Difficulties faced by care managers in interventions for family members who abouse the elderly : interviews with care workers

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Difficulties faced by care managers in interventions for family members who abuse the elderly: interviews with care workers

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Abstract

In most cases of abuse of elderly individuals who require in-home nursing care, the abuser is the caregiver. They are their sons, daughters, or daughters-in-law. Since 88.6% of elderly who suffer abuse live with their abuser, implementation of services alone will not solve the underlying causes of abuse.

The purpose of this study is to analyze the difficulties perceived by care managers who confront elderly abuse inflicted by family members. The research was executed according to the grounded theory approach. Participants were care managers who had handled elderly abuse cases. They (n=21) were all female, and had a mean of 4.3 ± 0.7 years of experience as a care manager. In-depth interviews were conducted by a researcher from 2004 to 2006. The following six categories and one core category of difficulties were extracted from the interview data: fear of confronting the abuser, unwelcome atmosphere to care manager's visit, having to continue the relationship with an abusive caregiver, unwillingness to upset the family relationship, inability to intervene in a family relationship that is the root cause of abuse, and wanting to believe in family bonds even in an abusive family. The core category that was ultimately extracted was the feeling of powerlessness in being unable to take on the abuser due to the principle of respect for caregivers' decisions.

These findings suggest that when confronting abusers care managers run the risk of losing their ability to make rational decisions and of feeling burdened. In addition, it is necessary to clarify the roles of care managers concerning intervening in family situations and to establish procedures for intervening in family situations where there is abuse.

Key words

Elderly abuse, care manager, family intervention, powerlessness, support system

Introduction

In most cases of abuse of elderly individuals who require care, the abuser is the caregiver, usually the elderly individual' s son, daughter or daughter-in-law[1,2]. The causes of this abuse are often complex, including the burden caused by prolonged care, reversal of roles between those requiring care and caregivers, pre-existing relationship problems within the family, or economic issues[3]. It has been reported that in the United States approximately 3% of the population 65 years of age and older has been abused[4]. In Japan, it has been reported that 10% of elderly who suffer abuse at home face risks to their lives[5]. Therefore, there is a need for support for abuse prevention that addresses the abused individual and the abuser, as well as early intervention when abuse first occurs.

In cases of abuse of the elderly who require in-

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home care, the use of long-term care insurance services has ameliorated abusive situations to a certain extent[5]. However, since 88.6% of those suffering abuse live with their abuser[6], implementation of services alone will not solve the underlying causes of abuse. Cases of abuse within the family present difficulties when determining the extent to which community health and welfare specialists are able to intervene in domestic problems. Families represent the most basic element of the system that allows elderly requiring nursing care to live at home, and they are also both an informal resource and a potentially crucial element. As a consequence, despite the associated difficulties intervening in the family situation is a vital means of support to improve or resolve the circumstances of the abuse.

In order to provide care management, care managers have a contract with the elderly requiring care and/or the family, and provide continuous assessment and planning of care[7]. Information on the individual requiring care and the family is gathered for the care manager by the service provider used by the person requiring care. For an effective elder abuse prevention network, the nature of the care manager's job requires that he/she must remain continuously and closely in touch with both the abused individual and the abusive caregiver. Recently, in a nationwide study 45% of care managers reported experiencing "serious difficulty in coping with abuse cases," and 43% reported experiencing "a certain degree of difficulty in coping with abuse cases"[6]. Furthermore, care managers face a great deal of on-the-job stress. One report stated that care managers suffer professional burnout[8].

In an elder abuse prevention network, public health nurses intervene in cases of abuse in coordination with care managers. At the same time, they are in the position of providing education and support to care managers. The situation, thoughts and feelings of care managers must be understood if they are to be provided with effective support and coordination. However, there has been no research on the situation of care managers when faced with cases of abuse, the kinds of difficulties they perceive, or background factors related to these difficulties.

The purpose of this study is to analyze the difficulties perceived by care managers when they detect that an elderly person requiring care is being abused by a family member responsible for providing care. As this research is conducted from the standpoint of care managers, it can provide effective suggestions and concrete methods for supporting care managers and identifying their roles in elder abuse prevention networks.

Research Methods

This research aims to analyze the perceptions of care managers. Perception is an internal process that occurs when we filter a particular phenomenon through our own frame of reference to convert it to meaning[9]. Accordingly, the grounded theory was used to analyze the meanings underlying these perceptions and to structure the responses[10].

Definition of terms

This research is concerned with elder abuse as defined in the Prevention of Elder Abuse and Caregiver Support Act[11], including physical abuse, psychological abuse, sexual abuse, economic abuse, and neglect. The family is defined as "two or more persons who are joined together by bonds of sharing and emotional closeness and who identify themselves as being part of the family". Intervening in the family is defined as "facilitative intervention that removes economic or transportation problems or social obstacles the impede care"[12]. It also includes support that facilitates adjustments so that changes can be made within the family in order to improve abusive situations.

Participants

Participants were care managers working at home-based care management service providers who had handled a case of elder abuse. They had at least three years' experience as care managers. The position of care manager was created with the implementation of the Long-term Care Insurance Act in 2000. Experienced care managers were

selected in order to ensure that sufficient data could be collected. Care managers can be nurses, care workers or others engaged in specialist care work in the healthcare and welfare system. Since it has been reported that views of care management depend on the care manager's field of specialization[13,14], it is necessary to understand the difficulties faced by each profession in providing support. The care workers in this research were either qualified care workers or home-helpers. Care workers represent about 45% of the total number of care managers[15]. They were also made the subject of this research because of their first-hand experience providing care to the elderly requiring care and because of the high degree of emotional exhaustion associated with their work[9].

Participant recruitment involved receiving an introduction to a candidate from the care manager leader of a home care support center. At the end of each interview, the next candidate was identified by introduction to the interviewer using the snowball sampling method[16]. Additional participants were also added by theoretical sampling.

Data collection

Data were collected from October 2004 to January 2006 using in-depth interviews conducted by a single researcher. Each interview lasted from 80 to 130 minutes per person. Interviews were conducted at a public institution in the region where the participant was employed, in an office at their place of work, or at a facility affiliated with the researcher's organization. The interviews comprised the following: a summary of the case(s) of abuse handled by the care manager, including difficulties faced in dealing with the elderly individual requiring care, the caregiver and their family, as well as the care manager's thoughts regarding the circumstances and reasons for them, and specific support measures implemented and reasons for their implementation. With the permission of the participants, the interviews were recorded on tape and verbatim transcripts were created. Notes were taken during the interviews, after which the interviewer recorded her impressions of the participant and analyzed other observations. The interviews continued until the concepts in each category had been saturated.

Analysis

Of the 24 care managers who agreed to participate in interviews, three were excluded due to insufficient experience or because they were not currently working at a home-based care management service provider. Using the interview transcripts, the interviewer considered the meaning of each participant's comments while taking their background into account, and created an open code and primary code for each participant. The final codes were created by comparing the similarities and differences of all the codes. The sub-categories were extracted from groups of codes with similar concepts. These sub-categories were then named. Links were made between categories and sub-categories, and to check that there were no inconsistencies between concepts, the dimensions and properties of each category, as well as consistent context, were confirmed. Categories were derived and the concepts expressing each category were carefully investigated and identified. The relationship between care managers and abusers and their families was analyzed further, which eventually generated a core category linking all the concepts of the other categories.

To ensure the credibility of the results and to ensure that the analysis process could be understood by those not involved in the research, interview transcripts and details of the analysis processes were recorded in detail. Meaningful discussions concerning the results of the analysis were held with researchers who were experts in qualitative research. The results were presented to study groups of community nursing researchers, and further analysis was conducted based on the opinions received. In addition, feedback on the results was provided by five interview participants to confirm that no errors in interpretation had been made and to obtain their approval for the categories.

Ethics

The protocol of this research was approved by the Medical Ethics Committee of Kanazawa University School of Medicine. The participants were assured that their personal information, their rights, and the confidentiality of their cases would be protected. Furthermore, all participants volunteered to participate, and the interviews were conducted after obtaining their written consent. In addition, access to the interview transcripts was strictly controlled, and these records were destroyed once the research was completed. To preserve the anonymity of each case, the names of individuals were not asked and in cases where names appeared in transcript records, they were either deleted or encoded by the researchers. For the discussion of the results and for publication purposes, some amendments were also made so that participants could not be identified by certain expressions used during the interviews.

Results

1) Summary of participants

Data from 21 participants, all female, were analyzed. Participants' mean age was 48.7±8.4 years. The average length of experience as a care manager was 4.3±0.7 years, and the average length of experience as a care worker was 12.6±5.4 years. Sixteen of the participants had experience both as a certified care worker and as a home-helper, while the remaining five had worked as either a certified care worker or a home-helper. Each participant had handled on average 3.2±3.0 cases of elder abuse. The incidents of abuse they discussed occurred on average 2.2±0.8 years after they began working as care managers.

The 21 cases addressed by care managers included cases where more than one type of abuse occurred and included 11 cases of physical abuse and 12 cases of neglect. The ages of the abusers ranged from their 30s to 80s, and they comprised seven men, 16 women (76.2%), and two married couples. As for their relationship with the abused elderly, in seven cases they were their children, in six cases their partners, and in eight cases their daughters-in-law. The abused individuals were in their 60s to 80s, and 17 of them (80.9%) were women. Fourteen of them (66.7%) were classified by the Long-term Care Insurance system as requiring a care level of three to five. Eighteen of the abused individuals (85.7%) suffered from dementia. Four individuals died following emergency hospitalization during the implementation of support. As for family structure, seventeen of the abused elderly (80.9%) lived with other family members besides the abuser, usually co-habiting with an elderly partner or children. For 20 of the abused elderly (95.2%), the abuser was a key person in their lives.

2) Perceptions of care managers intervening in abusive families

Care managers' responses on the difficulties faced when intervening were divided into six categories comprised of further explanatory sub-categories (Figure 1). An explanation of the background to the categories developed is given below. Category titles are written in ***bold italics***, sub-categories in italics and the final code used to explain the results is given between single apostrophes.

Fear of confronting the abuser

Care managers expressed the concern that 'Care managers feel a danger of being attacked by the abuser if they talk about abuse with the abuser', showing that not only the abused elderly, but also the care manager, has a *fear of the abuser.* Furthermore, some care managers reported that 'Just thinking about meeting the abusive caregiver is enough to make me hesitate to visit', leading them to circle the neighborhood where the abused elderly individual lives or postpone visits. In addition, when a 'Needs-based proposed care management plan for the elderly individual requiring care was rejected', there was the perception that *responding to the abuser would make the care managers lose their ability to think rationally.* When handling a case, care managers reported 'Thinking about the case immediately upon waking in the morning'. As a result of managing an abuse case they were *constantly*

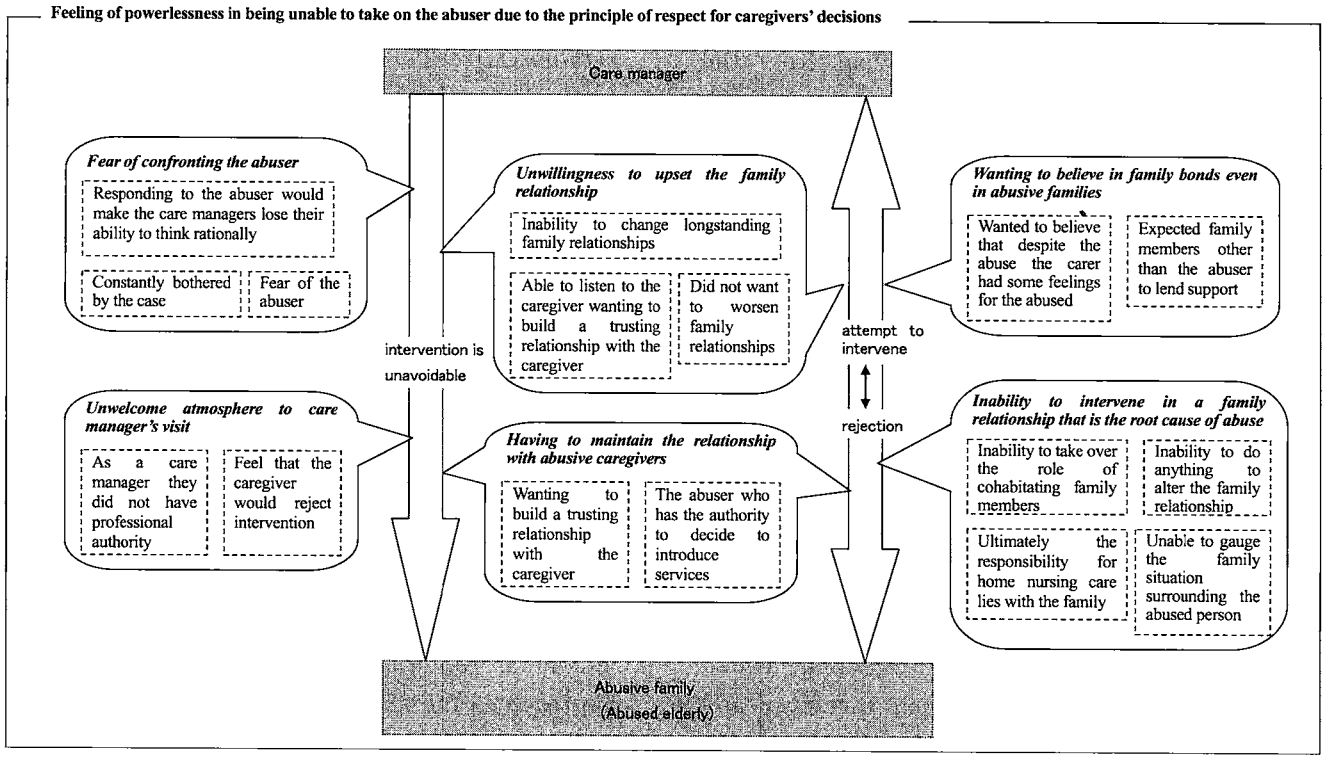

Fig. 1 Difficulties faced by care managers in intervention for family members who abuse the elderly

bothered by the case.

Unwelcome atmosphere to care manager's visit

When visiting the home in cases of elder abuse, care managers reported feeling an invisible barrier created by the abuser. In some cases an actual physical barrier was presented when care managers were not allowed to enter the entrance hall. On previous occasions the atmosphere suggested that they should not approach the daughter-in-law. Even inside the house the daughter-in-law remained distant, which made the care managers *feel that the caregiver would reject intervention.* In some cases the abuser was a distinguished member of the local community or involved in the medical profession. These people rejected medical services and even when they made no attempt to meet with the care manager the care manager reported 'Feeling socially inferior to the family with its high social status'. They also felt their position was inferior to that of the caregiver, resulting in the perception that *as a care manager they did not have professional authority* to intervene in the affairs of the family.

Having to maintain the relationship with the abusive caregiver

A care manager serves as a point of contact for using long-term insurance services for an individual requiring care and the family providing care. Abusive caregivers had the authority to make decisions within the family about the individual requiring care. Accordingly, it is *the abuser who has the authority to decide to introduce services* and who is in a position of power within the family. Since the abuser is the caregiver and key person in greater than 80% of cases, care managers felt they had to go along with the caregiver's mood to 'Continue the relationship despite repeated refusals'. They were aware of trying not to create a bad impression and of *wanting to build a trusting relationship with the caregiver* inflicting the abuse.

Unwillingness to upset the family relationship

Abusive caregivers often did not have good relationships with family members either living with them or living separately. When care managers visited the household, they felt that

there was little communication within the family from the way caregivers spoke and from the general atmosphere. When dealing with such families, care managers felt that 'Since it is the care manager who can do something about family problems, I felt powerless in not being able to do anything'. They perceived that although they were *able to listen to the caregiver they were unable to take the matter any further.* In addition, feeling that 'Longstanding disputes between mothers-in-law and daughters-in-law, which caused the abuse, could not be resolved', they perceived their *inability to change longstanding family relationships.* Although intervention in the family situation was necessary to improve an abusive situation, care managers felt that there was the 'Possibility that enforced intervention could damage the relationship between caregiver and care recipient'. Consequently, care managers felt that they *did not want to worsen family relationships* as a result of their intervention.

Inability to intervene in a family relationship that is the root cause of abuse

Even when family members other than the abuser lived with the abused elderly individual, in most cases the care manager was only able to speak with the abusive caregiver. Participants spoke of difficulties particular to cases of abuse, such as an 'Inability to elicit information from family members other than the caregiver', leading to the perception of being *unable to gauge the family situation surrounding the abused person.* In contrast to these perceptions, they expected that 'It was natural for cohabitant families to take responsibility for care', and felt that *ultimately the responsibility for home nursing care lies with the family.* In addition, because even in cases in which the abused elderly were not allowed to eat, care managers felt that 'As a care manager who does not provide direct care it is not possible to say anything to the family about care', which created the perception of their *inability to take over the role of cohabitating family members.* Furthermore, they felt 'Care managers have limited power to control families' and thus there was a sense of *inability to do anything to alter the family relationship.* There were even some care managers who wanted to believe that the object of management was the individual requiring care and that it was not the care manager's role to do anything about family relationships.

Wanting to believe in family bonds even in an abusive family

Abusive caregivers might be the abused individuals' children, daughters-in-law or spouses. Care managers felt that the caregiver who had decided to provide long-term care at home is 'Doing their best to provide care'. They also mentioned that 'Care managers and caregivers probably share the same feelings' toward the individual requiring care. They had a positive approach to the abusers as carers, and *wanted to believe that despite the abuse the carer had some feelings for the abused.* However, in reality the children of carers did not provide support and didn't even visit their house. There was one case where the abused individual's son did not give any support to his wife. Even with these kinds of families, care managers 'Wanted to believe as long as there was a family the problem could be resolved in some way' and hoped that 'Since they were family they would ultimately be of help', leading to the perception that they *expected family members other than the abuser to lend support.*

3) Feeling of powerlessness in being unable to take on the abuser due to the principle of respect for caregivers' decisions

The core category of the **feeling of powerlessness in being unable to take on the abuser due to the principle of respect for caregivers' decisions** was extracted from the categories above. Care managers perceived the **unwelcome atmosphere to care manager's visit** and a **fear of confronting the abuser.** However, despite these barriers and fears, care managers cannot avoid trying to intervene where the abuser and his/her family are concerned in order to resolve the situation. Although care managers thought of attempting to intervene, their role is one of **having to maintain a relationship with the abusive caregiver.** At the

same time, based on their sense of their own limitations and out of concern for the abused individual, care managers **did not want their intervention to upset the family relationship.** Therefore, although they might feel that intervention is necessary, they were unable to confront the abuser, which meant that they were unable to take the action they wanted to take. Moreover, problems leading to abuse that stem from long-standing family history should be resolved by the family. Care managers perceived **an inability to intervene in a family relationship that is the root cause of abuse**, citing the limitations of their care manager role as their reason. Similarly, believing in the strength of the family even if there was an abuser, they **wanted to believe in family bonds even in an abusive family**. Expecting that ultimately the family would attempt to remedy the situation, they tried not to feel powerless, using the fact that care managers cannot intervene as justification.

Discussion

1) Feeling of powerlessness regarding intervening in an abusive family situation

Based on the process leading to powerlessness felt by care managers toward intervening in abusive families where they sense a barrier and feel afraid of the abuser, care managers perceive abusers to be a threat. Feeling threatened by the abuser in turn prevents intervening in the family situation, which is their job. We may assume, therefore, that they felt paralyzed before they reached the stage of intervention. In some cases of abuse described by the participants the events led to the death of the abused elderly individual. In these cases, it is possible that the care managers struggled with having no choice but to maintain a negative situation. The threat which is a precondition for these perceptions is described by Maslow as follows: "Humiliation, rejection, isolation, loss of prestige, and loss of strength－these are all directly forms of threatening. Furthermore the misuse of abilities, or the inability to use them at all also directly threatens self-actualization"[17]. It follows that it is possible that confrontation with the abuser makes it difficult to succeed in care management, their primary duty, as well as intervention in the family needed to meet the needs of the individual requiring care. By losing their ability to make rational decisions, there is also the suggestion that they risk being stuck in a situation where there are insufficient remedies.

This conflict experienced by care managers is a problem that affects the principle governing their jobs which is to implement care management that will raise the quality of life of the elderly. Fry suggests that when moral values, demands for rights and associated duties are involved, it is difficult to resolve conflicting values and that on occasion this will upset decision making[18]. Care managers who handle abuse cases are constantly faced with the obligation to protect the abused and to allow the family's values take precedence when there is a family problem. One possible cause of this conflict is being unable to follow only one's own values. Furthermore, because care managers unconsciously have expectations of the family, it is presumed that they consign their role to the carer and so avoid having to take responsibility themselves. Repetition of this kind of conflict could well create a feeling of powerlessness. It is under such conditions that care managers probably affirmed their own raison d'etre and made themselves feel better by undertaking their primary duty of care management.

Research on support staff who assist victims of domestic violence has shown that those who provide assistance do not feel a sense of achievement and feel a sense of powerlessness, which can lead to emotional stress, anxiety, exhaustion, and burnout[19]. The position of care managers is to manage the abusive caregiver and the individual requiring care. Consequently, demanding that as a member of an abuse prevention network they intervene in abusive families in which improvements may be difficult creates a conflict between protection and intervention and also has a significant psychological impact on the care managers.

The lack of confidence that care managers have in their work is a possible factor behind their

feeling of powerlessness. Care managers have commented that they are 'Not sure how far we should become involved' and it is possible that their becoming aware of abuse in their second year working as a care manager has some relation. The participants in this study are care managers who are in the caring profession, for whom basic training is short. Because there is no family support in the curriculum, it cannot be denied that it is possible that setting experience as a carer as a criterion for the participants in this study has had an effect on the results. However, because this research does not aim to make comparisons with other specialist professions, such as nursing, this point require further investigation.

2) Recommendations for elder abuse prevention networks

Based on the above, it would appear necessary to investigate measures so that role expectations from abuse prevention networks and the desire of care managers to achieve their principles do not create conflict for care managers or make them feel a sense of powerlessness. Powerlessness is defined as the notion of being unable to control events[20]. Care managers who feel powerless require empowerment from both psychological and technical sides. When there is no sign of improvement in abuse even after the introduction of services, care managers must not let the situation worsen by failing to implement policies or continuing to have expectations of the family. There needs to be an investigation of abuse which care managers can intervene in and abuse which the local administration must intervene in, as well as the development of methods for intervening in abuse cases. As reflected by the findings of this study, when doing this account needs to be taken of the reality that it is too much to expect care managers to do everything[21] and to examine the role demanded of care managers. There is a need to set in motion a support system for care managers provided by professionals such as public health nurses, certified social workers and care management leaders from community support centers.

3) Limitations of research and future issues

Since all the participating care managers were women, it is possible that the perceptions described here are particular to women, though this is impossible to determine from the results. This is a limitation associated with recruiting participants at the present time, as adding criteria would probably make it difficult to obtain participants. This research focused on care managers with experience as care workers, though there are plans to study nurses working as care managers, from which it will be possible to add an analysis of any differences in perceptions between professions.

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高齢者を虐待する家族への介入に介護支援専門員が抱く困難さ ;介護職への面接から

表志津子，　佐伯和子*，　城戸照彦

要　　旨

家庭において要介護高齢者を虐待する者の多くは，介護者である息子や娘，嫁である。虐待されている高齢者の88.6%は家族と同居していることから，介護保険サービスの導入だけでは，虐待の根本的な解決には至らない。

本研究の目的は，介護を必要とする高齢者に対して介護を担当する家族が虐待していることを察知したときに，介護支援専門員が感ずる困難の内容を分析することである。研究方法は，グラウンデッドセオリーアプローチを用いた。研究参加者は居宅介護支援事業所に介護支援専門員として3年以上勤務し，虐待事例を担当したことのある介護職の介護支援専門員である。データ収集は2004年から2006年に実施し，非構造化面接法を用いた。参加者は21名，全員女性であった。抽出されたカテゴリーは6つであり，介護者である虐待者と対峙することが怖い，虐待者との間に心理的な壁が存在するという認識があった。また，虐待者である介護者との関係を維持したいという役割の一方で，介護支援専門員の介入で家族関係に波風を立てたくないと認識していた。そして，虐待の根底にある家族関係への介入には至れない，虐待家族にも家族の絆はあると信じたいという認識があった。これらから，介護支援専門員の理念ではたちうち出来ない虐待者への無力感という中核カテゴリーが抽出された。

以上から介護支援専門員には，虐待者との対峙により適切な判断ができなくなる可能性や，抱え込む可能性があると示唆された。また，虐待家族への介入に関する介護支援専門員の役割の明確化と，虐待家族への介入手法の構築が必要であると示唆された。