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Patterns of Elder Abuse

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Introduction

The study of the abuse of older people has become a major feature of aged care research since Peter Dunn presented on the topic to the 1989 conference on Crime and the Elderly. Major research has been published in Victoria, South Australia and New South Wales (Barron *et al.* 1990; McCallum *et al.* 1990). It is noticeable, however, that criminologists, police and the legal profession have been less visible in examining this area. Obviously a wider group to research elder abuse needs to be encouraged. This paper presents some of the findings of recent research by the Hornsby Ku-ring-gai Geriatric & Rehabilitation Service. An initial study of 15 cases of physical abuse and neglect was published in 1991 (Kurrle, Sadler & Cameron 1991). This later study involved a review of all cases of abuse and neglect seen by the service in 1990-91, a survey of local service providers, and the first interviews with Australian victims of elder abuse (Sadler 1992a; Kurrle, Sadler & Cameron 1992; Sadler & Kurrle, in press). The implications of the findings for policy development, interpersonal interventions and future research will be briefly discussed.

Case Study - Nelson & Caroline O'Reilly

A case study taken from semi-structured interviews conducted with members of one family illustrates the human side of elder abuse. This was one of three families interviewed in depth to provide qualitative data about the experiences of family members where elder abuse is occurring (Sadler 1992a).

Nelson and Caroline O'Reilly were both 84-years-old when interviewed. They lived in their own house and were part-Aged Pensioners. The couple's only son, Gerald (aged 50), had lived with his parents for most of his life and was often unemployed. When Gerald was in his mid-teens, he suffered a mental breakdown and was diagnosed as having schizophrenia. Caroline described how there have been "a series of attacks" by Gerald against Nelson over about thirty years:

In later years it got worse and he'd break up furniture ... He loved breaking up glass. Picks up the nearest thing, you know, throws it. Nelson's had nearly every lampshade thrown at him in the house.

Both Nelson and Caroline had white-collar occupations during their working years. In her later years Caroline developed osteoarthritis, asthma and poor vision. She had not been outside her house for over a year. She had resorted to drinking sherry to drown her sorrows about her son's behaviour. Nelson had Paget's Disease and poor circulation. He recently withdrew from his involvement in the local bowls club.

Not only was there physical violence but Gerald maintained a hold of fear over his parents. Nelson said that Gerald "always out-talked me or domineered me" and that he was "just made subservient to all Gerald's moods." Both Nelson and Caroline told of how "cranky" Gerald was in the mornings, and how they could not go into parts of the house, including the kitchen, if he was in a bad mood. Over recent years he had begun to be violent towards his mother as well.

The O'Reillys had been known to the Geriatric and Rehabilitation Service for many years and various social workers had regular contact. Help with house cleaning and maintenance was arranged through local Home and Community Care (HACC) services. Recent interventions included referral to the local police and the Mental Health Emergency Team. Nelson wanted Gerald removed from the house but Caroline would not countenance this. The situation was unresolved when Nelson and Caroline were interviewed for this research. Subsequently Gerald was arrested for assaulting his father and the police, and was prevented from returning to his parents' house by his bail conditions. However, his parents let him return a few months later, as well as paying his fine.

Geriatric Service Clients

Mr and Mrs O'Reilly were two of 54 elderly victims of abuse seen by the Hornsby Kuring-gai Geriatric and Rehabilitation Service in northern Sydney during 1990-91 (Kurrle et al. 1992). The medical records of all clients seen by the Geriatric and Rehabilitation Service in 1990-91 were reviewed. The 54 cases represented 4.6 per cent of the service's 1176 clients 65 years and over who lived in their own homes. Psychological abuse was the most common type of abuse identified, occurring in over half of elder abuse cases, followed by physical abuse, neglect and financial abuse. Twenty-one cases involved more than one type of abuse. Duration of abuse in the 54 cases ranged from 3 months to 50 years with a mean of 7 years. The duration for 6 cases was 30 years or more.

The pattern of referrals for elder abuse victims was similar to that for all clients of the Geriatric and Rehabilitation Service. General practitioners were the main referral source. The clients were not usually referred to the service because of the occurrence of abuse, but rather for general consultations, assessment for increased community services, or nursing home or hostel placement, or rehabilitation.

Those assessed as victims of elder abuse had a mean age of 79.3 years. They ranged in age from 67 to 95 years, although a lower proportion of victims were over 90 compared to all clients referred to the Geriatric and Rehabilitation Service. The victims were predominantly women, with 36 female victims to 18 male. The ratio of 2:1 is almost the same as the ratio of female to male clients of the Geriatric and Rehabilitation Service as a whole. The victims of elder abuse were generally frail and dependent on others for practical assistance, with 35 (64.8 per cent) having physical disabilities, and 25 (46.3 per cent) having a significant dementia. The rate of dementia was twice that diagnosed among all Geriatric and Rehabilitation Service clients (21.8 per cent), but the rate of physical disability was similar to that for all clients.

Four cases of reverse abuse were noted. In these cases, the carer was being abused by the person they were caring for, who in each case, had a significant dementia.

There were 53 people who were assessed to have abused an older person (30 males and 23 females). In the O'Reillys' case their son was abusing both his parents. Most abusers lived with their elderly victim. Twenty-seven abusers (51 per cent) were spouses, 13 (24.5 per cent) were children, 6 (11.3 per cent) were in-laws, 4 were other relatives and 3 were non-relatives. No cases of abuse by service providers were recorded. The abusers ranged from 26 to 85 years of age. Twenty-four abusers (45.3 per cent) were assessed as suffering from dementia, psychiatric disorders, or drug and alcohol abuse.

Analysis of the data suggests four main patterns of abuse:

1. Dependency of the older person, characterised by the abusive or neglectful behaviour beginning around or after the onset of the person's disability. This was the pattern in 57 per cent of cases;
2. Domestic violence, characterised by a history of violence (usually male to female) predating the onset of any disabilities. This was the pattern in 30 per cent of cases;

3. Carer abuse; and
4. Other relationship problems, including financial dependency of the abuser on the victim (Sadler 1992a).

The most commonly used interventions were social work counselling in 55.6 per cent of cases, home nursing in 50 per cent of cases, and institutional respite care in 35.2 per cent of cases. Most interventions were used more frequently for elder abuse victims than for all Geriatric and Rehabilitation Service clients. Following one or more interventions, abuse ceased or lessened significantly in 10 cases (18.5 per cent) with the victim remaining at home. In another 20 cases (37 per cent), abuse ceased following placement in a nursing home or hostel. In 2 of these cases it was the abuser who required institutionalisation. In 24 cases (44.5 per cent) the abuse continued despite counselling and assistance with community services.

Other Service Providers

A mail survey of 175 local service providers in the Hornsby Ku-ring-gai local government areas was also undertaken, with 32 per cent reporting that they had observed cases of elder abuse in the past year (Sadler & Kurrle, in press). Service providers likely to see older people were surveyed, including general practitioners, and staff in community services for the elderly and people with disabilities, hospitals, police, legal agencies, welfare agencies, and emergency services such as the ambulance service. Staff from the Geriatric and Rehabilitation Service were excluded as their involvement with elder abuse was assessed in the Geriatric and Rehabilitation Service research (Kurrle et al. 1992).

Approximately 320 questionnaires were distributed, with 175 responses, a rate of 54.7 per cent. There was a 49 per cent response rate from general practitioners. Sixty-one people from 23 local services replied. Eighty-four per cent of respondents from the 23 services were females. There were no respondents from five services, including one local council's meals-on-wheels service, the local court chamber magistrate, and three local hospitals.

The majority of the 175 respondents were not aware of any cases of elder abuse. Fifty-six (32 per cent) identified a total of 116 cases of abuse in the previous year. This figure may well involve double counting of individual cases and cannot be used to estimate prevalence. General practitioners were less likely than the average of all respondents to have identified abuse. Respondents from eleven of the 23 services reported no cases of abuse, most being services which have only occasional contact with their clients. However, community nurses, police, and social and welfare workers were very likely to have observed cases of abuse.

As with the cases of elder abuse identified by the Geriatric and Rehabilitation Service, psychological abuse was the type most frequently observed. However, in contrast to the Geriatric and Rehabilitation Service, the service providers surveyed (particularly home nurses and welfare workers) reported more cases of neglect than physical abuse.

In 40 per cent of the cases observed by service providers, the abuse lasted for three or more years. General practitioners, hospital social workers, community nurses and police were particularly likely to have seen cases of long-standing abuse. Sixteen per cent of cases were of one to two years' duration, 30 per cent lasted for three to twelve months, and 14 per cent for less than three months.

Only six of the 56 people who identified cases of abuse reported that in some cases they took no action. Four of these were doctors, one was a welfare worker and one a clergyman. In most cases they indicated that the victim had refused offers of help.

Approximately half of the service providers said that they had counselled the victim. The questionnaire gave no definition of counselling and activities varying from informal counselling to formal therapy will have been included by the respondents. Fifty-five per cent of GPs and 60 per cent of social/welfare workers said they counselled the elderly victims with whom they had contact. By comparison, only a quarter of those identifying abuse attempted to counsel the abuser. Only 20 per cent of social/welfare workers reported that they had engaged the abuser in counselling. General practitioners were the

most likely to attempt this intervention (41.4 per cent). GPs were less likely to initiate alternative accommodation, respite care or legal actions. Social/welfare workers were more likely than other groups to arrange alternative accommodation and respite care. The police were more likely to refer or take legal action. The majority of service providers referred the cases of abuse they observed to other agencies, half arranging community services.

Forty-four people made referrals. The most referrals were made to the local Geriatric and Rehabilitation Service. Only the police and the Home Care Service did not make referrals to the Geriatric and Rehabilitation Service. Overall, these figures may have been inflated since the authors sent out the questionnaire on Geriatric and Rehabilitation Service letterhead, thus cuing respondents to list the service. Referrals to the police from community services were infrequent, and the police rarely referred to services other than solicitors. Few referrals were made to the Guardianship Board. Most people who made referrals were satisfied with the response by the agencies to whom they referred. Those who were not satisfied indicated that problems included the inability to do anything unless the victim requested it, lack of awareness of options for intervention, slow response by agencies, and lack of feedback.

When the 56 respondents who identified cases of elder abuse were asked what caused the abuse, a variety of suggestions were forthcoming. No single cause gained more than 25 per cent support from respondents. However 35 suggestions involved characteristics of the abuser (e.g. psychiatric or drug and alcohol problems, selfishness, or poor education about caring and services available). Twelve suggested carer stress, making 47 suggestions that abuser characteristics caused the elder abuse seen by service providers. Twenty-three suggested causes focused on the victims' characteristics such as their dependency, refusal of help, or unwillingness to admit abuse was occurring; 15 suggestions involved poor family or marital relationship patterns. Other suggestions included social factors such as isolation and poverty, inadequate services or service denial

that abuse was occurring, and societal factors like ageism and denial of the importance of carers.

Implications of Research

The Hornsby Ku-ring-gai research has added to knowledge about the abuse of older people in Australia. It has been the first study in this country to provide information on the rate of occurrence of elder abuse among people presenting to a geriatric service; the first to have interviewed victims as well as service providers; and the first to suggest a relationship between long-standing domestic violence and elder abuse. Some commentators warn that researchers of topics like elder abuse "must always be wary of being stampeded with the latest 'moral panic' " (Fennell et al. 1988, p. 175). However, the findings of this study require attention and I shall discuss the implications of the research under four headings: (1) prevalence; (2) causes; (3) individual interventions and policy development; and (4) future research.

1. Prevalence

The findings from the search of the Hornsby Ku-ring-gai Geriatric and Rehabilitation Service's medical files for 1990-91 found that 4.6 per cent of the service's 1265 community clients 65-years-old and over were victims of domestic elder abuse. This is about half the rate reported by Lau and Kosberg (1979) in a similar study of clients of a community health service in Cleveland. Pedrick-Cornell and Gelles (1982) criticised the early US studies for being unrepresentative samples and based on professionals' reports. This study was based on professionals' reports as recorded in medical files, but had a sample three times the size of Lau and Kosberg's study. The clients of the Geriatric and Rehabilitation Service are not a representative sample of all elderly people in the Local Government Areas of Hornsby and Ku-ring-gai, although they represent about 4.4 per cent of the total population. The service's clients are the frail and disabled, and therefore perhaps most at risk of elder abuse. However, a rate of 4.6 per cent is within the range of most overseas studies. Random sample surveys in the USA and Canada have found prevalence rates of abuse of between 3 and 4 per cent (Pillemer & Finkelhor 1988; McCreadie 1991), slightly lower than the service-based studies. McCallum (1992) has

warned about the implications of a low prevalence rate, particularly the risk of misdiagnosing as abused people who are not abused. Our research, though, has confirmed that a small but significant proportion of clients of geriatric services in Australia will be victims of elder abuse.

2. *Causes*

The Hornsby Ku-ring-gai research supports arguments that a phenomenon such as elder abuse is not caused by a single factor. Indeed, it suggests that there is not a single phenomenon of elder abuse. There are significant differences between the various types of abuse and between individual cases.

Until Pillemer and Finkelhor's (1988, 1989) Boston random sample survey, conventional wisdom in the United States held that elder abuse involved children abusing their frail elderly parents (usually women). The Boston study changed this orthodoxy: 58 per cent of their abusers were spouses and they found pre-existing marital conflict in 44 per cent of these cases. Thirty per cent of cases of abuse seen by the Geriatric and Rehabilitation Service had a history of domestic violence. These 17 cases almost all involved psychological and physical abuse. Indeed, 42 per cent of all physical abuse cases and 43 per cent of all psychological abuse cases had histories of domestic violence. Few cases of neglect and no cases of financial abuse had such histories. The victims in cases with a history of domestic violence were less likely to have dementia than other elder abuse victims, but were as physically disabled as other victims. Most abusers were male spouses, although five were women, and the abuse lasted between 13 and 20 years on average, starting well before most abusers had developed physical problems or dementia. Five abusers had long-standing psychiatric problems. These people's experience is summed up by one victim I interviewed, "People say he's getting older, but it's exactly the same now"; her husband treated her the same way throughout their marriage.

Most cases of elder abuse do not follow a domestic violence pattern, however. Seventy per cent of cases seen by the Geriatric and Rehabilitation Service followed different

patterns. Most fitted a "dependency" pattern. Nearly all cases of neglect and financial abuse followed this pattern, and while under-represented compared to their rates for all cases of elder abuse, 42 per cent of physical abuse cases and 43 per cent of psychological abuse cases also fitted this pattern. The fact that about two-thirds of victims of abuse of this pattern had dementia, compared to 22 per cent of all Geriatric and Rehabilitation Service clients, supports findings that cognitive impairment is strongly linked to vulnerability to abuse (Jones et al. 1988).

There has been a recent move away from explanations of abuse based on the characteristics of the victim, in particular on their physical or mental dependency, to explanations based on the characteristics of the abuser (Pillemer & Finkelhor 1989; Bennett 1990a). Our 1989-90 study indicated that 11 of 15 abusers in cases of physical abuse and neglect had dementia, psychiatric or drug and alcohol problems (Kurrle et al. 1991). Forty-five per cent of abusers identified in the 56 cases of elder abuse in 1990-91 suffered from dementia, psychiatric disorders, drug and alcohol problems or had a criminal record. This explanation for elder abuse demands examination based on our results.

A closer look at cases where the abuser had a form of "psychopathology" indicates a complex pattern. People with such problems were over-represented as abusers in cases of physical and psychological abuse (around 60 per cent in each case), but were relatively unlikely to neglect or financially abuse victims. Only 9 cases of a dependency pattern involved people with dementia, psychiatric or drug and alcohol problems. While 12 abusers (71 per cent) in cases with a history of domestic violence had such problems, in 5 cases, the abuser had developed dementia well after the abusive pattern had commenced. All of the cases of carer abuse were directly attributable to the abuser's dementia. The O'Reillys were clear that Gerald's schizophrenia explained his violent behaviour towards them, but Caroline was convinced that her husband's attitude towards his son had caused his psychiatric illness. If psychiatric illness, alcoholism and criminal behaviour are linked to some types of elder abuse, as they appear to be, then they are not a sufficient

explanation for why they happen. The experiences of victims and abusers are much more complex than this (Sadler 1992a).

3. *Individual Interventions and Policy Development*

The implications of the Hornsby Ku-ring-gai research for individual interventions and policy development in Australia have been discussed at length elsewhere (Sadler 1992a, 1992b; NSW Task Force on Abuse of Older People 1992 1993). The research did not specifically trial different interventions. Rather the patterns of referral and intervention were examined as they existed at the time.

The implications for individual interventions can be summarised as follows:

1. Appropriate assessment of the dynamics of the abusive situation is required, paying particular attention to the personal biographies of those involved.
2. Special attention should be paid to the victim's and, where appropriate, the abuser's need for emotional support.
3. A high level of community services will be needed where the situation is to be handled at home. These have to be provided promptly, especially in crises. Coordination by social workers or other case managers is required.
4. Cases with a history of domestic violence are the least likely to be resolved quickly. Institutionalisation could be inappropriate as the victims are more often independent in activities of daily living and have fewer disabilities than other elder abuse victims. Referrals to the police are appropriate in cases where the abuser needs to be removed.
5. Institutional care is dependent on the severity of the person's disabilities, not on the type of abuse occurring. Referral to the Guardianship Board may be required where the person with a disability is unable to make a decision for themselves.

The recommendations for policy development include:

1. Development of education programs for professionals, other paid workers and volunteers likely to see cases of abuse. These programs should include information about the ageing process, the causes and types of elder abuse, and the interventions required.
2. Development of service protocols about intervention. Model protocols are included in the NSW Task Force's (1992, 1993) two reports.
3. Nomination of key agencies to respond to cases of abuse. The NSW Task Force on Abuse of Older People (1993) has recommended that geriatric services (including Aged Care Assessment Teams), the police and the Guardianship Board be key agencies in New South Wales.
4. Confirmation of the legislative authority for services to investigate suspicious cases, especially the right of entry.
5. A decision about whether to respond in a punitive manner towards abusers, as is recommended in cases of domestic violence. The current study suggests that it may not always be appropriate, especially in cases where the removal of the abuser may precipitate the institutionalisation of the victim against their expressed wishes.
6. Development of innovative schemes, such as "at risk registers" and schemes which link local residents to isolated elderly people in their local area (Sadler 1992b; DHHCS 1992; Pritchard 1992).

4. *Future Research*

The Hornsby Ku-ring-gai research has begun the process of analysing in detail elder abuse in Australia. Necessarily it has left some questions unanswered. Future research should

focus on four areas: (1) prevalence; (2) causes; (3) interventions; and (4) personal biographies.

Prevalence: The current study provides information about the number of cases of elder abuse seen by a geriatric service from a relatively wealthy, homogeneous urban area. Future studies should examine the occurrence and nature of elder abuse in different areas and different services. A population study could be undertaken similar to the Boston random sample survey (Pillemer & Finkelhor 1988).

Causes: This study has suggested that cases with a history of domestic violence can be differentiated from those with a dependency pattern. Other studies should examine these groups in greater detail. The dynamics in cases with a dependency pattern in particular need further study.

Interventions: This research has proposed different interventions for the differing types of elder abuse. A trial of these would provide detailed information about what factors contribute to successful interventions.

Personal Biographies: Few studies of elder abuse have documented the experiences of victims and abusers in their own words. Future research should concentrate on letting people tell their own stories where they can, otherwise researchers run the risk of divorcing elder abuse from the totality of these people's lives.

Conclusion

There has been an increasing interest in domestic elder abuse overseas and in Australia. The research undertaken at the Hornsby Ku-ring-gai Geriatric and Rehabilitation Service has confirmed the complexity of the phenomenon of elder abuse. The rate of occurrence of abuse (4.6 per cent of the service's clients 65 years and over) suggests that the prevalence of elder abuse in Australia is similar in this country to overseas. There is much work to be done in researching this topic and developing appropriate responses. Our research has provided important information for beginning this work.

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