

Research

Perceptions of elder abuse among Australian older adults and general practitioners

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Objectives: *To examine the perceptions of elder abuse among older Australian adults and general practitioners, a topic that has not been explored to the same extent as elsewhere.*

Methods: *Forty-eight general practitioners, 40 independent older adults, 38 older adult caregivers and 36 older care-receivers completed a modified version of Moon and Williams' (1993) questionnaire, which describes 10 potential elder abuse scenarios.*

Results: *Split-plot analysis of variance showed significant differences in the perceptions of severity of elder abuse scenarios across groups and gender. General practitioners tended to view the scenarios as less severe than the older-aged groups. Within the older adult groups, caregivers generally perceived the scenarios as less abusive. Females generally perceived sexual abuse scenarios as more severe compared to males.*

Conclusions: *With such differences in views evident, the development of effective assessment strategies will require more targeted efforts to increase the awareness of elder abuse in the community.*

Key words: *abuse, elder abuse, general practitioners, older adults, perceptions.*

Elder abuse is one of the last forms of familial violence to receive political, social and scientific attention. It has been the subject of study and debate in North America and Europe for approximately 30 years, but in Australia it has only comparatively recently been identified as a significant social problem [1,2]. Pritchard [3] and Kurrle [4] suggest that this has occurred for a number of reasons. First, ageism is very much a part of our society. Older adults may be viewed as less important as they are not seen to be economically productive members of society. Second, in this time of scarce resources and budget constraints, some professionals may be reluctant to confront another social problem because of existing demands upon

them. Third, victims may fail to report abuse because of isolation, poor physical health or fear of the perpetrator retaliating [5].

The topic of elder abuse increased in prominence in the late 1980s and early 1990s as a result of social and economic pressures influencing Australian governments to focus on policies that addressed the needs of the ageing population [6]. The attention to elder abuse was also assisted by the push towards deinstitutionalisation, which produced concern with the pressures faced by informal caregivers, and the potential for neglect of vulnerable groups such as the very old [7].

A significant impediment to the development of an adequate knowledge base on elder abuse has been the problem of developing a standardised definition [8]. Many early definitions were vague and subject to multiple interpretations [9]. However, in the 1990s, Australian researchers came to a general consensus with regard to the definition of elder abuse: that it involved harm caused to older persons by someone with whom they have a relationship involving trust [10,11]. The definition also highlighted that the direction of abusive behaviour may be towards either the older caregiver or the care-receiver. However, there is still debate concerning what the categories of elder abuse are, and which behaviours should be included in each category [11,12].

Two important aspects in answering those questions are older people's views on the topic, and determining whether those views are consistent with those views held by health-care professionals. Research suggests that general practitioners' and physicians' understanding of elder abuse is limited [13–16]. As physicians are in an ideal position to detect and treat some forms of elder abuse, their perspectives on the subject are vital, not only for improving intervention strategies but also for increasing awareness of the problem. Moon and Williams [17] also note that information on the subject of elder abuse has rarely been sought from older adults themselves. The limited studies that have been conducted have obtained conflicting results. For example, Johnson [18] found that both older adults and their caregivers viewed elder abuse in a similar manner. However, Anetzberger et al. [19] found that older adults were more likely to perceive a situation as abusive compared to caregivers. Therefore, examining whether there are differences in perceptions of abuse among older individuals receiving or providing care or those older individuals who are independent is also important.

The Office of Seniors' Interests in Western Australia developed an Australian definition of elder abuse and this was used in the current study. It was chosen because it is a rather broad

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definition, thus allowing examination of the perceptions of severity of abuse within a diverse range of situations. It also includes categories of abuse that have been cited in previous research [20]. The definition is as follows: 'Elder abuse is the wilful or unintentional harm caused to a senior by another person or persons with whom they have a relationship implying trust' [11, p. 3]. This definition of abuse includes the following harmful actions as defined by the Elder Protection Protocol (1997): (i) Physical abuse – infliction of physical pain, injury or physical coercion. (ii) Psychological abuse – infliction of mental anguish, including actions that lead to fear of violence, feelings of shame or powerlessness. (iii) Economic/financial abuse – illegal or improper use of an older person's property, or finances. (iv) Sexual abuse – exploitative behaviour ranging from rape and indecent assault to sexual harassment. (v) Neglect – failure to provide adequate food, shelter, clothing or medical care.

The aim of this study was thus to determine if there were differences or similarities in the perceived severity of abusive scenarios between three groups of older adults (older caregivers, older care-receivers, independent older adults) and general practitioners (GP). The current literature suggests that abusive situations are not seen in the same way by all relevant parties. Possible gender differences were also explored because of the lack of literature on possible gender differences in perceptions of elder abuse. Formal paid caregivers, such as Silver Chain nursing staff, were excluded as the focus was on relatives, family or close friends providing care.

Methods

Participants

The group of GPs comprised 24 males and 24 females, all practising in the Perth metropolitan area. The majority were between 35 and 49 years of age (67%). Most GPs had been practising medicine between 6 and 15 years (63%), and nine for more than 20 years. Half of the GPs reported that they had never encountered a case of elder abuse, and 39% had identified between one to five cases of abuse.

The independent older group consisted of 20 males and 20 females. Nearly half were aged between 65 and 74 years (42%). Most were living at home alone or with a spouse only (90%). The older caregivers' group comprised 20 males and 18 females. Over one-third of these participants were aged 70–74 years, with only six aged over 75 years (16%). Most responded that they were living at home with their spouse. All but seven caregivers were living with a spouse or other family member. The exceptions were living alone. The final group consisted of 36 older care-receivers with an equal number of males and females. The majority were aged 70 years and older (72%), and living with either their spouse or other family members (81%).

Ethics approval

The study was reviewed and approved by the Edith Cowan University Human Research Ethics Committee.

Materials

The participants' perceptions of elder abuse were assessed using a modified version of scenarios developed by Moon and Williams [17] after they reviewed the elder abuse literature and consulted with caseworkers at an Adult Protective Service Department in the USA. The modifications included reducing the number of scenarios from 13 to 10, adopting the five categories of elder abuse that had been identified in the Elder Protection Protocol [11], and including both males and females as potential victims. A pilot study with 45 older adults from five Senior Citizen Centres in Perth and five health-care professionals from a psychogeriatric service was then conducted to determine internal consistency reliability and face validity of the questionnaire. The questionnaire was found to be both reliable (Cronbach alpha of 0.83) and to have content validity, with the health-care professionals concluding that the instrument appeared to measure what it purported to measure. Some minor wording changes to the information letter and some scenarios were made following the suggestions made by the pilot study group.

In the modified questionnaire, the participants were asked to indicate whether or not they perceived each situation to represent an example of elder abuse by responding using a five-point rating-scale: 0, not an example of elder mistreatment; 1, possibly an example of mistreatment; 2, mild form of mistreatment; 3, moderately severe form of mistreatment; and 4, extremely severe form of mistreatment. Participants were also asked to identify what aspect of the scenario they perceived as abusive. Two examples of the scenarios are as follows: one describes a daughter forcing her 65-year-old paralysed father to eat and take his medication. Another describes a son who, when drunk, yells at his father to kill himself so that he no longer has to care for him and can save his money.

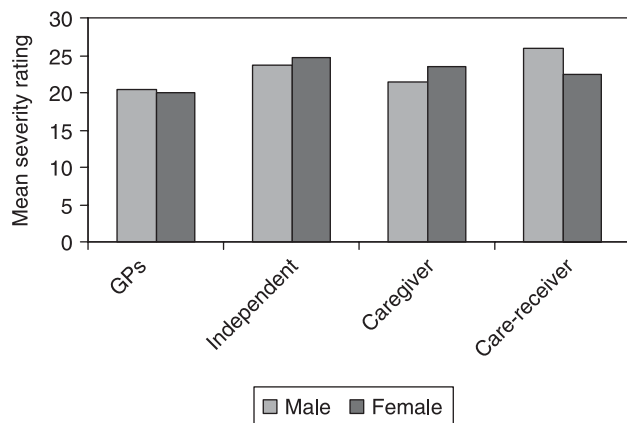
Procedure

Calculations using Pittenger's program [21] suggested that a sample size of 40 per group would provide a power in excess of 0.80 for an effect size between 0.20 and 0.25 for gender differences, between 0.25 and 0.30 for group differences, and between 0.10 and 0.15 for differences among the scenarios.

General practitioners were identified and randomly selected from the Perth metropolitan telephone directories. One hundred and eighty questionnaires were mailed out to ensure that a sample size of at least 40 per group would be obtained. Forty-eight questionnaires were returned – a rate of 26.7%.

A convenience sample of older participants comprising the three groups was obtained from Perth Senior Citizen Centres. These centres are for people over the age of 55 years who wish to participate in social, recreational and educational activities. They are funded by the local councils, the State and Commonwealth Governments under the Home and Community Care program, and by donations from clients. A total of 260 questionnaires were handed out to the various centres, with a return rate of 44%.

Figure 1: Mean ratings of severity of perceived abuse for four groups by gender.



Results

Preliminary *t*-tests were conducted between the pairs of scenarios within each category. With two exceptions for GPs in which the differences were less than 1.5 points, there were no significant differences between the pairs. For later analyses, the ratings for the pairs were summed and the total over two ratings used. The overall severity of perceived abuse collapsed across all categories is shown in Figure 1. A split-plot analysis of variance was the main analysis, with the independent variables of type of person (4) and gender (2) as between-subject factors and categories of abuse (5; physical, psychological, financial, sexual and neglect) as the within-subject factor. This form of analysis was used in order to examine the possible interactions among the groups with the various categories of forms of abuse.

Using an alpha level of .05, the main effect for gender was not significant (Fig. 1). However, significant results were obtained for the main effect for group ($F(3, 154) = 8.38, P < 0.001$), and the group by gender interaction ($F(3, 154) = 2.89, P < 0.05$). For the within-subject effects, both the main effect and interactions

were found to be significant: category, $F(4, 616) = 136.671, P < 0.001$; category by gender interaction, $F(4, 616) = 11.66, P < 0.001$; category by group interaction, $F(12, 616) = 3.73, P < 0.05$; and category by group by gender interaction, $F(12, 616) = 1.78, P < 0.05$. Table 1 indicates that the categories of abuse, neglect and sexual abuse were rated as the most severe forms, followed by psychological abuse and physical abuse, with financial abuse as the least severe form.

Descriptive statistics for the categories of abuse by gender ratings are given in Table 1. Pairwise post-hoc comparisons were conducted using Tukey’s Honestly Significant Difference Test in order to deal with the significant triple interactions and double interactions. For neglect, ratings by male GPs were significantly lower than those of older caregivers, and of male independent older adults and care-receivers. Female GPs rated neglect significantly lower than only the male care-receivers. For the sexual abuse scenarios, independent females and care-receivers rated significantly higher than male caregivers and male GPs. For psychological abuse, both genders of care-receivers and independent females had significantly higher ratings than did the male caregivers and the female GPs. Male GPs were also lower than male care-receivers. For physical abuse, male care-receivers were significantly higher than female GPs and male caregivers. Finally, for financial abuse, female GPs and female care-receivers were lower than male caregivers.

The complex pattern of results suggests that gender differences in the perception of elder abuse vary across both genders and classification of older adults. There were no simple patterns evident in the result beyond the rank ordering of perceived severity of abuse.

Discussion

This study was designed as an exploratory examination of GPs’ and older people’s perceptions of elder abuse. The results are of concern as they suggest that considerable differences exist across groups. For example, GPs tended to view all types of abuse scenarios as less severe compared to the groups of

Table 1: Mean scores as a function of type of elder abuse, group and gender

Type	Group																																																																																																																																					
	General practitioner		Independent		Caregiver		Care-receiver																																																																																																																															
	Mean	SD	Mean	SD	Mean	SD	Mean	SD																																																																																																																														
Physical									Male	3.63	1.38	4.50	1.82	3.55	1.57	4.94	1.26	Female	3.58	1.10	4.70	1.45	4.50	1.29	3.78	1.22	Psychological									Male	4.46	1.77	5.00	1.65	3.65	1.18	6.11	1.18	Female	3.67	1.13	5.35	1.53	4.83	1.65	5.28	1.27	Financial									Male	3.04	1.65	3.00	1.75	3.65	1.42	3.22	1.06	Female	2.13	1.60	2.85	2.16	2.50	1.50	1.67	1.14	Neglect									Male	4.63	1.47	5.85	1.23	5.95	0.94	6.28	1.32	Female	4.79	1.18	5.55	1.61	5.89	1.37	5.39	0.92	Sexual									Male	4.71	1.57	5.35	1.46	4.65	1.09	5.44	1.15	Female	5.75	1.22	6.20	1.44	5.67	1.33	6.28	1.32
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Psychological									Male	4.46	1.77	5.00	1.65	3.65	1.18	6.11	1.18	Female	3.67	1.13	5.35	1.53	4.83	1.65	5.28	1.27	Financial									Male	3.04	1.65	3.00	1.75	3.65	1.42	3.22	1.06	Female	2.13	1.60	2.85	2.16	2.50	1.50	1.67	1.14	Neglect									Male	4.63	1.47	5.85	1.23	5.95	0.94	6.28	1.32	Female	4.79	1.18	5.55	1.61	5.89	1.37	5.39	0.92	Sexual									Male	4.71	1.57	5.35	1.46	4.65	1.09	5.44	1.15	Female	5.75	1.22	6.20	1.44	5.67	1.33	6.28	1.32																											
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Lowest possible score is 0 and highest possible score is 8 per category. The higher the score, the more severe a category of abuse is perceived by the respondent.

older adults. This may reflect physicians' caution in labelling a situation as abusive before additional information is sought, and given that no test exists that can verify the presence of such a broad condition such as elder abuse, physicians may be reluctant to identify a particular set of signs as a consequence of abuse [15]. Other barriers to detection that were not studied here may include the coexistence of elder abuse with other medical and health problems [22], and the denial of abuse by victim and perpetrator [23]. The situation in which an older victim has cognitive impairment provides additional complexities. The overall proportion of GPs who reported experiencing cases of elder abuse was about half, a rate lower than found in previous studies of GPs in the UK [24] or Sweden [25], but more than were reported by a group of French GPs [26].

The groups of older adults in this study perceived the severity of the sexual abuse scenarios and neglect scenarios as more severe than the other scenarios. This finding on neglect partially supports that reported in Johnson [18], where three-quarters of the dependent older adults and their caregivers endorsed neglect as the primary form of elder abuse. The clinical assessment of neglect raises many difficult questions about what specifically are a caregiver's responsibilities to an older person and/or whether the neglect is intentional or unintentional [27]. It is interesting to note that females from across the four groups viewed the sexual abuse scenarios as more severe examples of abuse than did the males. This might be partly explained by the fact that the victims in the scenarios were female. Previous research has also suggested that females are more caring towards victims of sexual abuse and less empathic towards the perpetrators than males [28].

The perceived severity of the financial abuse scenarios was quite low, with most groups viewing them as either not examples of abuse or as only mild forms of elder abuse. Johnson [18] reported a similar result. This current finding is of concern as many overseas studies suggest that financial exploitation is the most common form of abuse encountered [29,30]. Additional research into the situational factors that may influence the decision as to what constitutes financial abuse might help clarify these results.

When comparing the three groups of older adults, the caregivers generally scored lower, perceiving the scenarios as less abusive. Anetzberger et al. [19] also found in their study that caregivers were less likely than dependent older adults to view situations presented to them as abusive. It is possible that the caregivers may have been more sensitive to, and identified with, the stresses and responsibilities that the caregivers in the scenarios faced, and while they did not condone the abusive behaviour (as they responded affirmatively), they may have been more understanding and sympathetic to the caregivers' situations.

The majority of the participants did not perceive the scenarios of psychological abuse or physical abuse as examples of the most severe form of elder abuse. Why this result was obtained

is unclear. However, the case may be that the behaviours depicted in the scenarios were not 'severe' enough.

A number of limitations were identified in the current study. First, the use of questionnaires provided limited data. Perhaps future research could involve in-depth interviews to obtain a broader range of information. Second, caution must be taken in generalising results to different cultures as some studies have shown that different ethnic groups vary in their perceptions of elder abuse (e.g. [17]). Third, the use of two scenarios per category provides one with only limited information. There are many ways that abusive behaviour manifests itself, as well as varying degrees of intensity. Finally, the present study did not include scenarios involving older people who reside in institutional settings, nor were such individuals sampled. They may hold different views on elder abuse, and thus the current findings may not be generalisable to that setting.

Implications and future directions

'There are different kinds of abuse' and different levels of severity [20, p. 7]. Though seemingly an obvious statement, the above statement is apt for the present study, which has provided some empirical evidence as to the range of views on the severity of abuse for five different kinds of elder abuse. Further research is needed to explore the ramifications of the results, especially in relation to the aetiology of abuse, risk factors, the history of the relationship between perpetrator and victim, and the type of prevention and treatment programs needed. Elder abuse is frequently embedded in complex intimate interactions that greatly complicate case identification for physicians [31] and other health-care professionals. Previous research [7,17] had suggested that the opinions and perceptions of older people on the subject of elder abuse should be sought. The current findings revealed that significant differences in the perceived severity of the scenarios existed not only between GPs and older people, but also among groups of older persons. However, there was some agreement in relation to which scenarios were viewed as most severe and least severe.

To conclude, although it has become axiomatic in many studies to state that additional research is needed, this is definitely the case in the area of elder abuse in Australia. One neglected area is the complex web of dependency and fear that influences the acceptance of mistreatment by an older person in order to protect a relationship with the abuser. Further studies of the risk factors of abuse, the determination of the most effective methods of assessment and the efficacy of intervention programs are all important. Whether the introduction of mandatory reporting of elder abuse, proposed in the wake of public disclosure of sexual assaults in a Victorian residential care facility [32], will be an effective intervention remains to be seen. The present results highlight the complexity of the perceptions of elder abuse among older adults themselves, and the differences of these perceptions from those of GPs. Such findings as these highlight that it will only be through extensive research and discussion on the topic of elder abuse that the difficulty of defining the problem and obtaining answers to other related questions will be resolved.

Key Points

- General practitioners saw the severity of forms of elder abuse in different scenarios as less severe than groups of older adults.
- Caregivers saw scenarios as less severe than other groups of older people.
- Females saw the scenarios involving sexual abuse as more severe than in males.
- The variability across types of elder abuse suggests that strategies to counter elder abuse will need to be tailored to specific types of abuse.

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