Difficulties for care managers in demonstrating the existence of elderly abuse: Interviews with care workers

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Difficulties for care managers in demonstrating the existence of elderly abuse - Interviews with care workers-

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ABSTRACT

The purpose of this study is to clarify the types of difficulties in demonstrating the existence of elderly abuse as recognized by care managers who provide care management to elderly who require care in their own homes. The study was conducted from October, 2004 through May, 2005. The method used for this study was the grounded theory approach. The subjects were 12 care managers working for home-based care management service providers.

All 12 participants were females (48.7 ± 2.7 years-old) with 4.0 ± 0.2 years of experience as care managers. There were five difficulties identified from the study: [Invisibility of the elderly person requiring care], [Reluctance in identifying abuse], [Attempting to handle the situation within the reach of their control], [Limitations of predicting health problems deriving from abuse], and [The final decision should be left to medical staff].

It is also suggested that these difficulties can result in a delay in early detection and taking action against the abuse, and suggested the necessity to create a support system to decision process of care managers.

KEY WORDS

elderly abuse, care manager, difficulty, care worker

Introduction

A great number of elderly abuse cases occur at home among family members living together due to various factors such as the burden of providing care over a long period of time, role reversals that take place when entrusting one's care and livelihood to a care-giver(s), and financial problems[1-4]. Although subsequent to the implementation of the long-term-care-insurance system, the situation had improved for 40 to 50 percent of elderly suspected to be victims of neglect or physical/psychological abuse who reaped the benefits of provided service programs and proper care management,[5] it is believed that many latent abuse cases still exist. While the incidence rate of Japanese elderly abuse has not been reported, in the United States, it has become clear that only one out of eight incidences of elderly abuse is reported compared with one incidence out of three in the case of child abuse, similarly suggesting the latency of elderly abuse cases[6] . Tsumura suggests that factors contributing to the latency of abuse are not only on the abuser side, but also on the specialist side[7].

A care manager is constantly involved with the elderly person requiring care right from the application for long-term care insurance. Since the information collected from service providers etc. is provided to care managers who perform care management, a care manager holds the most important position in the early detection and suitable intervention of abuse. Thus, the key in determining

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the direction of care management is expected to be the awareness of care managers in demonstrating the existence of elderly abuse. In an advance survey, 88% of care managers felt that they experience difficulties in dealing with abuse situations for the reasons such as refusal of intervention by the abusers and technical difficulties[8] and they felt the actual implementation of suitable care management for elderly people requiring care is very difficult. For this reason, it was thought necessary to clarify the difficulties that the care managers were feeling, through their perceptions, in addition to considering ways to overcome these difficulties.

Consequently, the purpose of this study was to describe how care managers with care worker qualifications recognize the difficulties in demonstrating the existence of elderly abuse. The results of this study will provide suggestions to the early detection and suitable management of abuse, as well as making it possible to further evaluate the roles of professionals who are involved with elderly abuse and the measures for operating cooperation systems in the future.

Methods

1. Research Design

The grounded theory approach,[9] a qualitative method of study, was used in order to examine the cognition of a participant and their implied meaning.

2. Participants

The prerequisites for participating in this study were defined as care managers who have worked for a home-based care management service provider within Ishikawa prefecture, and who have handled an elderly abuse case. The study also required more than three years of experience as a care manager. One of the reasons for this is that experience as a care manager can only be a maximum of 5 years in length because the long-term care insurance law only became effective from 2000. In addition, it was thought that answers from care managers with less than 3 years of experience would simply reflect their immaturity. Furthermore, it is reported that awareness of care management differs according to the official certification of the person involved in elderly abuse cases[10-12]. Consequently, the prerequisites for participation amount to approximately 30 percent of care managers; in other words qualified care workers who have been responsible for the direct care of elderly persons in the community.

Participants were introduced to the study by either their care manager leader or the interviewee.

3. Data collection

The data were collected through 90 - 120 min semi-structured interviews with the participants during the period of October, 2004 through May, 2005. The number of times of the interview was one per person. The interview dealt with items such as the abuse case considered to be the most difficult, the particular situations and reasons why it was considered the most difficult, the content of the support provided, and its intention. When consent was obtained from all the participants, we recorded the interview on audiotape and prepared a verbatim transcript. The interview was continued until the researcher decided that saturation point had been reached.

The definition of elderly abuse applied in this study was suggested by Tatara, and includes six types: physical abuse, emotional abuse, sexual abuse, financial abuse, abandonment and neglect of nursing care, self-neglect and self-abuse.[13]

4. Analysis and Ensuring Credibility

The meanings of the participants' responses were evaluated in the light of each individual background. The verbatim transcripts were open-coded, then sorted into codes. The final codes were created from these codes based on the similarity of the meanings. Next, comparing the similarities and differences between the final codes, they were classified into groups of similar prima-facie concepts thereby extracting subcategories. In addition, the categories were correlated, and then the scope of each concept ascertained.

In order to ensure credibility, the interview record and analytical process were indicated in detail so that a third party would be able to comprehend the analytical process. Feedback of the results were provided to the subjects so as to confirm that there were no errors in the interpretation of the results, in addition to conducting sufficient discussions amongst the researchers.

In terms of ethical considerations, we explained to the participants, in the form of a briefing paper in

advance of the interview, about the research outline, protection of personal data, rights of participants, consideration of actual cases, and the liberty of participation in and withdrawal from the study. We also gave an additional explanation to the participants on the day of the interview and obtained written consent from the participants.

This study was conducted after undergoing an examination by the Medical Ethics Committee of Kanazawa University.

Results

The number of participants was twelve, all of which were females who averaged 48.7 ± 2.7 years of age. The average number of years of experience as a care manager was 4.0 ± 0.2 years, and 14.0 ± 2.0 years as a care worker. Since there was no difference in the level of cognition according to the types of abuse or experience, the subjects were analyzed together as a whole unit. The breakdown of the primary abuse cases shared in the interviews was two individuals who experienced physical abuse, three who experienced psychological abuse, and seven who were neglected. The summary of the abuse victims was two males and ten females, and of the level of care required was five 1-2 level individuals and seven 3-4 level individuals. The relationships of the abuser to the victim of abuse were seven daughters-in-law, two wives, two children, and one husband. (Table 1)

Five categories were extracted indicating the difficulties of care management in elderly abuse cases as perceived by care managers. (Table 2) The results are shown in the following with the extracted categories hereinafter referred to as [ ], subcategories as < >, and the episode mentioned in *italics*.

1. Invisibility of the elderly person requiring care

The care managers perceived difficulty in relating to the abuse victims as [Invisibility of the elderly person requiring care], for instance: <Even when I cannot see him/her in person, I tend to trust the caregiver's word: He/she is "OK">, <The caregivers refuse my phone calls and visits, so I cannot see how he/she is doing on a daily basis> and <I focus on dealing with the caregiver and thus I cannot find out the needs of the elderly person>.

This is an example of a case in which an abusive wife was providing care for her husband from the care worker's perspective:

The wife didn't prevent my visits, but she didn't exactly invite me in either. She always tried to restrict my visit to a stand-up conversation, and didn't let me see her husband. She tried to wind-up our conversation with just chit-chat at the front door – "I'm looking after him - everything is fine". Even if

Table 1 Summary Data of the Participants n=12

Sex	Experience as a care manager§	Experience as a care worker§	Type of primary elderly abuse	Victim Sex / Level of care required		Primary Abuser Sex / Relationship to the victim	
F	4	10	Neglect	F	1	F	Daughter
F	4	15	Neglect	M	5	F	Wife
F	4	17	Psychological	F	2	M	Husband
F	4	18	Neglect	M	4	F	Wife
F	5	14	Physical	F	1	M	Son
F	4	16	Psychological	F	1	F	Daughter-in-law
F	3	13	Physical	F	3	F	Daughter-in-law
F	3	8	Neglect	F	4	F	Daughter-in-law
F	5	9	Neglect	F	4	F	Daughter-in-law
F	3	7	Neglect	F	4	F	Daughter-in-law
F	4	15	Psychological	F	1	F	Daughter-in-law
F	5	26	Neglect	F	3	F	Daughter-in-law

F: Female, M: Male
§ : Years of experience

I asked "Can I not come in?", there were numerous times when she would try to brush me off with a "No, really, we're fine". I was always careful to choose topics of conversation that wouldn't make her uncomfortable, so that she at least wouldn't lock the door on me during the day. (No2)

2. Reluctance in identifying abuse

As one example of the difficulties faced, [reluctance in identifying abuse] was observed among the care managers who had perceptions towards an abuse situation involving an assigned elderly person requiring care such as: <It is hard to call it "abuse" since the caregiver is caring for the elderly person to the best of his/her ability>, <It is hard to define the level at which it should be considered abuse>, <It cannot be determined as abuse without clear physical evidence> and <It's not that the caregiver is always neglecting to feed them>.

This is an example of a care manager describing a neglect case in which a daughter-in-law did not feed the mother-in-law for whom she was providing care:

At first I thought the neglect wasn't especially bad. Um, in a way, if you think about it, there are people in society that only have 1 or 2 rice balls for lunch right? I mean, it is not like every household has 3 or 4 different dishes for lunch. So what I thought at first was that "Well, I guess this family has just one dish for lunch, and there is the trouble with the mother-in-law to consider – that's just the reality of it". (No12)

3. Attempting to handle the situation within the reach of their control

Also, they found difficulties in [attempting to handle the situation within the reach of their control] as seen through the following perceptions: <The conditions of abuse can be intervened with through the program if minimum living conditions are maintained>, <I want to respond within the controllable limits of the programs> and <Resolutions can be found if corresponding service providers consult with one another>.

This example is of a case which was able to be handled within a facility run by an institution to which the care manager belonged to, and was described as follows:

I'm glad that this case was at our facility. Because there were other services that we made use of, and we were able to make the person stay put. If the case wasn't here, it would be a lot harder because we would have to make connections with other facilities. (No5)

4. Limitations of predicting health problems deriving from abuse

Another difficulty with the abuse victims' condition was [Limitations of predicting health problems deriving from abuse] as seen through the following perceptions: <It should be okay since he/she has been well until now as long as he/she has been able to eat>, < I just feel it will be okay judging from the mood/looks of the person> and <It would be a serious problem if he/she had to be hospitalized>.

This example is of a care manager who shared information about a case in which an abuse victim used an adult daycare service:

So to the Day Service Nurse, I said something like "Um, excuse me, but do you think you could take a look?", but at this time I didn't really think that there was much of a problem. Well, you know, I didn't think. (that it was this bad). After he/she was admitted, I realized that "it was that bad". So, well, after the person was treated intravenously and then went home, I still wasn't really aware that it was that bad. So, yeah. I was quite worried though. (No8)

5. The final decision should be left to medical staff

The stance of the care managers toward determining the physical conditions of the abused elderly persons requiring care was [The final decision should be left to medical staff] as seen in the following perceptions: <I would like to have a medical staff member conduct an assessment to find a clue to the solution>, <Conclusive evidence to assess dementia or dehydration is not available> and <I do not want to use a home-visit nursing care program without medical treatment>.

This example is of a care manager who shared the experience of consulting with an abuse victim's regular physician about the abuse victim as follows.

I am a care worker – a helper, so I am not very good at the medical side of things, and I always find it difficult to talk to doctors. So I often convey my messages through other people, but with the doctors in this area, I have begun to be able to approach them personally and say "I'd like to try to speak directly

with you", but with doctors at large hospitals, it is not so...(easy). I am not very good at the medical side of things, and I tend to avoid creating opportunities to speak, you know? So, yeah, that's why. (No4)

Discussion

The results of this study were thought to be significant since detailed clarification was made using the perceptions of the care managers, showing how these care managers, who stand face to face against such abuse cases, find them difficult to handle. In this discussion therefore, consideration will be given from the perspective of the importance of early detection and suitable intervention in the care management of abuse cases.

The importance of early detection in abuse cases is not limited to the elderly. However, if abuse does occur, the abuser will tend to prevent his or her actions from being discovered by hiding the victim. For this reason, it is characteristic for the specialist who is handling the case to not be able meet the victim face to face, making it difficult for the specialist to see the actual situation[14,15]. In this study, it was not uncommon for caregivers to prevent contact with the elderly people requiring care or their family/ other caregivers, so despite the fact that they lived with their families and the caregiver had enrolled in a long-term-care insurance service program, the care managers spoke about their dilemma of 'Invisibility of the elderly person requiring care' – that even though they wanted to, they could not confirm the situation with the person subject to care management.

This suggests that the care manager, who holds the crucial role of care management, is in a situation where he/she is prevented from assessing the needs of the elderly person requiring care, because he/she cannot confirm the situation directly with the elderly person himself/herself. In the long-term care insurance system, the signature of the person who is to use the insurance is required on the planning sheet[16]. However, since 80% of abused elderly people who require care have dementia and are supported and cared for by their families, in reality, a caregiver more often than not acts as an attorney for the contract, thus contributing to the 'invisibility' factor.

In addition, since care managers have 'reluctance in identifying abuse', reports of abuse do not accurately reflect the actual number, thus suggesting

Table2 Difficulties in Demonstrating the Existence of Elderly Abuse

Category	Subcategory
Invisibility of the elderly person requiring care	· Even when I cannot see him/her in person, I tend to trust the caregiver's word: He/she is "OK" · The caregivers refuse my phone calls and visits, so I cannot see how he/she is doing on a daily basis · I focus on dealing with the caregiver and thus I cannot find out the needs of the elderly person
Reluctance in identifying abuse	· It is hard to call it "abuse" since the caregiver is caring for the elderly person to the best of his/her ability · It is hard to define the level at which it should be considered abuse · It cannot be determined as abuse without clear physical evidence · It's not that the caregiver is always neglecting to feed them
Attempting to handle the situation within the reach of their control	· The conditions of abuse can be intervened with through the program if minimum living conditions are maintained · I want to respond within the controllable limits of the programs · Resolutions can be found if corresponding service providers consult with one another
Limitations of predicting health problems deriving from abuse	· It should be okay since he/she has been well until now as long as he/she has been able to eat · I just feel it will be okay judging from the mood/looks of the person · It would be a serious problem if he/she had to be hospitalized
The final decision should be left to medical staff	· I would like to have a medical staff member conduct an assessment to find a clue to the solution · Conclusive evidence to assess dementia or dehydration is not available · I do not want to use a home-visit nursing care program without medical treatment

the existence of latent abuse cases. This is thought to possibly be one of the reasons why care managers evaluated[17] the risk of neglect as lower than the official investigators for certification of need.

In the interviews, the care managers talked about how <It is hard to call it "abuse" since the caregiver is caring for the elderly person to the best of his/her ability>. This may be due to the long care worker experience of these care managers, of 8-26 years, as well as their awareness of the same nursing care burden that they have experienced through their work being felt by the caregivers, and thus it was thought that this understanding led to a feeling of profound empathy with the caregivers.

It also suggests that they think that identifying the abuse as a care manager would mean negating the caregiver, who, while feeling the burden of nursing care, has undertaken the responsibility of providing care to the elderly person at home, even though they may not be providing the proper care. However, the fact that the care managers (who provide the necessary services and management to elderly people requiring care) are reluctant to 'see' the abuse, let alone recognize it as actual abuse, implies that an early detection system would not, in reality, work effectively. These factors suggest that it is necessary to consider an abuse reporting system, something that has already begun in the community, as well as the necessity for training so that care managers can understand their own tendencies of perception.

In addition, in terms of appropriate measures to deal with the abuse, the perceptions revealed in this study suggested the possibility of late actioning of these measures past the most appropriate time. The care managers perceived that they could solve problems of abuse by 'Attempting to handle the situation within the reach of their control' through the use of services of the institution to which they belonged to. In this study, 7 out of 12 participants spoke of having difficulties with neglect cases, and so if services can be made use of to handle the state of neglect while putting aside the existence of abuse, there is the possibility that the case will not be treated as an abuse case.

It is presumed that behind this perception is the care managers' attempts to reduce the psychological burden resulting from judging a case as abuse and consulting/reporting it to the authorities[18,19].

Furthermore, from the perceptions of 'Limitations of predicting health problems deriving from abuse' and 'The final decision should be left to medical staff' it is suggested that the judgment of care managers has its limits. It has been reported that 10% of elderly victims of abuse have their lives endangered[20], and it is highly likely that there are a fair number of elderly people who are next in line to be put into this category.

For those elderly people requiring care who cannot lead independent lives, abuse is a serious situation that directly relates to their survival. However, this study was not able to determine precisely whether the contributing factors of these perceived difficulties come from the particular conditions of standing face to face against abuse cases, or whether they come from the particular characteristics of the care managers with care worker qualifications. Whatever the contributing factor, in order for an abused elderly person requiring care to be assured of health/well-being and safety in everyday living, it was thought that a specialist with an ability to predict health problems must be involved in the case from an early stage, in addition to the importance of organizing a system in which visiting nurses or public health nurses from a home care support center can be utilized easily when needed[21].

The role of the central or regional home care support center is to support difficult cases of home-based care management service providers. This study suggests that it is crucial for this external system to provide proactive support for care managers, as well as create an environment in which it is easy for them to evaluate a more effective intervention method at an early stage and thus avoid the late assessment of abuse.

As an issue for the future, there is a necessity for continued investigation of the difficulties common to all care managers and also the different difficulties depending on the care managers' qualifications. Furthermore, we would like to analyze the background to these difficulties in more detail, as well as structuralize them so that consideration can be given to concrete solutions to these problems.

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介護支援専門員が高齢者虐待の存在を明らかにすることの困難さ
ー介護職への面接からー

表　志津子，佐伯　和子

要　　旨

本研究は，在宅生活を送る要介護高齢者のケアマネジメントを行う介護支援専門員が，高齢者虐待がおきていることを明らかにすることにどのような困難さを認識しているかを明らかにすることを目的とした。方法は，グランデッドセオリーアプローチを用い，2004年10月から2005年5月に調査を実施した。対象は，居宅介護支援事業所に勤務する介護支援専門員である。

参加者は12名で全員女性，平均年齢は48.7 ± 2.7歳，介護支援専門員としての平均経験年数は4.0 ± 0.2年であった。抽出された困難さには，【要介護者の姿が見えない】，【虐待を認めることの抵抗感】，【自分ができる範囲で対処を試みる】，【虐待から派生する健康問題予測の限界】，【医療職に最終判断を委ねたい】の５つがあった。これらの困難は，虐待への早期発見，早期対応を遅らせる可能性があり，介護支援専門員の判断をサポートするシステムの構築が必要であると示唆された。