion.	5	4	3	2	1	N/A	N/APP
21. Expresses discomfort at not being able to help around the home.	5	4	3	2	1	N/A	N/APP
22. Feels that family has inappropriately removed decision-making responsibilities. (DETAIL)	5	4	3	2	1	N/A	N/APP
23. Caregiver has felt pressured into assuming the role of caregiver, eg. due to financial hardship, or guilt because parent raised him/her, etc.	5	4	3	2	1	N/A	N/APP
24. Caregiver feels inadequate in the caregiving role, eg. is concerned he/she doesn't understand the person's emotional needs, doesn't spend time with the person, etc.	5	4	3	2	1	N/A	N/APP

COMMENTS:

SUMMARY SCORE SHEETGENERAL LIFESTYLE ISSUES

	SUBSCORES	MEAN SCORES
a) Access to and Use of Formal Supports	_____	_____
b) Living Arrangements	_____	_____
c) General Wellbeing	_____	_____
Total	=====	

FINANCES

	SUBSCORES	MEAN SCORES
a) Personal Financial Decision Making	_____	_____
b) Family Financial Decision Making	_____	_____
Total	=====	

SOCIAL SUPPORTS (EXCLUDING FAMILY)

	SUBSCORES	MEAN SCORES
a) Activities	_____	_____
b) Social Network	_____	_____
Total	=====	

PERSONAL HISTORY

	SUBSCORES	MEAN SCORES
a) Childhood	_____	_____
b) Adulthood	_____	_____
Total	=====	

FAMILY

	SUBSCORES	MEAN SCORES
a) Communication	_____	_____
b) Affective Relationships	_____	_____
c) Behaviour/Control Issues	_____	_____
d) Roles	_____	_____
Total	=====	
 TOTAL RAW SCORE	_____	

**APPENDIX C**

**Tomita and Quinn Protocol**

## Appendix C

### Elder Abuse and Neglect:

#### Written Protocol for Identification and Assessment

---

### ASSESSMENT

#### History

##### Methodology Technique

1. Examine client alone without caregiver
2. Explain to caregiver he/she will be interviewed separately after client is interviewed; this is part of routine exam.
3. Do not rush during interview. Provide support to client and caregiver. Work questions into conversation in relaxed manner
4. Do not be judgmental or allow personal feelings to interfere with providing optimal care. do not prematurely diagnose client as a victim of elder abuse or neglect; do not tell caregiver what treatment plans are until all facts are gathered.
5. Pay special attention to trauma, burns, nutrition, recent change in condition, and financial status.
6. Do collateral contacts as soon as possible with others, i.e., visiting nurse, neighbours, friends, to obtain additional information

#### Signs and Symptoms Suspicious for Abuse/Neglect

1. Client brought in to hospital Emergency Room by someone other than caregiver.
2. Prolonged interval between trauma/illness and presentation for medical care (i.e., gross decubiti).
3. Suspicious history: client is new to system with history of "shopping" or "doctor hopping". Description of how injury occurred is alien to the physical findings, either better or worse; client has injuries not mentioned in history; has history of previous similar episodes; too many "explained" injuries or inconsistent explanations over time.
4. Medication bottles or the client's pharmacy profile indicates medications are not being taken or given as prescribed.

#### Functional Assessment Evaluation

1. Administer Mini-Mental State Exam or Dementia Scale to determine current mental status > (Kahn-Goldfarb Dementia Scale - 1 point each if patient knows age, day, month, year, month of birth, year of birth, street address, city, President of United States, last past President of United States) (Poor = 0-2, Fair = 3-7, Good = 8-10).
2. Collect pertinent data: i.e., length of time at residence, medical insurance source, income source(s).
3. Assess client's ability to perform activities of daily living - i.e., ability to do self-care, ambulation status, ability to do meal preparation, pay bills, shop; mode of transportation, etc.
4. Ask client to describe a typical day to determine degree of independence or dependence on others, most frequent and significant contacts, who and how often seen.
5. Ask client role expectations of self and caregiver.

6. Have client report recent crisis in family life.
7. Ask if there is alcohol use, drug use, mental illness, or behaviour dyscontrol among household or family members.
8. Ask directly if patient has experienced:
  - a. Being shoved, shaken, or hit (record verbatim; when, where on body, examine body).
  - b. Being left alone, tied to chair or bed, or left locked in room (record verbatim; when and duration).
  - c. Having money or property taken or signed over to someone else. Determine current assets, financial status (specify).
  - d. Withholding of food or medication or medical care, being over-sedated with medication or alcohol.
  - e. Being threatened or experiences fear of caregiver.
9. Assess how client responds in situations listed above.
10. Ask client how he/she copes with stress and upsetting incidents.
11. Assess degree of patient's dependence on caregiver alone for financial, physical and/or emotional support.

#### Physical Exam

1. In medical setting, a standard comprehensive examination should be completed on a gowned undressed patient (no exceptions). In home, attempt review of body while protecting client's modesty.
2. If injury is due to an accident, document circumstances (i.e., client was pushed, client was balance problem, patient was drowsy from medications and fell).



3. Examine closely for effects of undermedication, overmedication, assess nutrition , hygiene, and personal care for evidence of abuse/neglect (i.e., dehydration or malnourishment without illness-related cause).
4. Assess for
  - a. Burns, unusual location or type
  - b. Physical or thermal injury on head, scalp, or face.
  - c. Bruises and haematomas:
    - (1) Bilaterally on soft parts of body, not over bony prominences (knees and elbows). Inner arm/thigh bruises are very suspicious.
    - (2) Clustered as from repeated striking.
    - (3) Shape similar to an object or thumb/finger prints.
    - (4) Presence of old and new bruises at the same time as from repeated injury, injuries in different stages of resolution.

#### Dating of Bruises

0-2 days	swollen, tender
0-5 days	red-blue
5-7 days	green
7-10 days	yellow
10-14 days	brown
2-4 weeks	clear

- (5) Presence of bruises after changing health care provider or after prolonged absence from health care agency.
- d. Mental status and neurological exam changes from previous level.

- e. Fractures, falls, or evidence of physical restraint. Contractures may indicate confinement for long periods.
- f. Ambulation status: poor ambulation may be suggestive of sexual assault or other "hidden" injuries.

5. Observe and Document

- a. Size, colour, shape, and location of injury. Use sketch sheet and/or take photographs.
- b. No new lesions during patient's hospitalization.
- c. Family/caregiver(s) do not visit or show concern.
- d. Client's affect and nonverbal behaviour: abnormal/suspicious behaviour of client - extremely fearful or agitated, overly quiet and passive, or expressing fear of caregiver.
- e. Your intuition that all is not well between patient and caregiver.
- f. Client-caregiver interaction: if the caregiver yells at client and client yells back, determine if they "need" to yell at each other and/or if this is a long-term pattern with which both are comfortable. On the contrary, if the verbal threats or yelling incidents are "new" behaviours and the contents of the yelling indicate escalation toward more abusive acts or severe verbal abuse, the practitioner should be concerned.

6. In medical setting, diagnostic procedures as indicated by history or exam may include:

- a. Radiological screening for fractures or evidence of physical restraint.
- b. Metabolic screening for nutritional, electrolyte, or endocrine abnormality.
- c. Toxicology screening or drug levels for over- or undermedication.

- d. Haematology screening for coagulation defect when abnormal bleeding or bruising is documented.
- e. CAT scan for major change in neurological status or head trauma that could result in subdural haematoma.
- f. Gynaecological procedures to rule out STD from sexual assault.

#### Interview with Caregiver

"Thank you for waiting while interviewed your mother. Now it's your turn. I need your help - I am doing an (psychosocial) assessment of your mother's current functioning and situation in order to determine what services are appropriate at this time. I would like to spend some time with you and have you tell me your perception of how things are here."

- 1. "Tell me what you want me to know about your mother."
- 2. "What is her medical condition? What medicine does she take?"
- 3. "What kind of care does she require?"
- 4. "How involved are you with your mother's everyday activities and care?"
- 5. "What do you expect her to do for herself?"
- 6. "What does she expect you to do for her?"
  - a. And do you do those things?
  - b. Are you able to do them?
  - c. Have you had any difficulties? What kind?"
- 7. "Please describe how you spend a typical day."
- 8. "How do you cope with having to care for your mother all the time?"
- 9. "Do you have supports or respite care? Who and what? Are there other siblings who help?"

10. "What responsibilities do you have outside the home? Do you work? What are your hours? What do you do?"
11. "Would you mind telling me what your income is?" (If this question seems touchy to the caregiver, say, "I just wondered if your family can afford the pills she needs to take." At the same time you are assessing the caregiver's degree of dependence on the elderly client's income/pensions/assets.)
12. "Is your mother's Social Security check directly deposited in the bank?"
13. "Who owns this house? Do you pay rent? Whose name is on the deed?"
14. "If you help your mother pay her bills, how do you do it? Is your name on her account? Do you have power of attorney? Does it have a durable clause? When did you get it?"

Save more delicate questions for last:

1. "You know those bruises on your mother's arm (head, nose, etc.). How do you suppose she got them?" (Document response verbatim. If possible, follow up with request that caregiver demonstrate how injury may have happened.)
2. "Your mother is suffering from malnourishment and/or dehydration", or "Your mother seems rather undernourished and thin. how do you think she got this way?"
3. "Is there any reason you waited this long to seek medical care for your mother?"
4. "Caring for someone as impaired as your mother is, is a difficult task. Have you ever felt so frustrated with her that you pushed her a little harder than you expected? How about hitting or slapping her? What were the circumstances?" (Record verbatim.)
5. "Have you ever had to tie your mother to a bed or chair, or lock her in a room when you go out at night?"
6. "Have there been times when you've yelled at her or threatened her verbally?"

Signs of high-risk situation:

1. Alcohol use, drug abuse, and/or mental illness in caregiver's residence.
2. Caregiver is alienated, socially isolated, has poor self-image.
3. Caregiver is young, immature, and behaviour indicates own dependency needs have not been met.
4. Caregiver is forced by circumstances to care for patient who is unwanted.
5. Caregiver is unemployed, without sufficient funds, dependent on client for housing and money.
6. Caregiver's and/or client's poor health or chronic illness may exacerbate poor relationship.
7. Caregiver exhibits abnormal behaviour, e.g., overly hostile or frustrated, secretive, shows little concern, demonstrates poor self-control, "blames" client, exhibits exaggerated defensiveness and denial, lacks physical contact, lacks facial or eye contact with client, shows overconcern regarding correcting client's bad behaviour, visits patient with alcohol on breath.

Collateral Contacts

1. Do collateral contacts promptly before caregiver attempts to collude with patient.
2. Number of contacts may range from 2 to 17.

Diagnosis

Integrate patient history, physical exam, caregiver history, and collateral contact information.

1. No evidence for elder abuse/neglect
2. Suspicion of neglect
3. Suspicion of abuse

4. Positive for abuse/neglect, gross neglect

Types of Clients (Billamore & Bergman, 1981)

1. Competent, consenting
2. Competent, nonconsenting
3. Incompetent
4. Emergency

## INTERVENTION OPTIONS

### Agency/Professional Intervention

#### Indirect Intervention

1. Documentation - review of chart may later point to abuse.
2. Reporting - most states have Adult Protective Services Units. Approximately 40 states have some form of reporting law, some are mandatory reporting laws, some are voluntary reporting laws.
3. Referral out - refer the case to another agency for follow-up.

#### Direct Intervention to Client

1. Diagnostic Plan
  - a. Geriatric evaluation team home visit or in-clinic assessment
  - b. Short hospital stay or repeated contact for further assessment and case planning.
2. Therapeutic Plan
  - a. Repeated home visits or appointments in office to gain trust, to persuade and bargain with elderly client, to help elder with decision making, ventilation, problem solving (takes up to two years).
  - b. Legal intervention - use least restrictive option to the extent possible (see scale of legal interventions), i.e., apply for guardianship or protective payee status; press charges and/or prosecute.
  - c. Financial crisis intervention:
    - (1) Call the bank to place an alert on the account.
    - (2) Transport the client to the bank to discuss the incident with the bank manager.

- (3) Bring bank personnel to the client's home.
  - (4) Report the incident(s) to the Social Security office.
  - (5) Attempt to void the client's signature on forms signed without the client's knowledge or recall, on forms signed under duress, or when the client most likely was legally incompetent.
3. Education Plan/Empowerment Training to acquire/strengthen positive, powerful self-image.
- a. Assertiveness training.
  - b. How to fend off an attacker
  - c. How to care better for self to reduce dependency on caregiver.
  - d. Advise elder not to have observable pattern of behaviour (i.e., change walking route regularly when going to and from store, bank, etc.).
4. Environmental change - use the least restrictive environmental option to the extent possible (see range of interventions)
- a. Block watch.
  - b. Move to safer place, i.e., elderly housing, another friend, relative, adult foster home, boarding home.
  - c. Home improvements.
  - d. Increased contacts outside of home, i.e., day-care centre.
5. Advocacy/Resource Linkage
- a. Assist elder with obtaining meals-on-wheels, chorework service.
  - b. Link elder to natural helpers and "gatekeepers".
  - c. Telephone checks, i.e., Dial-A-Care.



### Direct Intervention to Caregiver

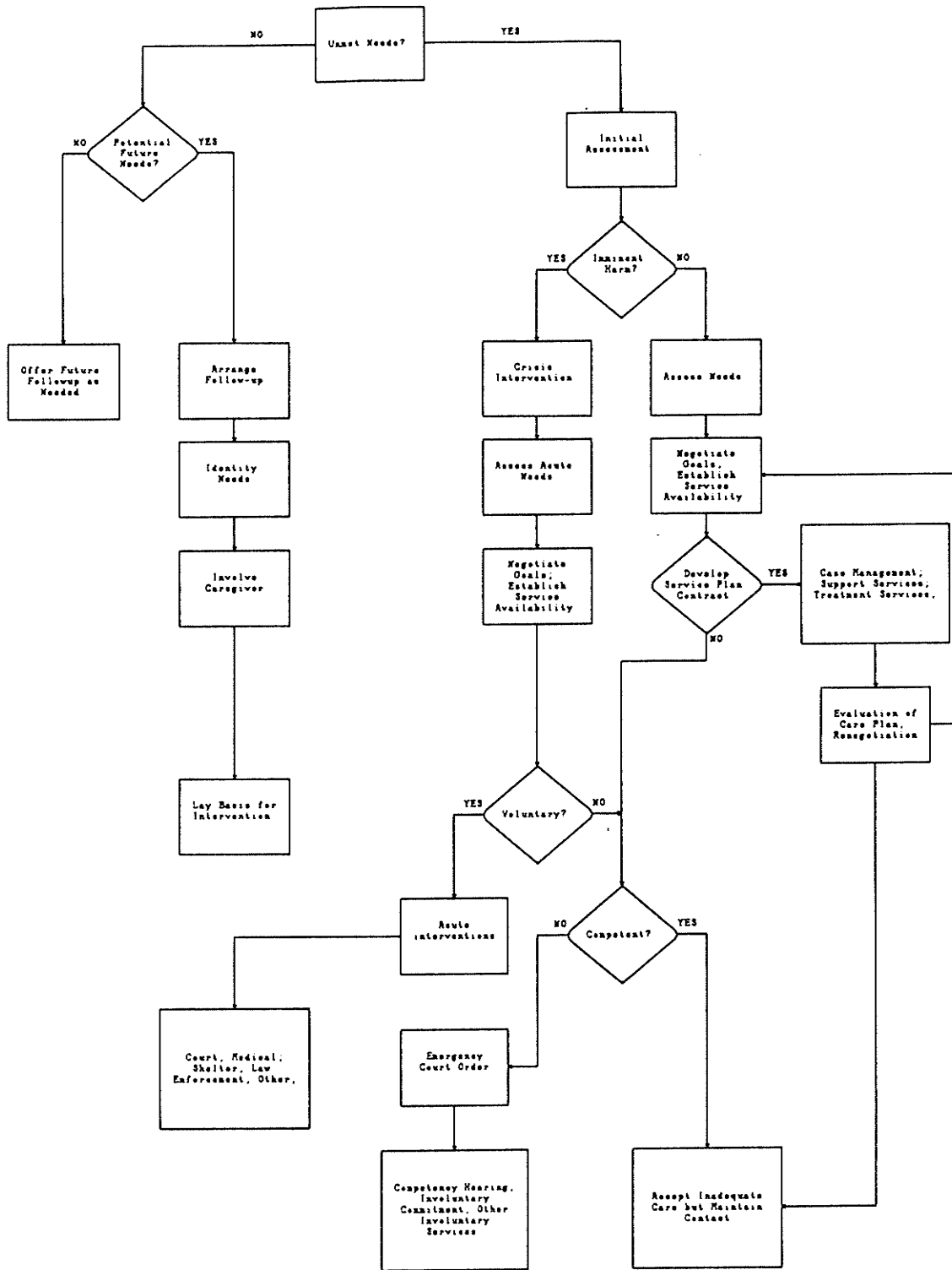
1. Therapeutic Plan
  - a. Repeated home or office visits for family counselling to clarify role expectations and reduce conflict.
  - b. Respite care for elder to give caregiver a rest.
  - c. Obtain cash grants for caregiver when possible.
2. Educational Plan
  - a. Group programs - community-wide information meetings and small informal discussion of groups. Provide information on aging resources and aging process, mutual problem solving and support. Help improve ability to cope with elder and to recognize own needs and limitations.
  - b. Individual contacts, articles to explain "normal" dependency of aging, "senility", Alzheimer's disease, etc.
3. Resource linkage
  - a. Strengthen resources and social supports available to caregivers, i.e., chorework, home health aide.

**APPENDIX D**

**Fulmer and O'Malley Flowchart**

APPENDIX D

Overview of the Process of Intervention



**APPENDIX E**

**Consumer Satisfaction Questionnaire**

## Appendix E

### Responses to Consumer Satisfaction Questionnaire

1. How would you rate the quality of service?  
Excellent (5)  
Good (1)
2. Did you get the kind of service you wanted?  
Yes, generally (3)  
Yes, definitely (3)
3. To what extent has our program met your needs?  
Almost all of my needs have been met (3)  
Most of my needs have been met (3)
4. If a friend were in need of similar help would you recommend our program to him/her?  
Yes definitely (6)
5. How satisfied are you with the amount of help you received?  
Very satisfied (6)
6. Have the services you received helped you to deal more effectively with your problems?  
Yes they have helped a great deal (4)  
Yes they have helped somewhat (2)
7. In an overall, general sense, how satisfied are you with the service you received?  
Very satisfied (5)  
Mostly satisfied (1)
8. If you were to seek help again, would you come back to our program?

**Yes definitely (6)**

**Comments**

**Two general themes were expressed in this category:**

- 1. Appreciation for the opportunity to communicate**
- 2. Appreciation for the respect and empathy demonstrated.**

The student recognizes the limitations of this questionnaire. Not only does the social desirability factor need to be considered but also the fact that those individuals who considered the intervention not to be helpful resisted engagement and were therefore not available to complete the questionnaire (Mrs. A's daughter, Mrs. D's son, Mrs. E's husband and Mrs. F's husband).

It is reasonable to assume that those individuals who exercised their free choice to continue participating in the intervention would be experiencing some degree of satisfaction.

The Client Satisfaction Questionnaire (CSQ)

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much, we appreciate your help.

---

CIRCLE YOUR ANSWER

1. How would you rate the quality of service you received?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of service you wanted?

4	3	2	1
No definitely not	No not really	Yes generally	Yes definitely

3. To what extent has our program met your needs?

4	3	2	1
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need of similar help, would you recommend our program to him/her?

4	3	2	1
No definitely not	No I don't think so	Yes I think so	Yes definitely

5. How satisfied are you with the amount of help you received?

4	3	2	1
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

(OVER)

Have the services you received helped you to deal more effectively with your problems?

4  
Yes they have  
helped a great  
deal

3  
Yes they  
have helped  
somewhat

2  
No they  
really didn't  
help

1  
No they seemed  
to make things  
worse

In an overall, general sense, how satisfied are you with the service you received?

4  
Very  
satisfied

3  
Mostly  
satisfied

2  
Indifferent  
or mildly  
dissatisfied

1  
Quite  
dissatisfied

3. If you were to seek help again, would you come back to our program?

4  
No definitely  
not

3  
No I don't  
think so

2  
Yes I  
think so

1  
Yes definitely

-----  
ADDITIONAL COMMENTS:

PLEASE ATTACH ADDITIONAL SHEETS IF YOU WISH

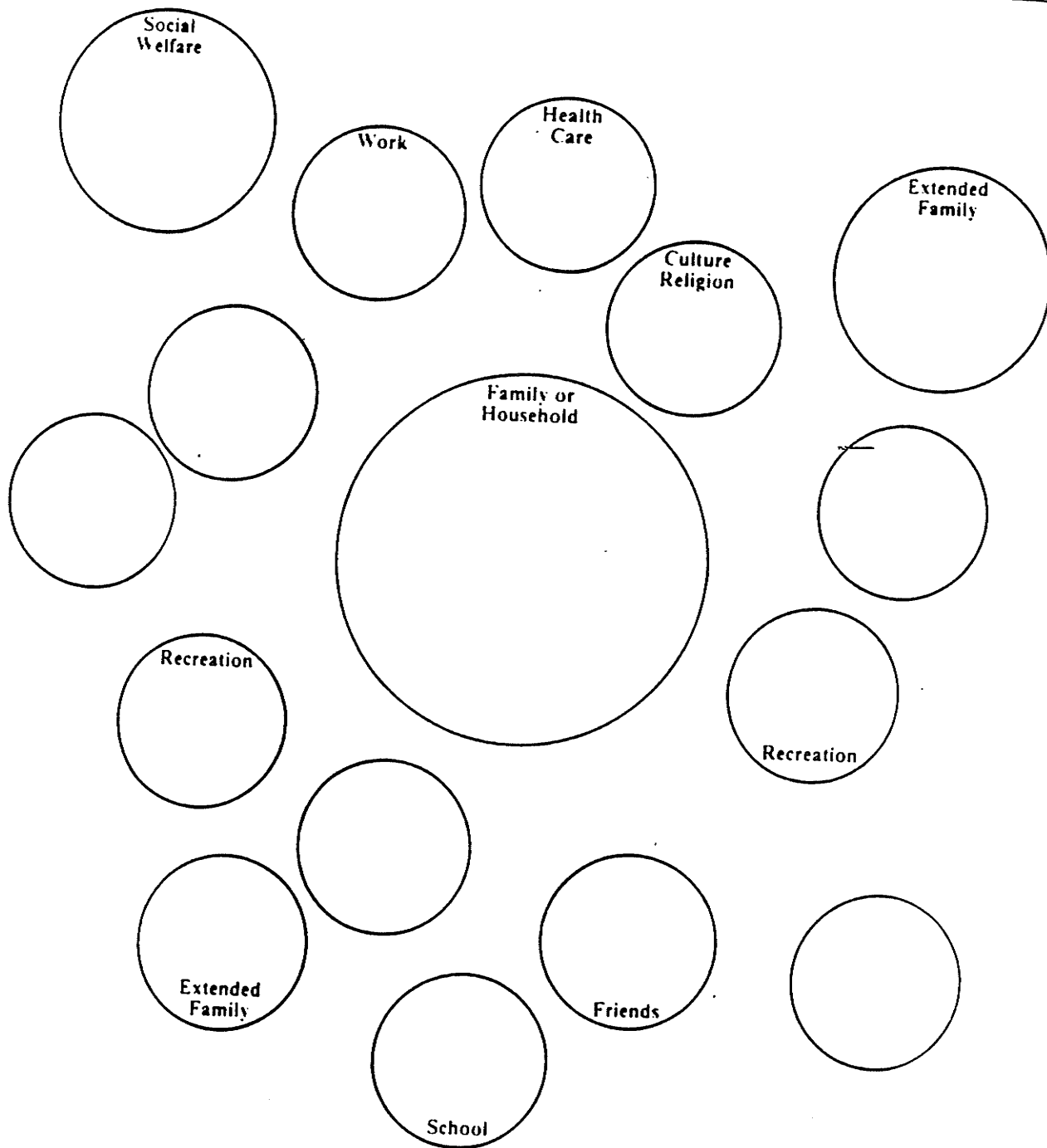


**APPENDIX F**

Ecomap

Name \_\_\_\_\_

Date \_\_\_\_\_



Fill in connections where they exist.  
Indicate nature of connections with a descriptive word or by drawing different kinds of lines:  
\_\_\_\_\_ for strong. ----- for tenuous ++++++ for stressful.  
Draw arrows along lines to signify flow of energy, resources, etc. → → →  
Identify significant people and fill in empty circles as needed.

**APPENDIX G**

**Quality Assurance Form For Elder Abuse  
and Neglect Protocol**





COMMENT: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Auditor Date

Quality Assurance Committee  
Department of Social Work  
Harborview Medical Center