Understanding help-seeking in elder abuse from the perspectives of victims and their supporters

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A thesis submitted for the degree of Doctor of Philosophy

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Declaration of Authorship

I, Silvia Fraga Domínguez, hereby declare that this thesis and the work presented in it is entirely my own. Where I have consulted the work of others, this is always clearly stated.

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Abstract

The abuse of older adults by someone in a position of trust—also known as elder abuse—is estimated to affect one in six people aged 60 and older worldwide, with severe consequences for victims and society. Researchers have identified under-reporting as one of the major challenges in the field, which leads to many victims and perpetrators not receiving intervention, and thus to abuse reoccurrence and further harm. In this thesis the researcher aimed to address under-reporting by improving the understanding of victims' help-seeking behaviours and those of others who help them informally: family members, friends, and neighbours ("concerned persons", Breckman et al., 2017).

Guided by psychological theory, particularly the Theory of Planned Behaviour (Ajzen, 1985) and utilising a mixed methods design, this thesis consisted of three studies. Study 1 was a systematic review of research about victims' help-seeking behaviours. Across studies, many barriers were reported; however, there was less focus on facilitators, responses and outcomes of seeking help, and characteristics of victims most likely to seek help. In Study 2, the researcher addressed these gaps through a cross-sectional secondary analysis of enquiries to a major UK helpline and explored concerned persons' experience of help-seeking. Study 3 involved gathering data about help-seeking experiences from concerned persons via interview and survey. The findings for victims expanded on the barriers and facilitators from Study 1 and indicated that several barriers were more common for certain abuse types, victim characteristics, and victim-perpetrator relationships. Concerned persons experienced barriers similar to victims, were negatively impacted by their involvement, and received largely inadequate responses from formal sources of help, which affected the likelihood of further help-seeking. In the discussion, recommendations for research, practice, and policy are provided; there is an emphasis on person-centred approaches and further integration of victims' and concerned persons' views in intervention.

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List of Abbreviations

AEA	Action on Elder Abuse
AvMA	Action against Medical Accidents
BAME	Black and Minority Ethnic
BPSD	Behavioural and Psychological Symptoms of Dementia
CASP	Critical Appraisal Skills Program
CDC	Centers for Disease Control
CoP	Court of Protection
CP	Concerned Person
EA	Elder Abuse
GP	General Practitioner
ICC	Intraclass Correlation Coefficient
IDA	Interview for Decisional Abilities
IPV	Intimate Partner Violence
IRIS	World Health Organization Institutional Repository
MP	Member of Parliament
NIH	National Institutes of Health
NYC EAC	New York City Elder Abuse Center
ONS	Office for National Statistics
OPG	Office of the Public Guardian
POA	Power of Attorney
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PROSPERO	International prospective register of systematic reviews
RA	Research Assistant
SPSS	Statistical Package for the Social Sciences
TPB	Theory of Planned Behaviour
UK	United Kingdom
U.S.	United States (as an adjective; e.g., “U.S. population”)
WHO	World Health Organization

List of Publications

Three publications (two peer-reviewed journal articles and a peer-reviewed conference proceeding) have been developed as a result of the literature review and studies presented in this thesis.

The first is a systematic review— Study 1, reported in Chapter 3:

Fraga Domínguez, S., Storey, J. E., & Glorney, E. (2021). Help-seeking behavior in victims of elder abuse. *Trauma, Violence, & Abuse, 22*(3), 466-480. https://doi.org/10.1177/1524838019860616

The second is a review article with two case studies, which has been partly based on the literature review of this thesis, reported in Chapter 1:

Fraga Domínguez, S., Valiquette, J., Storey, J. E., & Glorney, E. (2020). Elder abuse intervention and detection: Challenges for professionals and strategies for engagement from a Canadian specialist service. *Journal of Forensic Nursing, 16*(4), 199-206. https://doi.org/10.1097/JFN.0000000000000301

The third is a presentation of a subset of the findings reported in Chapter 5 about the impact suffered by concerned persons, published as a conference proceeding:

Fraga Domínguez, S., Storey, J., & Glorney, E. (2020). Exploring the help-seeking experience of concerned persons: Findings from an elder abuse UK helpline. *Innovation in Aging, 4*(S1), 628-629. https://doi.org/10.1093/geroni/igaa057.2146

INTRODUCTION

The importance of research on elder abuse and neglect, hereafter elder abuse, is growing as the population of most countries ages (United Nations, 2019). In the UK, the Office for National Statistics (ONS) projects that by the year 2050, people aged 65 and older will become almost a quarter of the total population; this also reflects an increase in those aged 90 and older (ONS, 2018, 2020). Within the context of an ageing global population, the phenomenon of elder abuse becomes increasingly important, and one in six older people, equivalent to more than 100 million, are estimated to suffer elder abuse worldwide every year (Viergever et al., 2018; Yon et al., 2017).

Elder abuse can be defined as "A single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person" (World Health Organization [WHO], 2020a, para. 2). However, there exists disagreement as to what elder abuse refers to, with multiple definitions available, and also about the use of the term "elder abuse", with other terms alternatively used (Bows, 2018; Erlingsson, 2007; Ploeg et al., 2013; Storey, 2020). This thesis uses the term elder abuse (hereafter "EA"), while acknowledging that its use is not universal and that other terms such as "elder mistreatment", "elder maltreatment", or "older adult mistreatment" are also used (Lithwick et al., 2000). Relatedly, despite disagreement about the types of abuse that are understood under EA, this thesis considers financial abuse, psychological abuse, physical abuse, sexual abuse, and neglect, consistent with the UK prevalence study by O'Keeffe et al. (2007). These EA types are further defined in Chapters 1 and 2 of this thesis.

EA, as defined above, is a complex type of interpersonal violence, the term used to refer to "the intentional use of physical force or power, threatened or actual (…) against another person or small group that either results or has a high likelihood of resulting in injury, death,

psychological harm, maldevelopment or deprivation" (Butchart & Mikton, 2014, p. 82). EA usually involves family members as perpetrators, and, as a result, very often happens behind closed doors (Aas, 2018; Hamby et al., 2016; Hayman, 2011; Ryan & Roman, 2019; Weissberger et al., 2020). The impact of EA is substantial, and has been associated with outcomes such as depression and an increased risk of mortality in longitudinal studies (Acierno et al., 2017; Dong, 2015; Lachs et al., 1998). However, EA has generally received less attention as compared to other public health problems, such as child abuse or intimate partner violence (IPV), and has been identified as the most neglected form of interpersonal violence (Butchart & Mikton, 2014; Yon et al., 2017). As the population ages, however, it is likely that the number of EA cases will increase, a worrying fact considering that current prevalence figures are likely to be an underestimation of the real scope of the problem (Aday et al., 2017). Unfortunately, tackling EA is not without challenges, due to its complex dynamics and the difficulties in intervening and advancing research (Burnes, Lachs, et al., 2019).

Some of the major barriers to development in the field are the low rates of disclosure by victims and the lack of formal reporting to authorities or agencies, followed by the rejection of intervention or lack of service utilisation once victims contact services or are identified (Burnes, Lachs, et al., 2019). Specifically, between 4 and 14% of cases are estimated to reach formal response systems (Acierno et al., 2020; Amstadter et al., 2011; Lachs & Berman, 2011). Although these barriers are common in other types of interpersonal violence, such as IPV, research on those other types of violence has a longer history (Dyer et al., 2003; Voth Schrag et al., 2020). As a result, there is more established knowledge of several relevant aspects of help-seeking: e.g., what prevents victims from disclosing as well as what facilitates it, which victims are more likely to disclose, and the effect that third parties' reactions to disclosure have on victims (Sylaska & Edwards, 2014; Voth Schrag et al., 2020). Comprehensive research of this kind is, for the most part, lacking in the field of EA. The scant research available suggests

that variables such as awareness of the abuse, perceived abuse seriousness, relationship with the perpetrator, type(s) of abuse, the influence of culture, and attitudes towards third-party intervention are important and should be further investigated (Burnes, Lachs et al., 2019; Jackson & Hafemeister, 2015; Yan, 2015).

Despite the widespread acknowledgement of victims' lack of reporting, until recently, most explanations for this phenomenon were based on professionals' assumptions or anecdotal evidence, rather than on research data (Gibson, 2013). The available research is limited in other regards, namely because it has been conducted from the perspective of professionals and because research based on the victim's experience has failed to explore several important aspects of help-seeking. Since most research has focused on professionals' experience of reporting, there is little knowledge about the reporting behaviour of non-professional concerned persons, such as family members, including the assistance they provide, and their experience with help-seeking and access to services (Breckman et al., 2017; Truong et al., 2019). In addition, when research has been conducted with non-professionals, it has for the most part focused on older adults who have not been victimised and hypothetical situations, thus failing to consider the victim's perspective, a widely acknowledged flaw in EA research (Burnes, Lachs, et al., 2019). Available research with victims has failed to extensively explore knowledge regarding determinants of informal disclosure and the responses that victims obtain from sources. Given that in other types of interpersonal violence (e.g., IPV; child sexual abuse) victims more frequently disclose the victimisation to informal sources, the focus on victims' reporting to professionals may be underestimating victims' ability to talk about their experiences (Chabot et al. 2018; Sylaska & Edwards, 2014; Winters et al., 2020). Finally, research has also paid limited attention to the potential influence of attitudes towards intervention on help-seeking. The available research has identified that victims' negative expectations of what will happen if they seek help (e.g., institutionalisation, isolation, harm to

the perpetrator) may prevent them from seeking help (Jackson & Hafemeister, 2015; Mackay, 2017; Vrantsidis et al., 2016).

Based on these research gaps, there is scope for providing a better understanding of help-seeking behaviour in EA, which can be critical to further research in the field. A better understanding can also help to improve prevention efforts, for example, by identifying and targeting information at victims least likely to disclose. This thesis aimed to fill several gaps in knowledge around help-seeking in EA, from the perspective of victims and non-professional third parties who try to help them ("concerned persons"; Breckman et al., 2017, p. 719). The purpose was to understand the barriers to and facilitators of disclosure, and also the experience of victims and others once they decide to seek help (e.g., the responses they receive from the recipients of disclosure, the support they are offered, and the outcomes). There was also an aim to comprehend how attitudes towards and experiences with intervention affect the help-seeking process. Providing this understanding can help to improve the services and responses offered to victims and others who seek to remedy a case of EA, and recommendations for research and practice are provided. For example, there is a discussion about the way in which services can be tailored with the purpose of facilitating engagement and enhancing acceptability among victims. To achieve the aims of this thesis, three studies were conducted: a systematic literature review, an analysis of secondary data, and a study encompassing interviews and surveys.

1.1. The Content of This Thesis

The overarching literature review presented in Chapter 1 provides a context to understanding victims' help-seeking behaviours as well as their attitudes towards intervention and their potential impact in this process. Because victims may not always disclose, current research on informal third parties' help-seeking behaviour is also discussed. The first part of the literature review concentrates on general research on EA, focusing on UK research where possible, but generally drawing on findings from other countries due to the higher volume of

research abroad. This discussion is followed by a review of research about EA victims' help-seeking behaviour and help-seeking behaviour by concerned persons. Finally, the third part of the literature review section includes an overview of EA intervention in order to provide a context to understand victims' views or attitudes towards intervention and the ways it has been suggested that these attitudes may affect help-seeking behaviour. Throughout the chapter, relevant theories and models are introduced to connect help-seeking and attitudes towards intervention, focusing particularly on the Theory of Planned Behaviour (Ajzen, 1985) and the Ecological Systems Theory (Bronfenbrenner, 1979). In addition, Andersen's Behavioral Model of Health Services Use (Andersen, 1968) is discussed. Because of the potential relevance to help-seeking behaviour by a third party, this thesis also addresses the Bystander Intervention Model (Latané & Darley, 1970).

Chapter 2 presents the overarching methodology of this thesis, discussing the research paradigm, and providing general definitions that are common throughout the thesis, as well as the justification for the inclusion of specific variables to study help-seeking. There is also a discussion of why the specific groups of study were chosen, and ethical considerations are addressed. Chapter 2 includes the most specific methodological details of Study 3, including the sampling, recruitment steps, and data collection materials.

Following Chapter 2, the subsequent chapters are empirical and present the findings from the studies conducted for this thesis. Study 1 was a systematic review focused on help-seeking behaviour by victims. Study 2 was a secondary analysis of data from a UK helpline and focused on help-seeking by victims and concerned persons. Finally, Study 3 was a study involving primary data gathered from concerned persons via semi-structured interviews and a survey. While Study 1 is reported in its own chapter (Chapter 3), Studies 2 and 3 are reported thematically: Chapter 4 focuses on the findings regarding victims, from Study 2 (secondary data) and Study 3 (primary data), and Chapter 5 focuses on the findings regarding concerned

persons, from Studies 2 and 3. The decision to report findings thematically by groups was adopted to allow for a further integration of the findings from Studies 2 and 3 in relation to each group.

Chapter 3 presents the literature review, methodological details, findings, and discussion of Study 1, a systematic review focused on studies that report on victims' help-seeking behaviour. This chapter connects with Chapter 1 and expands the overarching literature review. Of note in Chapter 3 is that the findings reported, particularly the gaps identified in the literature reviewed and outlined in the discussion, were critical in the planning of Studies 2 and 3 in this thesis. Similarly, parts of Study 1's findings, particularly relating to barriers and facilitators, were tested in Studies 2 and 3.

Chapter 4 presents the literature review, methodological details, findings, and discussion from Studies 2 and 3 in relation to victims. Aspects worth highlighting in this chapter are the new findings regarding barriers, facilitators, and victims' wishes towards intervention.

Chapter 5 presents the literature review, methodological details, findings, and discussion from Studies 2 and 3 in relation to concerned persons. Of note in this chapter are the findings regarding the barriers and facilitators to help-seeking for concerned persons. In addition, this chapter provides support for previous research identifying the wide-ranging impact for concerned persons in EA cases, and answers questions about the sources of this impact.

Finally, Chapter 6 brings the findings from the empirical chapters together and integrates results regarding victims and concerned persons. This chapter includes a summary of theoretical contributions and recommendations for practice and research. Within the contributions to theory, a model of help-seeking is presented. This model combines elements

of the theories and models presented in the overarching literature review (Chapter 1) and may help guide further research in the field.

CHAPTER 1- LITERATURE REVIEW

1.2. Literature Review

1.2.1. Elder Abuse

Recent decades have seen the ageing of the global population due to factors such as the continued increase in life expectancy and the decreasing birth rate. Worldwide, it has been projected that people aged 65 and over will reach 1.5 billion by 2050, at which time older persons are projected to account for 16% of the population, compared to 703 million or 9% in 2019 (United Nations, 2019). Within the context of an ageing population, EA is in increasingly urgent need of study (Dong & Wang, 2016; Pillemer et al., 2016). Since the first article on "granny battering" (Burston, 1975) and the first UK population study were published (Ogg & Bennett, 1992), attention on the topic of EA has been constantly growing. It is not a new problem, though it remained hidden until the last quarter of the century (Krug et al., 2002). However, with the unprecedented ageing of the population, it has the potential to have an equally unprecedented impact. In the context of the COVID-19 pandemic, the study of EA has acquired even more importance. Rates of this type of abuse are likely to increase both during the pandemic and its aftermath. This increase can occur because of the measures to protect the population (e.g., social distancing, which may lead to risk factors such as isolation), and the health care and economic impact (e.g., causing financial hardship) (Elman et al., 2020). Currently considered a public health, social, and legal problem (Aday et al., 2017; Clarke et al., 2016; Inelmen et al., 2019; United Nations, 2019), the societal cost of EA is considerable (Weissberger et al., 2020), with estimates amounting to billions of dollars in the United States annually, encompassing the costs of services, the medical expenses, and the direct financial loss for victims (Rosen et al., 2019).

Despite years of research, one area of continuous debate in the field has been reaching an agreement on what the term “elder abuse” means (Erlingsson, 2007). Several definitions exist and there are ongoing challenges around its conceptualisation, which have resulted in no agreed-upon, uniform definition (Bows, 2018; Erlingsson, 2007; Ploeg et al., 2013; Storey, 2020). This general lack of agreement as to what constitutes EA exists both among scholars and between scholars and practitioners. In addition, it has been highlighted that definitions may lack validity if they do not integrate older people’s subjective conceptualisations of abuse (Burnes, Lachs, et al., 2019). This is an important consideration because these conceptualisations vary between researchers and older people, and also across cultures, given that what is seen as abusive in a certain culture or minority ethnic group may not be understood as such in others (Enguidanos et al., 2014; Jervis et al., 2016; Moon et al., 2002; Walsh et al., 2010).

Despite these challenges, some EA definitions have received more acceptance than others. One of the most widely used definitions was developed by the UK charity Action on Elder Abuse—now called Hourglass—and was later adopted by the World Health Organisation (WHO) (Action on Elder Abuse, 1995). According to this definition, EA is understood as: “A single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person” (WHO, 2020a, para. 2). A similar definition is employed by the Centers for Disease Control and Prevention (CDC) in the U.S, specifying that EA is “an intentional act or failure to act that causes or creates a risk of harm to an older adult” (CDC, 2020, para. 1). The CDC further specifies that “An older adult is someone age 60 or older” and that “the abuse often occurs at the hands of a caregiver or a person the elder trusts” (CDC, 2020, para. 1).”

The implications of the above definitions are that acts committed by strangers, such as theft or burglary, are excluded, and that acts of discrimination on the grounds of age or *ageism*

are unlikely to be considered as EA (Lachs & Pillemer, 2015; Storey, 2020). Most researchers and practitioners recognise five types of abuse: financial abuse or exploitation; physical abuse; psychological or emotional abuse; neglect; and sexual abuse (Pillemer et al., 2016). Financial abuse can be defined as the misappropriation of the older person's money or property and physical abuse as acts carried out with the intention to cause physical pain or injury (Lachs & Pillemer, 2015). Psychological abuse involves acts that intend to cause emotional pain or injury, and sexual abuse is the direct or indirect involvement in sexual activity without consent (Lachs & Pillemer, 2015; O'Keeffe et al., 2007). Finally, neglect is the deprivation of assistance needed by the older person for important activities of daily living and can be both an act of omission or a lack of appropriate action, whether intentional or unintentional (WHO, 2020a).

While the above definitions consider neglect as part of EA, they do not include self-neglect, which is sometimes considered by researchers and by several organisations in their conceptualisations (Schiamberg & Gans, 2000). Self-neglect can be defined as a "form of refusal or failure to provide oneself with adequate food, water, clothing, shelter, personal hygiene, medication, and safety precautions" (Dong, 2017, p. 949). Elder self-neglect is a major concern and often increases the vulnerability of suffering abuse; however, it lacks the interpersonal dimension that characterises the EA definitions highlighted above and is not usually considered a type of EA in the UK (McDermott, 2010; Penhale, 2008; Rowan et al., 2020).

Considering the multiple types of EA that exist, there are researchers who highlight the importance of studying these abuse types separately (e.g., Jackson & Hafemeister, 2011); however, there is also a need to consider poly-victimisation or abuse co-occurrence. Research studies indicate that different abuse types frequently co-occur (e.g., Weissberger et al., 2020; Williams et al., 2020); however, it has been only recently that benefits of a poly-abuse or poly-victimisation framework have been increasingly discussed (Hamby et al., 2016; Heisler, 2017;

Ramsey-Klawsnik, 2017; Ramsey-Klawsnik & Heisler, 2014; Teaster, 2017). Poly-victimisation researchers argue that considering isolated incidents of abuse may not meet victims' needs or hold perpetrators accountable. Thus, practitioners should be ready to consider that multiple types of abuse may be occurring, and thus, they should aim to probe further even if presented with a single type of abuse (Heisler, 2017). Similarly, researchers on EA should measure and report abuse co-occurrence where possible in their studies.

Concerning disagreement regarding the age at which a person is considered "older", Western countries usually consider the start of "older age" to be the age at which people retire (e.g., 60 or 65). However, this may be less meaningful in developing countries, where it may be more important to take into account the roles assigned to people, with "old age being regarded as that time of life when people, because of physical decline, can no longer carry out their family or work roles" (Krug et al., 2002, p. 125). Some of these considerations need to be examined critically, however, as they may reflect ageism (societal discrimination on the grounds of a person's age). This reflection is particularly important in the face of ageism displays during the COVID-19 pandemic, such as public discourse attributing less value to the lives of older adults (Fraser et al., 2020). In addition, there is a need to consider different life expectancies not only between countries but also within countries, given that certain minorities may have a lower life expectancy (e.g., Aboriginal populations in Australia; Vrantsidis et al., 2016). Despite these discrepancies, studies in several countries (e.g., Amstadter et al., 2011; Bows, 2018; Gil et al., 2017; Yan, 2015), including the most recent review of EA prevalence research worldwide (Yon et al., 2017) consider 60 to be the age cut-off, following the age cut-off usually considered in publications by organisations such as the WHO (WHO, 2020a) and the CDC (CDC, 2020).

Despite the increased attention from academics and practitioners, research has mainly come from countries such as the United States or Canada and has grown slowly and in a non-

linear manner (Daly et al., 2011). EA has been identified as the most overlooked type of interpersonal violence, receiving far less attention than that devoted to other types. For example, IPV (i.e., the "behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours"; WHO, 2017, para. 3) and child maltreatment (i.e., "the abuse or neglect that occurs to children under 18 years of age […] in the context of a relationship of responsibility, trust or power" (WHO, 2020b, para. 2) (Butchart & Mikton, 2014; Coombs, 2014; Dyer et al., 2003). In addition, in the UK, it is estimated that research on EA lags 10 years in comparison with the United States (Penhale & Kingston, 1997). Existing research on EA has not paid equal attention to different areas of study or interest and has frequently focused on obtaining prevalence estimates in different countries, or else in investigating EA typologies and definitions (Erlingsson, 2007). Certain topics, such as the understanding of the views of EA victims and the characterisation of perpetrators, have been overlooked in comparison (Burnes, Lachs et al., 2019; DeLiema et al., 2018; Jackson, 2016). Similarly, even though EA occurs within an existing relationship, the dynamics of the relationship between victims and perpetrators have rarely been acknowledged in research (Aday et al., 2017; Clarke et al., 2016; Jackson & Hafemeister, 2015). It is also possible that an initial framing of EA as abuse and neglect occurring in a caregiving relationship may have treated perpetrators of harm uniformly as adult children and other family members responsible for caregiving as opposed to the diverse group that they are (Jackson, 2016; Storey et al., 2021)

1.2.2. Prevalence and Impact of Elder Abuse

Regarding the scope of EA, many prevalence studies have been conducted, usually through random sampling of the general older population, and using face-to-face interviews to examine whether participants have suffered EA within a certain period of time—e.g., in the previous year—or since becoming "older" (Yon et al., 2017). These prevalence studies have

provided widely varied figures, which has been attributed to the use of differing conceptualisations of EA and research methodologies (Cooper et al., 2008). For example, a study may require a minimum number of abusive behaviours in order to consider a certain type of abuse (e.g., O'Keeffe et al., 2007). Variance in prevalence estimates may also be due to the type of sampling (random vs convenience) and the sample size (Yon et al., 2017). In addition, wide-ranging estimates potentially result from real differences between countries, as prevalence studies are usually conducted at a national level (Yon et al., 2017). A recent meta-analysis identified the global prevalence of EA in community settings to be 15.7% or about one in six older adults (Yon et al., 2017). Considering 2015 population estimates, the authors highlighted that worldwide, EA could affect 141.4 million older people (Viergever et al., 2018; Yon et al., 2017). In addition, in institutional settings, a meta-analysis of staff-to-resident abuse was also recently published (Yon et al., 2018) which reported that 64.2% of staff had self-reported perpetrating EA in the previous year, with psychological abuse being most frequent, followed by financial abuse (Yon et al., 2018). However, there was not enough data in this systematic review to report the findings for institutional abuse self-reported by older adults.

In the UK, the most recent data were obtained from the National Prevalence Study, published in 2007 (O'Keeffe et al., 2007). This prevalence study focused on peopled aged 66 and older residing in private households in the UK and used a weighted sample representative of the UK population. Data about the experience of EA were self-reported and researchers interviewed participants using a questionnaire. This prevalence study identified that 2.6% of adults aged 66 and over living in private households had been victims of abuse committed by a family member, close friend, or care worker during the previous year. This percentage increased to 4% when acquaintances and neighbours were also included as potential perpetrators (O'Keeffe et al., 2007). Unfortunately, there are no more recent prevalence studies in the UK available, so the use of these data should be treated with caution.

The impact of EA has not been extensively studied, due to the difficulty of implementing longitudinal studies and because, in cross-sectional studies, the potential effects of EA could exist prior to the abuse (Krug et al., 2002). However, available research has linked EA to outcomes such as premature mortality and EA has also been associated with other types of negative emotional and physical consequences, such as depression and hospitalisation (Dong, 2015; Dong & Wang, 2016; Lachs et al., 1998; Yunus et al., 2019). Significantly, an early longitudinal study from the United States found that victims of EA were three times more likely to have died by the end of the 13-year follow-up period as compared to non-victims (Lachs et al., 1998). This study, after controlling for other variables associated with early mortality in older adults, found that suffering EA was an independent predictor of early death.

In addition, certain types of abuse may have an impact on older adults that they would not otherwise have on younger people. Specifically, for financial abuse, the impact is likely to be more significant than for younger victims, as older people may not have the capacity to deal with its consequences as effectively due to lack of earning power (Age UK, 2015). In addition, the increasing care needs that people require as they age may intensify the impact of any loss of money or property, a loss which is not frequently returned by the perpetrators (Coombs, 2014). The specific financial loss can range widely; however, a U.S. study found that each victim of elder financial abuse in their sample lost more than 100,000 dollars on average (Jackson & Hafemeister, 2011). Similarly, the consequences of physical abuse are varied and can range from bruises to head injuries that lead to long-lasting disability. Regardless of the specific injury, and even though this will not be the case for every older adult, it is likely that these will be more considerable with increased age, and it may be harder or may take longer for victims to recover (Krug et al., 2002).

1.2.3. The Dynamics and Risk Factors of Elder Abuse

In terms of EA dynamics, victims are often in close relationships with their perpetrators, who are very frequently family members (Jackson & Hafemeister, 2011; Ryan & Roman, 2019; Vrantsidis et al., 2016; Weissberger et al., 2020). Thus, outsiders may perceive the perpetrators as sources of help for the victims, rather than a threat (Roberto, 2016). However, perpetrators can also be friends, or acquaintances whom the victim trusts, as well as professionals responsible for the victims' care (Roberto, 2017). EA can occur in domestic settings, but older people are also victimised in institutions, such as care homes and nursing homes (Band-Winterstein et al., 2021; Lachs & Pillemer, 2015; Penhale, 2008; Schiamberg et al., 2012). Thus, because of the variety of relationships and different settings where EA takes place, both EA victims and perpetrators are a very heterogeneous group (Jackson, 2016; Labrum & Solomon, 2018; Santos et al., 2019). Attempts to develop perpetrator typologies are scarce but are starting to receive increased attention so that cases can be understood and targeted more efficiently (DeLiema et al., 2018). Existing knowledge about perpetrators remains limited mainly due to lack of research conducted with this group, which has been mostly descriptive (Roberto, 2017). In addition to under-reporting and lack of detection, many cases that are detected are not prosecuted (Dalley et al., 2017; Jackson, 2016). These dynamics limit both the intervention EA perpetrators receive and any opportunities for research. The lack of research and intervention also stands in contrast with other types of interpersonal violence, where research with perpetrators of abuse, including on effective interventions, is common (e.g., sexual violence; Lösel & Schmucker, 2005).

Despite these limitations, several risk factors have been identified at the victim and perpetrator level, as well as at the community level, usually by comparing groups of abused older adults with groups of non-abused older adults (Dong & Wang, 2016; Johannesen & LoGiudice, 2013; Storey, 2020). These studies are mostly cross-sectional in nature and

retrospective; thus, the risk factors reflect an association, and the studies are affected by recall bias (Johannesen & LoGiudice, 2013). A recent systematic review published by Storey (2020) reviewed and synthesised the data from 198 studies on EA and extracted several evidence-based risk factors for perpetrators, and vulnerability factors for victims. Both for perpetrators and victims, there were several common factors: mental health problems, physical health problems, dependency, previous victimisation, and substance abuse problems (Storey, 2020). In addition, co-habitation with the perpetrator was considered a vulnerability factor for the victim.

Despite these risk factors portraying a physically or cognitively frail victim, it is important to consider that older adults may be vulnerable in different ways, and that limited financial, psychological, social, and legal support may place them at risk of abuse by people close to them (Inelmen et al., 2019; Mackay, 2017; McClurg, 2013). In fact, in Johannesen and LoGiudice's (2013) review, the researchers identified that the risk factors with the highest odd ratios referred to the relationship (i.e., family disharmony and poor or conflictual relationships) or environment (e.g., low social support or living with others). There is also evidence of the importance of socioeconomic indicators, such as economic inequality or level of formal education, in explaining cross-country variation in psychological and financial abuse (Fraga et al., 2014; Podnieks et al., 2010). It is also understood that other factors at a societal level—e.g., ageism—play a role (Clarke et al., 2016; Lachs & Pillemer, 2015; Pillemer et al., 2021; Podnieks et al., 2010; Walsh et al., 2010). However, empirical research to support the connection between ageism and EA remains limited (Pillemer et al., 2021).

1.2.4. Explanatory Theories of Elder Abuse

Explanatory theories for the perpetration of EA have changed throughout the years, as research on EA has accumulated (Jackson, 2016). Most theories that have been employed to explain EA are adaptations of theories from multiple fields previously used to explain other

phenomena (Band-Winterstein et al., 2021; O'Brien et al., 2016), and several of these theories have not been tested empirically. Many of the theories have focused on the influence of factors at a single level, such as dependency or caregiver stress (Jackson & Hafemeister, 2016). However, others have focused on multiple levels (e.g., individual, interpersonal, societal), acknowledging the complexity of EA (Band-Winterstein et al., 2021).

Of the theories that can be categorised as focusing on a single level or factor, some that are frequently utilised are the theory of caregiver stress (Anetzberger, 2000), the social exchange theory (Homans, 1958), and the social learning theory (Bandura, 1978), all of which focus on interpersonal relationships. On the other hand, frequently mentioned theories that focus on societal factors are power and control theory (Gibson, 2013; Straka & Montminy, 2008) and positioning theory (Harre & Van Langenhove, 1999; O'Brien et al., 2016; Stevens et al., 2013).

Among the theories above, perhaps the most widespread, at least in early EA research, was that of "caregiver stress" (Anetzberger, 2000). This theory was concordant with the understanding that perpetrators were very frequently family members, often adult children or current or former spouses or partners, and that victims were commonly frail and dependent on others (Schiamberg & Gans, 2000). According to this theory, EA largely occurred in relationships where the older person was being cared for by a family member, and the abuse was a result of the stress associated with caregiving (Anetzberger, 2000; Quinn & Tomita, 1997). Hence, perpetrators were understood as caregivers who needed social support (Jackson, 2016).

However, with growing research about EA and the characteristics of victims and perpetrators, there were challenges to the theory of caregiver stress, arising from contradictions with research findings. For example, researchers have frequently found that the perpetrator is

also dependent on the victim (e.g., for housing, financially; Jackson, 2016; Labrum & Solomon, 2018; Storey, 2020) and that EA is multi-faceted and so are the perpetrators of abuse (Band-Winterstein et al., 2021; Jackson, 2016). "Caregiver stress" may explain abuse in a fraction of EA cases, where the perpetrator is a family member caring for a victim with significant needs, and where there is no adequate support in place (O'Brien et al., 2016). However, many risk factors have been associated with perpetrating EA, some of which do not necessarily relate to a caregiving relationship (Storey, 2020). As a result of these limitations, the theory of caregiver stress has been replaced in favour of other, more comprehensive theories (Jackson, 2016).

Given that EA takes places in different settings and in the context of different relationships (Yon et al., 2017, 2018), it is likely that the phenomenon is explained by more than a single factor. In fact, theories have been criticised for their understanding of EA cases as a uniform category (Jackson & Hafemeister, 2016). Hence, focusing on single factors may result in an inadequate understanding of the phenomenon, and ineffective intervention and responses. Consistent with the consideration of risk factors at different levels, one of the theories currently used to understand EA is the Ecological Systems Theory (Bronfenbrenner, 1979; O'Brien et al., 2016) or adaptations arising from it, such as the ecosystemic-based theoretical framework proposed by the National Research Coucil (2003). Ecological Systems Theory identifies the influence of different environmental systems on the individual, thus encompassing not only the individual but also their immediate settings and overarching societal norms and beliefs (Bronfenbrenner, 1979). As a multi-system theory, it is different from other theories mentioned in the previous paragraphs, which have generally focused on the influence of factors at fewer levels (Jackson & Hafemeister, 2016). As an organising framework, it also allows for the understanding of the inter-relations between risk factors (Schiamberg & Gans, 2000). Based on this framework, Schiamberg and Gans (2000) published a theoretical paper in which they identified the influence of different environmental systems—micro-system, meso-

system, exo-system, macro-system, and chrono-system—in the context of abuse perpetrated by adult children, though the chrono-system is not always considered in other publications that make use of the theory (O'Brien et al., 2016).

The micro-system level would encompass the relationship between the older adult and individuals within their immediate settings (e.g., home, care home), while the meso-system refers to relationships between micro-systems that involve the older adult (e.g., institutions responsible for service provision). The exo-system centres on social structures and systems that have an impact on the older adult's micro-system but do not directly contain the older adult (e.g., social welfare systems). Finally, the macro-system focuses on overarching beliefs and social values (e.g., ageism; O'Brien et al., 2016).

In their report about risk and prevalence of EA, the National Research Council (2003) presented an eco-systems-based theoretical perspective with the aim to provide a framework to organise past and future research efforts. This framework considers multiple interacting domains: factors related to the victim, the perpetrator, their relationship, the family system, home environment, social embeddedness, and the victim's intersection with broader sociocultural arrangements (Burnes, 2017; National Research Council, 2003). In sum, the Ecological Systems Theory (Bronfenbrenner, 1979) and perspectives based on it are helpful in responding to EA. They can encompass the complexities of EA and have been used by researchers as organising frameworks for understanding different types of EA occurring in different settings (e.g., domestic, institutional) (Burnes, 2017; National Research Council, 2003; O'Brien et al., 2016; Roberto, 2016; Schiamberg et al., 2011).

Finally, Jackson and Hafemeister (2016) developed theories to explain four different types of abuse: caregiver neglect; physical abuse; pure financial exploitation; and hybrid financial exploitation (i.e., co-occurring with physical abuse or caregiver neglect). Their

purpose was to move away from one-size-fits-all explanations of EA and offer a more nuanced perspective of the dynamics of different abuse types. They noted different patterns of victim-perpetrator relationships, and victim and perpetrator characteristics by type of abuse. For example, they stated that victims of pure financial exploitation were more likely to live alone and be cognitively intact, while victims of physical abuse were victimised by perpetrators that they had been supporting throughout their lives. Although the differences noted may be of utility to practitioners and may facilitate the development of more nuanced theoretical approaches in the field, this approach stands in contrast with the fact that, frequently, different types of abuse co-occur (e.g., in 23% of the cases reported to a national U.S. helpline, Weissberger et al., 2020). Thus, the study of variances between abuse types may not be so relevant in the context of a poly-abuse or poly-victimisation framework (Hamby et al., 2016; Heisler, 2017; Ramsey-Klawsnik, 2017). The approach is also limited by the lack of a theory for psychological abuse perpetration, which was identified as the most prevalent abuse type in the most recent worldwide systematic review (Yon et al., 2017).

1.2.5. The Tip of an Iceberg: Help-Seeking in Elder Abuse

Despite the prevalence estimates and the substantial impact that EA has on victims and society, many cases remain unreported and are therefore unlikely to reach formal services (Bergeron & Gray, 2003; Coombs, 2014; Cooper et al., 2008; Cooper & Livingston, 2016; Dalley et al., 2017; Kaye et al., 2007; Killick & Taylor, 2009; Lachs & Berman, 2011; Tatara, 1999). The number of cases that are reported has been compared to the "tip of an iceberg" (Coombs, 2014, p. 250). As a result of under-reporting, many victims of EA may not receive any formal support, and the abuse may continue or escalate over time (Burnes, Lachs et al., 2019; Burnes, Acierno, & Hernandez-Tejada, 2019; Storey & Perka, 2018). Reporting estimates may be calculated in prevalence studies, using random and non-random sampling, by asking victims to self-report whether they have sought help before (informally, formally, or

without specifying) (Amstadter et al., 2011). They can also be calculated by comparing the number of older adults self-reporting EA in a study and the number of cases that are referred to formal services (Lachs & Berman, 2011). According to U.S. estimates based on previous research, only 4-14% of cases reach formal response systems (Acierno et al., 2020; Amstadter et al., 2011; Lachs & Berman, 2011).

The limitations to the ways in which one can calculate reporting rates, and how they might either underestimate or overestimate under-reporting, have been discussed elsewhere (e.g., London et al., 2005). The calculation of these estimates in EA is in its infancy, especially as compared to other fields of victimisation, so further caution should be taken when interpreting these estimates, as compared to other fields with more established research. Reporting may also be affected by external events at a societal level and may fluctuate as a result. A good example is the recent impact of COVID-19, where EA victimisation reports to UK and U.S. helplines increased, probably related to the effects of the pandemic on EA risk and vulnerability factors (Elman et al., 2020; Makaroun et al., 2021; Snowdon et al., 2020).

Understanding victims' determinants of reporting and the barriers that they experience is essential in order to increase reporting, provide victims and perpetrators with intervention, and prevent further victimisation. When EA remains under-reported, victims and perpetrators may not receive support, and risk and vulnerability factors will not be addressed. Unless a professional or non-professional known to the victim suspects or is aware of signs that an older person may be suffering abuse and then decides to report it, the first step to EA being formally reported is the victim disclosing (i.e., telling someone about it). Thus, it is essential to improve the understanding of why they may or may not disclose. The implications of an improved understanding of the process of seeking help from the perspective of victims are far-reaching for practitioners. It is often highlighted that General Practitioners (GPs) and other healthcare professionals need to know what signs of abuse to look for (Dow et al., 2018). It would be

helpful if they also knew what to expect in terms of barriers to disclosure, how to screen for those, and how to react to victims' behaviour in a way that they do not prevent further disclosure or help-seeking behaviour (Fraga Domínguez et al., 2020). This knowledge could help them not only be aware of potential victims, but also of those older persons that are more likely to remain silent about the abuse.

Defining Disclosure and Help-Seeking. The processes of disclosure and help-seeking can be hard to define and have received more attention in fields other than EA (Truong et al., 2019). A definition taken from the field of IPV referred to disclosure as "any conversation where the victim provides information regarding the abuse occurring in the relationship to another individual" (Sylaska & Edwards, 2014, p. 4). The National Institute for Care and Excellence (2014) defines disclosure as when "an adult or child who has experienced or perpetrated domestic violence or abuse informs a health or social care worker or any other third party" (p. 41). While abuse "disclosure" can be formal or informal, it is sometimes used to encompass both, and sometimes to refer to any informal conversation as opposed to formal disclosure (frequently referred to as "reporting").

Similarly, help-seeking also lacks an agreed-upon definition in EA research, but has been previously defined in research as "disclosing to a third party any incident of financial abuse, physical or psychological mistreatment, or neglect since the age of 65 years old" (Naughton et al., 2013, p. 1259). This definition would equate help-seeking with both informal and formal disclosure. However, studies have operationalised help-seeking behaviour in various ways, ranging from talking about the abuse with any third party, to exclusively considering the disclosure to a formal source of help (e.g., police or other kind of authority; Acierno et al., 2020; Jackson & Hafemeister, 2015), usually referring to this as "reporting". Importantly, informal and formal disclosure are rarely isolated events, and are better thought of as a continuous process that may take a long time to unfold, given that victims may disclose

victimisation over several conversations or may not initially disclose abuse as such (Alaggia, 2010; Mowlam et al., 2007; Truong et al., 2019; Vrantsidis et al., 2016). In the field of child sexual abuse, a recent review of the literature concluded that disclosure is viewed as "an ongoing process as opposed to a discrete event—iterative and interactive in nature" (Alaggia et al., 2019, p.276). Disclosing may be the first step in asking for help about abuse, and, for some individuals, it may be that disclosing is a way of asking for help, even if they do not do so explicitly. A disclosure may be followed by an offer of help, particularly if the disclosure is formal, and depending on professional obligations, it may lead to the receiver of that disclosure filing a formal report, which will be followed by an investigation. Thus, it is hard to isolate the process of disclosure from the process of seeking help.

With the above considerations in mind, this thesis uses the term "disclosure" to refer to talking about the abusive event with someone else, where that source is not specified, or where it may be both informal or formal sources. "Informal disclosure" is used to refer to disclosure to sources such as friends or family, with whom the victim does not have a professional relationship, and "formal disclosure" or "reporting" are used to refer to disclosure to professional sources. "Help-seeking" is used to refer to the broader process of disclosing to informal or formal sources, filing a report with the police, as well as actively seeking, and engaging with, help. "Help-seeking" is also the preferred term where the specific action involved (i.e., disclosure, asking for help) is less clear, acknowledging that these two processes may be intertwined and difficult to separate. Based on research in other fields, such as child sexual abuse and IPV, and also on the available research, both disclosure and help-seeking more generally are approached as an ongoing process rather than isolated events (Alaggia et al., 2019; Sylaska & Edwards, 2014; Truong et al., 2019).

The process of disclosure and its determinants have received more attention in the fields of IPV, child sexual abuse, and sexual assault; a review of previous research identified shame,

self-blame, and anticipatory stigma as key barriers to disclosure across these three fields (Kennedy & Prock, 2018). Research on disclosure of child sexual abuse found it to be determined by factors at different levels, related not only to the victim but also to family, community, and cultural and societal attitudes (Alaggia, 2010; Sorsoli et al., 2008). Studies in the field of IPV have found that most victims disclose the abuse to informal sources, such as a friend or neighbour, and that disclosure and social support in response to this disclosure are associated with better mental health in victims; however, these studies were cross-sectional in nature (Coker et al., 2002; Sylaska & Edwards, 2014). A review of IPV research reported that the least helpful reactions for victims were expressions of disbelief or victim-blaming (Sylaska & Edwards, 2014).

Research on disclosure in other adult victims of abuse, such as IPV, can guide interventions in EA, and similar barriers may be found (Kennedy & Prock, 2018). However, it is likely that help-seeking in EA is different because of specific characteristics of this type of interpersonal violence (Dong & Wang, 2016). As noted by Truong et al. (2019), there are different relationship dynamics involved in EA cases as compared to IPV, and there are also types of abuse, such as neglect, that are not usually considered as part of IPV (WHO, 2017, para. 3). In addition, changes related to the ageing of victims can have an influence on the characteristics of help-seeking. For instance, it could be that EA victims are dealing with different challenges due to loneliness, isolation, a more reduced social network, disability, or cognitive impairment (Burgess & Phillips, 2006; Coombs, 2014; Crichton et al., 1999; Hightower et al., 2006; Sirey et al., 2015). It could also be that they have different concerns related to services due to their experiences with services earlier in their lives if victimised in other ways (Ernst & Maschi, 2018; Ramsey-Klawsnik & Miller, 2017; Storey, 2020). For these reasons, research on disclosure and help-seeking specific to the field of EA and EA victims is necessary.

1.2.5.1. Theories and Models of Help-Seeking Behaviour. In terms of available theories and models of help-seeking behaviour in EA and mirroring the general trend in theories used to explain in EA, no theory has been consistently applied to help-seeking. As with the general explanatory theories of EA, help-seeking theories in the field have been adaptations of theories that already existed to explain other phenomena (O'Brien et al., 2016). One theory that has been utilised to explain help-seeking behaviour in other types of interpersonal violence (e.g., Fleming & Resick, 2017) is the Theory of Planned Behaviour (Ajzen, 1985), which has also been frequently employed to explain help-seeking behaviour in other contexts (e.g., for mental health problems; Schomerus et al., 2009). Additionally, a popular model amongst EA researchers is Andersen's Behavioral Model of Health Services Use (Andersen, 1968), so far used primarily to explain service utilisation once EA victims are in contact with (and have been offered) services (Barker & Himchak, 2006). A recent study in the field of IPV has found that the combination of the Theory of Planned Behaviour and Andersen's model had the largest explanatory impact in understanding victims' help-seeking behaviour, thus suggesting that help-seeking may be explained by a combination of theories and models (Fleming & Resick, 2017). Similarly, a review of studies on IPV and informal disclosure concluded that a "meta-theory" (Sylaska & Edwards, 2014, p.17) combining essential elements of multiple theories would be helpful in advancing research in the field.

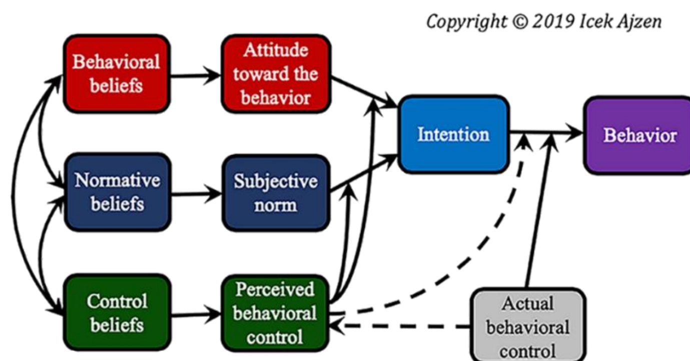
The Theory of Planned Behaviour (Ajzen, 1985) posits that the most important determinant of a behaviour is a person's intent to perform said behaviour. Three variables, which can interact with each other, are identified as determinants of intention: attitude towards the behaviour, subjective norm, and perceived behavioural control (Ajzen, 2020) (see Figure 1.1 for a visual representation of the model provided by the author). Attitudes towards the behaviour are based on behavioural beliefs, or an individual's perceptions of the likely consequences of performing said behaviour. Subjective norms are based on normative beliefs,

which reflect an individual's perception of social approval or disapproval by referents in their life (e.g., family, friends) for performing the behaviour. Finally, perceived behavioural control is based on control beliefs and represents an individual's perceptions of control over behavioural performance, such as factors that may hinder or further such performance (Ajzen, 1985, 2002). Perceived behavioural control moderates the influence of the two other components (attitude and subjective norm) on intention (Ajzen, 2020).

Importantly, the theory considers that once a person carries out a behaviour, they will acquire information about the actual outcomes of the behaviour (positive or negative), the experience of performing the behaviour, and the favourable and unfavourable reactions of others (e.g., loved ones) (Ajzen, 2015, 2020). Performing the behaviour will also reveal factors which are hindering or facilitating (Ajzen, 2015, 2020). This information (i.e., feedback) may then modify their beliefs (e.g., behavioural, normative, control), and through this modification, it could impact future intentions to perform the same behaviour (Ajzen, 2020).

Figure 1.1

A Representation of the Theory of Planned Behaviour by Ajzen (2019)



Note. Available from: https://people.umass.edu/aizen/tpb.diag.html

Applying this general theory to help-seeking in EA, attitudes towards the behaviour could be influenced by the expectations of what is going to happen when the victim seeks help

(e.g., being listened to, receiving emotional support, or being blamed; Sylaska & Edwards, 2014). Similarly, the subjective norms may be based on certain perceptions of the social acceptability of seeking help (e.g., whether the victim believes that their family would approve of their seeking help). Finally, perceived behavioural control is likely to be influenced by factors such as physical and cognitive ability, and economic and other types of resources (Ajzen, 2020). According to the feedback effect of the theory, if an EA victim sought help, the reactions from those around them (e.g., approval, disapproval), their experience of seeking help, and the outcomes of seeking help (e.g., abuse ceasing or worsening) would have an impact on the victim's intention to seek help in the future.

The Theory of Planned Behaviour has been widely used to explain a variety of behaviours and has received both commendation and criticism (Ajzen, 2015, 2020). It remains popular in the field of psychology (Ajzen, 2011), and it is recognised that new models would be likely to retain constructs based on attitudes and control (Rhodes, 2015). One of its strengths is that it can be used to study a multitude of behaviours, and that it provides a conceptual framework for considering a behaviour and its determinants (Ajzen, 2020). In terms of the role of other factors such as personality traits or demographic characteristics in determining the likelihood of a person performing a behaviour, these are considered background factors (Ajzen, 2011). Hence, according to the theory, they would affect beliefs (behavioural, normative, and control), which would then influence intentions and behaviours (Ajzen, 2020).

A model that has been applied to the field of EA is Andersen's Behavioral Model of Health Services Use, later modified by Andersen and Newman (Andersen, 1968; Andersen & Newman, 1973) and reviewed by the original author and others throughout the following decades (see Andersen, 1995 for the different models). This model has previously been used to understand the use of health and social services by EA victims (Barker & Himchak, 2006; Burnes et al., 2016; Burnes, Breckman, et al., 2019) and formal help-seeking (Burnes, Acierno,

& Hernandez-Tejada, 2019), and is popular in social gerontological research (Burnes, Breckman, et al., 2019). The initial model posited that an individual's health service use was a function of three factors: their predisposition to use those services, factors which enable or impede use, and their need for those services (Andersen, 1995). Predisposing characteristics include individual characteristics such as age, gender, or race/ethnicity that may predispose a person to identify services. Social structure and health beliefs are also considered predisposing factors. Health beliefs are "attitudes, values, and knowledge people have about health and health services that might influence their subsequent perceptions of need and use of health services" (Andersen, 1995, p. 2). It is considered that these beliefs have medium mutability because they can be altered (Andersen, 1995). Secondly, enabling factors refer to the social and economic conditions that may assist an individual to access services, such as a victim's financial resources, but also to resources at the interpersonal, social, and community level (Andersen, 1995; Burnes, Acierno, & Hernandez-Tejada, 2019). These are considered as having high mutability.

Finally, the need factors in this model are the most significant indicators of service utilisation and reflect the actual perceived cause for service use or the presenting problem; it is generally agreed that some type of need has to be defined for use to take place (Andersen, 1995; Burnes, Acierno, & Hernandez-Tejada, 2019). For example, in the case of EA, a need factor could be the person's perceived severity of abuse. In relation to this, factors such as the nature and magnitude of the abuse and other morbidities are important (Burnes, Acierno, & Hernandez-Tejada, 2019; Fleming & Resick, 2017). The need factor was not originally considered to be subjective to mutability (i.e., it was thought that it could not be modified). However, more recently, it has been recognised that the perceived need for service utilisation or care can be modified through educational programs (Andersen, 1995). In the case of abuse, one could think about awareness programs about EA, its signs, and consequences. Another

addition in later modifications of the model were the feedback loops. In a manner similar to the Theory of Planned Behaviour presented above, this means that the outcome "affects subsequent predisposing factors and perceived need for services as well as health behavior" (Andersen, 1995, p. 7).

Although worth considering, Andersen's model is more likely to be helpful in explaining specific modes of help-seeking or specific help-seeking behaviours (such as seeking formal services' help or engaging with health services' help once offered). However, based on the definition presented previously in this section (p. 38), help-seeking is understood in this thesis as a broader phenomenon, which also includes informal disclosure. Thus, Andersen's model may not be an appropriate framework for explaining informal disclosure. However, it has been helpful in previous research in EA, and thus was also considered in this thesis.

Finally, although not applied to EA help-seeking specifically, the Ecological Systems Theory (Bronfenbrenner, 1979) might be considered a suitable organising framework to understand help-seeking. It has been used to explain EA risk factors (Schiamberg & Gans, 2000) and one of its strengths is its potential to adapt to the complexity of EA (National Research Council, 2003). Further, ecological perspectives have also been employed in child sexual abuse research on disclosure (Alaggia, 2010; Alaggia et al., 2019; Sorsoli et al., 2008). Alaggia (2010) indicates that "disclosure of child sexual abuse is multiply determined by factors related to child characteristics and history, family dynamics, community context, and larger cultural and societal attitudes" (p. 36). Hence, the different levels (see Section 1.2.4) could be an appropriate framework to understand help-seeking barriers and facilitators in EA.

The theories and models described above are considered throughout the thesis as a framework for understanding help-seeking in EA. Due to the scope of studies, the purpose was

not to test these theories and models empirically, but rather to examine whether they were helpful as a framework for understanding help-seeking and interpreting findings in the studies.

1.2.5.2. Research on Help-Seeking Behaviour in Elder Abuse. Available research on EA aiming to tackle under-reporting has generally focused on the perspective of professionals, (i.e., the challenges they experience with screening, detection, reporting, and intervention in EA cases) (Adams et al., 2014; Beach et al., 2016; Killick & Taylor, 2009). These studies have primarily focused on health care professionals and social workers and have found problems such as dilemmas that professionals experience making objective decisions when faced with a victim's rejection of services or complex relationship dynamics (Killick & Taylor, 2009). Although the focus on professional recognition and reporting is important, particularly in those countries where mandatory reporting laws exist, it has resulted in less attention being paid to victims of abuse and their own help-seeking barriers and experience (Truong et al., 2019). This focus on professionals also ignores victims who may not be in contact with professionals or raise their suspicions (Yan, 2015). Research not focusing on professionals has generally concentrated on older adults who have not been victimised (or where researchers do not know whether they have been victimised before participation in the study) who are asked to report on what they would do if they were. These participants usually take part in focus groups, interviews, surveys, or experimental vignette studies (e.g., Pickering & Rempusheski, 2014). The focus of other researchers has been on groups not generally understood to fit the definition of EA victims, such as IPV victims older than 45 or older than 50 (e.g., Beaulaurier et al., 2008). The following outlines the main findings and limitations of research with non-victim older adults and research with those who are not usually considered EA victims.

Research Studies With Non-Victim Older Adults. Most studies have recruited older adults who have not been victimised and used simulated case scenarios as materials (e.g., Gibson, 2013; Pickering & Rempusheski, 2014). However, researchers have also involved

older adults in focus group discussions or surveys, and many studies have focused on a specific cultural minority (e.g., Chinese-Americans, Korean-Americans; Chang, 2016; Dong et al., 2011; Lee & Eaton, 2009; Moon & Williams, 1993). Pickering and Rempusheski (2014) conducted a study in the United States in which they used vignettes with 76 participants to describe older adults' perceptions of elder abuse. The participants were presented with different vignettes, and the researchers manipulated the perpetrator type (paid caregiver, non-resident, and resident adult children) and the type of physical abuse. Participants were then asked to rate whether the situation was abusive, their likelihood of reporting it if they were the victim, and that likelihood when presented with a specific barrier, which was manipulated (i.e., threat of institutionalisation, and limited resources either of the older adult or the adult children). The results showed that participants were more likely to perceive the situation as abusive when perpetrated by a paid caregiver and that the barrier with the highest impact on likelihood of reporting was the threat of institutionalisation.

A large number of studies have aimed to study the influence of culture and ethnic belonging in help-seeking behaviours (e.g., H. W. Chang, 2004; M. Chang, 2016; Dong et al., 2011, 2014; Enguidanos et al., 2014; Lee & Eaton, 2009; Moon & Williams, 1993; Zannettino et al., 2015). These studies have generally included older adults as participants, and several have also included EA victims in their sampling, but have not generally separated findings for the two samples. The underlying assumption in these studies was that EA may exist within a cultural context, and that culture and ethnicity could shape the older people's perceptions of what does and does not constitute abuse (Zannettino et al., 2015).

Several of the studies on culture and help-seeking behaviours have been conducted in the United States and have concentrated on Asian American populations (e.g., Chang, 2016; Lee & Eaton, 2009). For example, Chang (2016) studied the experience of EA among older Korean immigrants and highlighted that the perception of EA and help-seeking behaviours was

influenced by the participants' culture. Specifically, for Korean immigrants, they stated that certain cultural factors (such as the duty of caregiving for a family member) may play a role in shaping help-seeking behaviour. In their sample, 64% of the participants who had experienced EA did not seek assistance, and participants preferred informal sources for help (i.e., family members and relatives). Lee and Eaton (2009) used vignettes with Korean American participants, and reported on the influence of culture in responding to financial abuse victimisation. They mentioned five major themes in their participants' reasons for not seeking help: issues related to family problems, abuse tolerance, shame, victim blame, and mistrust toward third party intervention. They also found that those with a higher level of adherence to traditional values were less likely to endorse seeking formal types of help (Lee & Eaton, 2009).

Several of the studies that fit into this general topic area have focused on older adult participants who were not victimised, and a number of them have involved both victims and non-victims; however, they have not necessarily separated the findings for both groups (e.g., Lee et al., 2014). Although the inclusion of victim participants provides more generalisability to their findings, the lack of separation limits the understanding of behaviours that are specific to victims. Many of the studies have used simulated case scenarios or vignette methodology. Although it is possible with this methodology to manipulate several case characteristics (e.g., type of perpetrator; Pickering & Rempusheski, 2014) and test their influence on help-seeking, these studies may not elicit a genuine response (Gibson, 2013). For example, non-victimised participants may have difficulty putting themselves in the position of the older adults described, especially if they do not feel in a vulnerable position or are highly functioning (Gibson, 2013).

Research Studies With Victims not Usually Considered as Elder Abuse Victims. Other studies, usually cross-sectional in nature and mostly descriptive, have focused on groups that are not what researchers usually consider EA victims, as previously noted by Chokkanathan et al. (2014). For example, there are several studies based on research with older female victims

of IPV (usually considering an age cut-off of 45 or 50; e.g., Beaulaurier et al., 2008). These publications are potentially relevant to understanding the behaviour of older adults when they are victimised; however, they are limited by their focus on intimate partner relationships and female victims usually slightly younger than the commonly used cut-off of 60 (Yon et al., 2017).

Research with 134 female victims of IPV who were 45 or older utilising focus groups (Beaulaurier et al., 2008) resulted in a model of barriers to help-seeking. According to this model, there were a series of factors that referred to the victim's internal and external perception of barriers to help-seeking, which interrelated with each other and also with the abuser's behaviour (Beaulaurier et al., 2008). The explanatory power of this model was later tested with victims and non-victims of family-perpetrated violence occurring in domestic settings by using a survey (Newman et al., 2013). The model which best explained why victims did not seek help was a six-factor model with the following factors: self-blame, secrecy, emotional gridlock, abuser behaviour, informal external responses, and formal system responses. The strength of these factors varied depending on the relationship with the perpetrator, victims' race/ethnicity, level of abuse, age, and perpetrator gender (Newman et al., 2013). For example, they found that secrecy was a stronger barrier when the abuser was in a close relationship. Abuser behaviour encompassed an abuser's tactics that negatively impacted a victim's willingness to seek help, and they found that this factor was related to the victims' response to such tactics (Newman et al., 2013). The factor of abuser behaviour is important, given the scarce knowledge regarding EA perpetrator's behaviours and, specifically, behaviours that could stop a victim from seeking help. Despite the importance of these findings in explaining older victims' help-seeking behaviour, they may be more applicable to female victims and to those cases where the perpetrator is a family member. In addition, even though it was tested on victims with different family perpetrators, initial development resulted from

research based solely on intimate perpetrators, meaning that part of these factors may be more applicable to cases of partner-perpetrated abuse (Beaulaurier et al., 2008).

Research Studies With Elder Abuse Victims and Research on Service Utilisation. Though scarce, several research studies have been conducted focusing on EA victims, many of those involving them as participants. Research with victims is overall characterised by heterogeneity (e.g., in sample size, methodology, geographic location) and a lack of specificity (e.g., not identifying what is understood as "help-seeking"), which make it difficult to synthesise and interpret. Further, the specific studies conducted with victims are hard to identify because of the volume of help-seeking studies not involving victims. Other studies have commented on help-seeking behaviour without it being the focus of the study (e.g., Lafferty et al., 2013; Mysyuk et al., 2016), also making their identification harder. Thus, the first study of this thesis encompassed a systematic review of the literature in order to identify and synthesise research on help-seeking focused on EA victims' views (see Chapter 3). Therefore, research in those studies is summarised and presented later in this thesis.

Other studies with EA victims have looked at service utilisation once these victims are identified, with services not being exclusively related to the abuse suffered (e.g., Barker & Himchak, 2006; Burnes et al., 2016), and usually testing Andersen's Behavioral Model of Health Services Use (Andersen, 1965). Studies on service utilisation are not covered in Chapter 3 of this thesis, as service utilisation is outside of the scope of the definition for the systematic review (Study 1). However, understanding service utilisation is important because even once an EA case reaches formal services, victims have the right to refuse investigation and/or intervention (Coombs, 2014; Department of Health and Social Care, 2020). These studies have expanded knowledge regarding which victims are more likely to utilise services that are offered to them, and these characteristics may be predictors of help-seeking, as considered in this

thesis. For example, Burnes et al. (2016) focused on service utilisation as "the proportion of interventions pursued out of the initial total safety plan" (p. 1043).

In a study by Barker and Himchak (2006), disadvantaged Hispanic older persons in the United States manifested lower service utilisation than White and African American older persons. These researchers also found several need factors that predicted service utilisation: cognitive and activities of daily leaving (ADL) impairments, poor self-rated health status, and the abuser's financial dependency on the victim and their status as primary caregivers of the victim (Barker & Himchak, 2006). In addition, they found one enabling factor—the victim living alone—and two predisposing factors: substance abuse in the perpetrator and the perpetrator being female were predictors of service utilisation. Differences in service utilisation have also been found by gender and marital status, with females displaying more service utilisation in financial abuse cases and married older adults less service utilisation in physical abuse cases (Burnes et al., 2016). Victims who perceived themselves as in danger because of the abuse were more likely to utilise services; this is consistent with the finding in other studies that victims seek help out of fear (Yan, 2015), and it led Burnes et al. to suggest that treatment may sometimes require helping the victim understand the seriousness of the situation. Hence, it is possible that certain factors that have been linked to service utilisation may also predict informal or formal disclosure.

1.2.5.2.1. Factors and Variables That may Influence Help-Seeking. Generally, in the different research outlined in the previous paragraphs (with older adults, victims), several factors or variables have been proposed as influential to understanding help-seeking. Several of these are also suggested based on research on other types of interpersonal violence. These are victim's awareness of abuse, appraisal of seriousness, abuse type(s), and the relationship between victim and perpetrator (i.e., both the specific familial or non-familial relationship and the closeness of the relationship as perceived by the victim) (Burnes, Lachs et al., 2019; Gibson,

2013; Jackson & Hafemeister, 2015; Lee et al., 2011). In addition, culture may play a special role in help-seeking due to its influence on the perception of abusive behaviours, and also the effect it can have on perceptions of help-seeking behaviour and its acceptability (Lee et al., 2014; Yan, 2015).

Victim's Awareness of Abuse. A victim's awareness of the abuse is a logical pre-condition for seeking help, and it can be considered under the need factor within Andersen's Behavioral Model of Health Services Use, specifically the individuals' perceived need (Andersen, 1968). Awareness of abuse may include both being aware of the specific behaviour or abusive situation, as well as understanding that the behaviour is abusive or harmful (Lafferty et al., 2013). This distinction is clearer in cases of financial abuse, where a person may be coerced or manipulated into giving money away, and thus be aware of the money being given while not identifying this as exploitation (McClurg, 2013). Similarly, in financial abuse cases, victims may not always be aware of the behaviours occurring, because the perpetrator could be withdrawing funds from their bank account without their knowledge.

The understanding of what is abusive varies by culture (Moon & Benton, 2000). Although most research regarding the influence of culture in help-seeking has been limited to vignette methodology and non-victim sampling, these studies provide interesting insights into the ways in which different cultures in different countries perceive behaviours as harmful or abusive (Chang, 2016; Dong et al., 2011). For example, research has found that Korean Americans tended to have a higher degree of tolerance for certain types of abuse than Caucasians or African Americans (Moon & Williams, 1993). On the other hand, certain minorities may consider abusive behaviours that are not recognised by others, and that are not usually encompassed in definitions. For example, Enguidanos et al. (2014) conducted focus groups with older adults using vignettes and found that U.S. Latino communities tended to place special emphasis on "sending" a family member to a nursing home as a form of abuse.

For these participants, looking after one's parents or other older relatives was an obligation, and ignoring this obligation was understood as a form of abandonment and abuse.

Similarly, in focus groups with older Chinese and Korean immigrants conducted in the United States, participants identified that adult children who did not live with their parents should perform filial responsibilities through frequent visits or telephone contact and understood the failure to do so as neglect or mistreatment (Lee et al., 2014). It has been suggested that the individualist or collectivist nature of a certain culture may tailor different responses to certain types of abuse (e.g., Lee & Eaton, 2009). Cultural differences seem to be of great impact when financial abuse is discussed, as, for example, Korean Americans are expected to help their offspring throughout life, even when they become adults, and thus, adult children may feel entitled to this economic "support" (Lee et al., 2014). In some of these studies it becomes clear that the degree of acculturation may play a role in their perceptions and subjective experiences, with less acculturated immigrants adhering to more traditional views, which influence their perception of abuse (Lee & Eaton, 2009; Pablo & Braun, 1998).

Victims' Appraisal of Seriousness. Related to the perception of EA is the perception of abuse seriousness, which may or may not coincide with the abuse's objective severity. Research indicates that victims are more likely to seek help when the abuse is more serious (Tamutiene et al., 2013). In relation to this, in a sample with victims, Burnes, Lachs, et al. (2019) found that many victims did not perceive the abuse as having a high degree of seriousness. They suggested that these perceptions may explain why some victims seek or accept help, while others remain in abusive situations, but they were not able to test this in their study. However, other researchers have attempted to measure seriousness by computing the number of abusive behaviours and their frequency (Tamutiene et al., 2013) and found that women who self-reported lower density and intensity of abuse were less likely to seek help.

Consistent with these findings about severity, it seems that when several types of abuse co-occur, reporting is more likely (Burnes, Acierno, & Hernandez-Tejada, 2019).

Types of Elder Abuse. It might be that perceived severity of the abuse is influenced by the type of abuse, and that certain types of abuse are perceived more seriously than others; this has been suggested by research looking at the targets of interventions and at the perceptions of non-victim participants (Aday et al., 2017; Rosen et al., 2019). Perceptions of abuse seriousness may also be related to the perpetrator of abuse (e.g., neglect was appraised with greater seriousness if perpetrated by a paid worker; Burnes, Lachs et al., 2019). In studies in different countries, it was found that psychological abuse and neglect were less commonly reported than financial or physical abuse (Amstadter et al., 2011; Markovik et al., 2014; Naughton et al., 2013), which could relate to the visibility of these types of abuse (Mysyuk et al., 2016), and perhaps the availability of evidence. In addition, professionals working with older women have identified that victims experience many barriers to disclosing sexual abuse (Goldblatt et al., 2020) and thus, that sexual abuse may be one of the most likely types of abuse to remain hidden (Nóbrega Pinto et al., 2014). Prevalence studies usually find that elder sexual abuse is the least prevalent of all five types of EA. However, it is also one of the least acknowledged, and Band-Winterstein et al. (2021) argue that, within EA research, it has not been addressed in depth. In fact, it has previously been conflated with other types of abuse (e.g., physical abuse; Naughton et al., 2013). It is likely that sexual abuse is less prevalent than other types of abuse—e.g., psychological abuse—but it is necessary to bear in mind that it may be an artefact of it being the most difficult for victims to disclose—particularly if the victim has dementia—or for professionals to address, partially due to assumptions about ageing and sex (Acierno et al., 2002; Burgess & Phillips, 2006; Goldblatt et al., 2020; Nahmiash, 1999; Nóbrega Pinto et al., 2014).

Victim-Perpetrator Relationship. The victim's relationship with the perpetrator and its influence on help-seeking has been the focus of considerable research in the area, and there are suggestions that abuse may be perceived differently depending on who perpetrates it (Pickering & Rempusheski, 2014). In a study using national prevalence data from the United States, which included questions about help-seeking, they found that reporting abuse perpetrated by a family member was less common than reporting stranger-perpetrated abuse (Acierno et al., 2020). Further, in their qualitative research study with EA victims, Mysyuk et al. (2016) found that their participants tended to take longer to seek help for family-perpetrated abuse and were more likely to disclose this informally. Thus, EA dynamics may complicate the process of seeking and accepting help, because of the frequency of family members as perpetrators (Vrantsidis et al., 2016).

In addition to looking at family perpetrators, the specific nature of that relationship (e.g., closeness) may also matter, as, according to studies using vignette methodology, reporting abuse by a closer family member may be more difficult than if the behaviour is perpetrated by an extended family member or an acquaintance (Gibson, 2013). Jackson and Hafemeister (2015) found that the temporal relationship between detection and reporting was affected not only by the relationship between victim and perpetrator, but also between victim and reporter (in cases where the victims did not self-report). Jackson and Hafemeister (2015) suggested a longer wait between detection and reporting in cases of a long-standing and intimate relationship between victim and perpetrator. However, this study focused only on help-seeking as the most visible way of reporting to authorities or any organization, without taking into account informal disclosure. For that reason, it is not clear if the same dynamics may affect victims' informal disclosure. Connected to the closeness between victim and perpetrator is the effect of dependency and co-dependency, and Burnes, Acierno, and Hernandez-Tejada (2019) found that reporting behaviour was less frequent among victims who

were dependent on their perpetrator. Furthermore, interdependency may complicate case resolution (Jackson, 2016; Labrum & Solomon, 2018). It is also common for the victim and the perpetrator to live in the same house, and living together has been associated to lower service utilisation by the victims; thus, co-habitation could also be related to disclosure (Burnes, Breckman, et al., 2019).

Cultural Identity, Minorities, and Help-Seeking. Certain cultures, and specifically minorities within a country, may experience added barriers to reporting EA. Walsh et al.'s (2010) work in Canada seems to point to additional obstacles for older immigrant minorities due to language barriers, or when their immigration status increases their dependence on family members. Lee et al. (2014) also found that older Chinese and Korean adults experienced barriers related to their immigration status and discrimination against minorities. The study of culture and the way it may affect help-seeking in different immigrant minorities has not received extensive attention in the UK; however, Bowes et al. (2008) considered different minorities in relation to help-seeking. They conducted focus group research with 58 participants, 39 of which self-identified as "older people". Their results showed that minorities experienced different barriers accessing services, although several of these were not attributed to their minority status, but rather to a general difficulty for older people in reaching those services. Despite their general conclusion, there was some evidence of wider social exclusion as a reason for lack of reporting in this population and mistrust of BAME (Black and Minority Ethnic) voluntary sector organisations (Bowes et al., 2012). Importantly, 81% of participants reported that an older person from a BAME group would do nothing about the abuse and cited cultural factors as one of the reasons (Bowes et al., 2008).

1.2.5.3. Research Limitations and Priorities for Future Research. On the basis of the limitations identified in previous research on help-seeking, and on suggestions by other researchers, this section outlines several research priorities. First of all, research studies that

concentrate on EA victims are needed. The previous section has specified the limitations of focusing only on professionals reporting, on older adults who have not been victimised, or who do not fit within the profile of EA victims. The focus on professionals, as well as the common reference to the barriers that victims experience, may have given the impression that older people are generally incapable of disclosing abuse. While this might be the case for victims with severe cognitive limitations or communication barriers, who may only be able to communicate through behavioural cues of distress (Burgess et al., 2008), many victims are able to disclose (Brank et al., 2011; Richmond et al., 2020). In fact, recent cross-sectional research conducted with professionals working with older adults in emergency departments found that participants had absolute confidence in victims' ability to report in 96% of cases, a percentage which included patients with cognitive impairment (Richmond et al., 2020).

In addition, even though research involving older adults and hearing their voices is becoming increasingly more common and is a step in the right direction (e.g., O'Brien et al., 2011), studies hearing the voices of older adults who have been victimised is important in understanding their views. Asking older adults to report on their reactions in a hypothetical situation may not elicit a genuine response (Gibson, 2013). Where studies involve older adults and do not exclude those who self-report victimisation, results for this group should be presented separately. This gap is addressed in Chapter 3, by reviewing the literature specific to EA victims' help-seeking.

Secondly, research on help-seeking in EA should attempt to differentiate between informal and formal disclosure, where possible, as well as between disclosure and service engagement or utilisation (Barker & Himchak, 2006; Truong et al., 2019). The understanding of victims' disclosure is important, considering findings that self-referral is associated to higher service utilisation (Burnes et al., 2016). A victim's formal disclosure to services may have a positive effect and relate to higher engagement with services and more positive outcomes in

their cases. Similarly, an informal disclosure may lead to the receiver of that disclosure providing support, advising the older person to seek formal help, or reporting to authorities or informal agencies on behalf of the victim (Campbell et al., 2015; Lafferty et al., 2013; Sylaska & Edwards, 2014). In addition, it is argued that if a victim's disclosure is met by a positive response, even without any further interaction or support from the receiver, this experience can already lead to positive feelings for the victim, such as relief as a result of talking with somebody about what is happening (Truong et al., 2019). It can also facilitate further action and evaluation of the options available.

Thirdly, research is needed exploring the responses that EA victims obtain when they disclose, both informally and formally, as well as the outcomes of help-seeking. Research with IPV and child sexual abuse victims finds that the responses and reactions of others influence victims' future help-seeking intention (Sylaska & Edwards, 2014; Voth Schrag et al., 2020; Winters et al., 2020). This is also consistent with the Theory of Planned Behaviour (Ajzen, 1985), which posits that information about the outcomes of a behaviour influence a person's intention to perform that behaviour in the future.

1.2.6. Help-Seeking by "Concerned Persons" or Informal Supporters

It is unreasonable to expect that every victim will disclose their victimisation or seek help. Some will not be able to do so due to factors such as severe physical or cognitive disability, isolation, or simply because they are unable to overcome other barriers, such as fear. In those cases, third parties (family, friends, acquaintances, professionals) may seek help on their behalf. The focus of researchers has generally been on professionals' behaviour should they become aware of or suspect abuse. Even when victims cannot disclose, they may display certain behaviours or signs that could be spotted by professionals (Burgess et al., 2008). However, this approach does not reach all cases, for example, when victims may not be in contact with formal services due to isolation, or when professionals fail to detect or report abuse

(Lachs & Pillemer, 2015; Rosen et al., 2019). An important area that has only recently been the focus of research is the experience of non-professionals known to the victim, such as family members, friends, or neighbours ("concerned persons") who become aware of abuse and decide to seek help on their behalf, or get involved in other ways (Breckman et al., 2017; Burnes, Breckman, et al., 2019).

It has been acknowledged that in many cases close or extended family members, friends, neighbours, or other acquaintances report EA on behalf of a victim (Jackson & Hafemeister, 2011; Storey & Perka, 2018). While knowledge is more limited in EA, in other fields of interpersonal violence, victims frequently disclose their victimisation to informal sources (e.g., friends or family; Chabot et al., 2018) and they do so before seeking help from other sources (Voth Schrag et al., 2020). Thus, these informal sources are in a privileged position not only to support victims but also to seek help on their behalf (Mowlam et al., 2007). In fact, they have been previously identified as those who initiate help-seeking pathways in EA (Lafferty et al., 2013), and, in other fields, research with this group has been identified as essential in advancing intervention programming (Sylaska & Edwards, 2014). However, there is little knowledge about the experiences of these informal reporters in EA research, which limits their ability to support victims (Breckman et al., 2017). Yet, these concerned persons are important, and their referral to services has been associated to higher service utilisation (Burnes, Breckman, et al., 2019).

1.2.6.1. Bystander Intervention Model. The Bystander Intervention Model is an influential model rooted in social psychology that has been used to explain the intervention of bystanders in several contexts (Latané & Darley, 1970). Thus, it can be relevant to explain the behaviours of both professionals and non-professional concerned persons who decide to help an EA victim. Initially aimed at explaining bystander intervention in emergency situations, it has since been used to explain bystander behaviour when faced with instances of IPV and

sexual assault (Chabot et al., 2018; Moschella et al., 2018). The model aims to explain the process bystanders experience before they decide to intervene in a given situation, which includes several steps: noticing the event, interpreting it as problematic, accepting responsibility for acting, determining ways of helping, and finally choosing to intervene (Latané & Darley, 1970; Moschella et al., 2018). In the EA field, Gilhooly et al. (2016) identified the model as helpful in aiming to understand whether professionals decide to act on a case of suspected financial abuse. They used a modified model, previously presented by Gilhooly et al. (2013) as a "professional bystander intervention model" and characterised by the following stages: 1) noticing relevant cues to abuse; 2) construing the situation as abuse; 3) deciding that the situation is a personal responsibility; 4) knowing how to deal with the situation; and finally, 5) deciding to intervene.

The authors applied the model to financial EA specifically. However, both the original model and this modification can be applied to other EA types or to cases of poly-victimisation. Generally, for a person to be involved, they would first need to notice cues relating to abuse and would need to construe the situation as abusive (or problematic). For example, if a neighbour witnesses an older person displaying signs of malnutrition, but attributes those signs to illness, instead of as a result of neglect by a carer, they would be less likely to intervene according to this model. The same would happen if they attributed the situation to neglect but did not consider this problematic.

The next step, accepting responsibility for acting (Gilhooly et al., 2013), is likely to be influenced by legal factors, for example, mandatory reporting laws. Mandatory reporting laws usually identify specific individuals who are legally mandated to report EA if they become aware of it. Not all countries have mandatory reporting laws and the majority of countries that do target only professionals (Donnelly, 2019; Gilhooly et al., 2016), with few places prescribing what is known as universal mandatory reporting, which would also encompass the

public (e.g., Nova Scotia in Canada; Donnelly, 2019). Mandatory reporting is addressed in more detail in Section 1.2.6.2; however, it is not considered as influential in determining non-professionals' involvement, due to the lack of commonality of universal mandatory reporting. Fourth, considering the following step (Gilhooly et al., 2013), knowing how to deal with the situation, professionals sometimes struggle to know how to proceed and they identify the need for further guidance (Gilhooly et al., 2016). One can only expect non-professional concerned persons to be generally less aware of how to deal with situations they have not been trained for, which may present further challenges to deciding to intervene.

Further to the points identified above, previous research in other contexts has found that several factors may affect the likelihood to intervene: expectations of what will happen if the bystander intervenes, the presence of other bystanders, and the nature of the relationships between the bystander and both the victim and perpetrator (Moschella et al., 2018). The expectations of what will happen if the bystander intervenes can be related to the Theory of Planned Behaviour, within the component of attitudes towards help-seeking (Ajzen, 1985). Previous research with professionals has identified that they worry about the impact that getting involved will have on their relationship with their client (Adams et al., 2014); thus, concerned persons are likely to worry about related factors. Relating to the second point, research has generally identified that the larger the number of people involved, the less likely it is that any individual will intervene (Gilhooly et al., 2016). Finally, concerning the last point, in the EA field, Jackson and Hafemeister (2015) carried out a study with victims, third party adults who knew the victim, and professionals. They found that reporting by third parties was delayed when the victim and the reporter were in a close relationship.

1.2.6.2. Research on help-seeking behaviour by informal third parties. The section above identified research on bystander intervention in other fields and in EA, without excluding professionals; this section aims to focus on available research on informal third parties. Similar

to general research on victims' help-seeking, studies investigating third parties' help-seeking behaviour have primarily employed vignette methodology and hypothetical situations in focus groups or survey studies (e.g., Aday et al., 2017; Blakely & Dolon, 1999), which has the same limitations acknowledged in previous sections. However, research has also involved interviews or surveys with third-party adults who knew an older victim (e.g., Breckman et al.., 2017; Hourglass, 2020; Jackson & Hafemeister, 2015). Much of this research has focused on the likelihood of a third party recognising and getting involved in a situation of EA, with more recent research focusing on the help-seeking experience of these third parties, such as its impact or the challenges accessing support (Breckman et al., 2017; Kilaberia & Stum, 2020).

Research on Third Parties' Recognition of Abuse and Their Decision to Intervene. Available research in this area has identified how many third parties identify abusive situations as such, as well as factors that may affect their decision to get involved (e.g., feelings of empathy, relationship with victim). In terms of recognition, a vignette study by Werner et al. (2005) found that the majority of participants identified EA, and that EA recognition was associated with higher feelings of sympathy towards the hypothetical abused person. However, one quarter of participants did not identify the situation as abuse (Werner et al., 2005).

Relevant to whether a third party would construe a situation of abuse as problematic, studying the general public's perceptions of EA can be helpful. Of note here is recent research conducted by the UK charity Hourglass ("The Growing Old in the UK 2020 survey"), which surveyed over 2,500 adults across the four nations of the UK and identified that substantial percentages of participants did not identify examples of EA as such (Hourglass, 2020). For example, one in three people did not identify "inappropriate sexual acts" directed at older people as abuse, and 32% did not believe that taking items from an older family member's home without consent was abuse. Finally, 30% did not see examples of physical abuse

(pushing, hitting, or beating) as EA. This research could explain why some informal third parties do not get involved, as they would not identify the acts of abuse as problematic.

In terms of factors that may affect a decision to intervene, the findings of vignette research studies indicate that some individuals would only report the victimisation if they are completely certain that it is happening (Aday et al., 2017; Moon et al., 2002). However, research also seems to point to variations based on culture, with some cultures placing more importance on the privacy of others (Yan, 2015). In the UK, Gilhooly et al. (2016) state that the country "has strong social and cultural norms of nonintervention in the affairs of neighbors, other family members, and friends" (p. 9).

The decision to intervene also seems to relate to the relationship with the victim. For example, Blakely and Dolon (1999) found that participants were more likely to accept responsibility for helping victims who were relatives or friends rather than strangers. However, participants were less likely to say that they would immediately formally report the abuse when the victim was a relative. This is consistent with Jackson and Hafemeister's (2015) findings, which indicate a delay in reporting when the reporter and the victim are close. Similarly, research indicates that some people may believe that, as neighbours, they should only get involved if they are completely sure that abuse is occurring (Moon et al., 2002). In addition, Chang (2016) identified that older people believed that if the perpetrator is a relative, people outside of the family should not get involved. Finally, the vignette study by Blakely and Dolon (1999) found that empathy correlated with believing the victim, suggesting that this may be an important factor to consider (e.g., by measuring empathy in studies with bystanders).

Unfortunately, many of these studies were vignette studies that have the limitation of not being conducted with people with lived experience of helping a victim of EA. Nonetheless,

they are consistent with studies that did not use vignette methodology but instead interviewed informal third parties (e.g., Jackson & Hafemeister, 2015).

Research on the Experience of Third Parties who Intervene in Elder Abuse Cases. Recognising abuse, identifying it as problematic, and deciding to intervene are part of the help-seeking process, but the process is likely to be more complex and last longer than those individual moments. Research about concerned persons' experiences accessing help, interacting with the victim or the perpetrator, as well as the impact that these activities have on them, is scant.

Recently, Breckman et al.'s survey study (2017) focused on the experiences and behaviour of people who had encountered EA. They found that, of those who knew someone experiencing mistreatment, 60% became involved as helpers. Thus, despite the potential barriers identified in the previous section, this would indicate that a substantial number of non-professional third parties would get involved in an EA situation. Their study also pointed to the possibility of negative consequences for those who are aware of the abuse, and even more so for those who sought help, given that they found helping status to be positively associated with level of distress (Breckman et al., 2017). The level of distress attributed to the abusive situation was also predicted by the concerned person being female, having lower income, or increased age; however, relationship with the victim did not predict level of distress. In a different study, Burnes, Breckman, et al. (2019) investigated whether having a concerned person in the victims' lives led to service utilisation using logistic regression and found that this factor predicted service utilisation by the victim (Burnes, Breckman, et al., 2019). Thus, concerned persons may play an important role in connecting victims to services.

Breckman et al. (2017) suggested that the higher level of distress in those who helped the victims could be a result of the burden of getting involved, mentioning that professionals

may ask concerned persons to gather financial documents, prepare a petition for guardianship, or assist financially (New York City Elder Abuse Center, 2014). This suggestion would be consistent with the finding that those with lower income experienced more distress, perhaps indicating that those activities would be more impactful for those individuals due to more limited resources (Breckman et al., 2017). However, Breckman et al.'s research study is limited by it being based only on a few questions asked as part of a larger survey, which restricts the understanding of the participants' experiences and the potential reasons for distress. More recently, Kilaberia and Stum (2020) presented findings related to U.S. concerned family members who had helped a victim in a situation of financial EA and reported evidence of a wide-ranging impact for this group. However, it is not clear whether the same findings would be obtained in the context of the UK or other countries, as this study was based in the United States. The burden of getting involved as a concerned other is likely to vary across and within countries (e.g., in different states), given that different interventions and services are available and different legislation exists to deal with EA cases (Gilhooly et al., 2016; Rosen et al., 2019; Weissberger et al., 2020).

Some evidence regarding the experience of concerned persons in the UK comes from the study by Bowes et al. (2008), who conducted focus groups with older adults belonging to BAME groups. When researchers asked about their awareness of other people in their community suffering from abuse, they found that almost half had assisted a victim they knew, by listening or providing information, and several of them had also provided more practical assistance. However, the impact of providing this assistance was not studied. Still, participants highlighted the difficulty of providing help and knowing when to intervene because of their belief that they were interfering with private matters.

Even though the intervention by concerned persons has not been studied in detail in the context of EA, on the basis of what is known about professionals' detection and reporting and

the dilemmas that they usually experience, it is reasonable to expect non-professionals to experience similar dilemmas (Bergeron & Gray, 2003). For example, concerned persons may not know whether their suspicions are accurate, and may be concerned that getting involved is likely to result in losing the trust of the victim, which could further complicate the situation. These dilemmas have been found in research with professionals, who were concerned about the victim or perpetrator withdrawing from their services if they tried to get involved and report abuse, and thus could also apply to non-professionals trying to help (Adams et al., 2014). Research in the field of IPV with individuals holding a close relationship to a victim found that they often struggled to define their role and that the process of providing support was characterised as difficult and frustrating (Latta & Goodman, 2011). To avoid this frustration, several participants had disengaged with the victim and the situation.

Since EA is largely family-perpetrated, it is likely that amongst family members who get involved in helping a victim, some will also be related to the perpetrator. This could potentially complicate or delay help-seeking (Jackson & Hafemeister, 2015). Similarly, they may be the subject of threats by the perpetrator, which has often been reported in other fields (e.g., IPV; Latta & Goodman, 2011). Given the difficulties a number of EA victims experience in trusting and accessing services, it is reasonable to expect that these concerned persons will experience similar challenges in receiving support (Fraga Domínguez et al., 2021).

The limited research on non-professional helpers indicates that concerned persons may have an important impact on victims' engagement with services and case resolution. It also suggests that those who get involved in helping an older victim of abuse may experience distress as a result (Breckman et al., 2017). Because of their important role in supporting the victim, there is a need to gather a further understanding of their experience so that service providers find ways of supporting them as well. In general, these results seem to point to the

need to move part of researchers' attention away from professionals, who already receive training in detection and safeguarding, and start engaging other bystanders in the process.

1.2.7. Intervention in Elder Abuse Cases, Victims' Views, and Their Potential Impact on Help-Seeking

It is important to address and understand intervention in the context of help-seeking. The main reason is that one of the likely outcomes of disclosure to a formal source will be the offer of EA formal interventions, regardless of whether the offer is accepted. Even when disclosing to an informal source, there is the potential that this informal source will seek formal help. Hence, it is reasonable to expect that the interventions available to victims and the perceptions that older people have of these interventions will play a role in victims' motivations to seek help in any form. In addition, consistent with the Theory of Planned Behaviour, one of the determinants of behaviour is "personal beliefs about a behaviour including perceptions of whether the help sought will be useful" (Fleming & Resick, 2017, p. 197).

The purpose of this section is to first outline what is currently offered in terms of intervention by providing an overview of several countries' services and a more detailed explanation of the interventions offered in the UK. Afterwards, there is a discussion of how victims perceive intervention, what their needs and wishes may be, and the potential impact that these perceptions of intervention can have on help-seeking. This second part of the section makes reference to a number of victim barriers to help-seeking that highlight their fear of the consequences of seeking help. Although one of the outcomes of seeking help may be receiving informal help, with no formal intervention, this section primarily focuses on formal intervention, as this is the type of intervention most susceptible to change by policymakers and practitioners.

1.2.7.1. An Overview of Elder Abuse Intervention. There is generally a dearth of research on successful prevention and intervention for EA; Dong and Wang (2016) state that there is "little evidence […] to support effective treatment solutions for EA" (p. 347). A recent systematic review found that most programmes aimed at tackling EA were focused on intervention rather than on prevention, were largely educational, and only focused on perpetrators in a minority of cases (Rosen et al., 2019). In addition, these have generally focused on management and intervention of perpetrators who are caregivers (Storey et al., 2021). According to Krug et al. (2002), agencies generally responsible for EA intervention are social services, health care services, legal services, and agencies in charge of education and public awareness campaigns. Intervention efforts vary by country, but most Western countries deal with EA through adult protection services, volunteer organisations, and, less strongly, with the use of law enforcement and police (Crome et al., 2014). However, availability of services is dependent on geographical location and, in 2014, two thirds of the countries participating in a worldwide survey lacked any adult protective services to deal with these cases (Butchart & Mikton, 2014).

Intervention in the UK and Other Countries. In the UK, there is no separate legal framework for EA; however, there is relevant legislation, such as the Mental Capacity Act 2005 and the Care Act 2014 (Age UK, 2015; Crome et al., 2014), that is influential in cases of adult safeguarding more generally (i.e., safeguarding of younger vulnerable adults). Guidance from the Care Act 2014 specifies that adult safeguarding means "protecting an adult's right to live in safety, free from abuse and neglect" (Department of Health and Social Care, 2020, Section 14.7). The Mental Capacity Act 2005 expresses that people "must be assumed to have capacity to make their own decisions and be given all practicable help before anyone treats them as not being able to make their own decisions" (Department of Health and Social Care, 2020, Section 14.55).

In the UK, local authorities (e.g., governments such as boroughs, county councils) are likely to deal with EA cases through adult safeguarding, while the police and law enforcement play a less important role (Crome et al., 2014). UK adult protective services and adult safeguarding are responsible for protecting and servicing both vulnerable older people and other adults who are vulnerable due to mental health problems or physical or intellectual disabilities (Department of Health and Social Care, 2020). Local authorities have the duty to make the necessary enquiries in a case of alleged abuse. These enquiries could involve a conversation with the older adult or a formal investigation involving other agencies. Safeguarding professionals have a difficult task balancing protection and respect for autonomy as, when the victim retains mental capacity, they have the right to refuse assessment and intervention (Coombs, 2014; Department of Health and Social Care, 2020; Mackay, 2017).

When the abusive situation involves a familial or personal relationship, professionals are advised to balance the right to safety and the right to family life (Age UK, 2019). The aim to respect a person's autonomy is consistent with the course of action by services in other countries. For example, the Elder Abuse Resource and Support Team in Canada considers the older person's wishes a priority during the assessment and management of cases (Storey & Perka, 2018). In the United States, it is also recommended that professionals respect victim's wishes when they are competent, and Coombs (2014) states that Adult Protective Services should start with voluntary interventions and move to involuntary interventions only if absolutely necessary. However, it is not clear whether this is the common course of action, and inconsistencies are likely given the variance in mandatory reporting requirements in different states (Coombs, 2014; Dong & Wang, 2016).

Considering the legislation highlighted above, agencies in the UK, Canada, and the United States (e.g., Adult Protective Services) are commonly required to consider the individual's mental capacity as part of their duties (Abrams et al., 2019; Storey et al., 2021).

Determining whether an individual retains mental capacity usually involves a formal mental capacity assessment, which is challenging and can be associated with professional errors (Abrams et al., 2019). The decision to perform this assessment may be preceded by a decision based on a quicker screening. In the United States, researchers have proposed a decision tool called Interview for Decisional Abilities (IDA) aimed at making a quick assessment of the individual's ability to assess risk as it pertains to the abusive situation (Abrams et al., 2019). This approach is promising, as it focuses on the individual's ability to make decisions regarding the risky situation, and not only about their lives overall. This is consistent with the recommendation that mental capacity assessments should be specific to the decision that older adults are making (Social Care Institute for Excellence, 2017). As a result, an individual may lack capacity for financial decisions but be able to make decisions about other aspects of their lives. Therefore, a capacity assessment approach focusing on the older adult's ability to assess risk related to the abusive situation may be beneficial.

Other agencies operating in the UK that aim to protect older people and oversee abuse are the Court of Protection (CoP) and the Office of the Public Guardian (OPG), which are especially important in the case of financial abuse or exploitation through the use of Powers of Attorney, but also in the case of care decisions for older people lacking mental capacity (Dalley et al., 2017). Powers of Attorney are created and signed while the older adult retains mental capacity and can be ordinary—coming to an end when the older adult loses capacity—or Lasting Powers of Attorney (LPA); however, deputyships or guardianships are created after the person loses capacity (Age UK, 2020; Coombs, 2014; UK Government, n.d.). The Court of Protection and the Office of the Public Guardian have led to an increase in the number of applications made to revoke powers of attorney due to misuse; however, it is not clear how these actions have affected the incidence of elder financial abuse (Dalley et al., 2017).

The above agencies are usually involved in reported financial EA cases. It is likely that different services are needed to deal with different abuse types, and the help of different organisations may be required depending on the particularities of the case (e.g., financial institutions, care regulators). Research from the United States indicates that cases of financial EA are more effectively dealt with by legal strategies, rather than through Adult Protective Services (Brownell & Wolden, 2003). Similarly, Burgess et al., (2008) found prosecutors to be more successful in elder sexual abuse cases initially reported to the Criminal Justice System.

Mandatory Reporting Legislation. As identified in Section 1.2.6.1, several countries (e.g., the United States, Canada) have enacted some type of mandatory reporting statutes, which "oblige designated categories of people to report instances of abuse/neglect" (Donnelly, 2019, p. 147). Mandatory reporting is an important tool that aims to increase the awareness of EA among mandated reporters and protect older people from harm. However, it has encountered mixed reactions in the United States and is not without criticism (Brank et al., 2011). For example, it has been criticised as merely mirroring child abuse mandatory reporting, which does not acknowledge that most older victims retain mental capacity and can make their own decisions (Barber, 2008; Brank et al., 2011). Hence, it has been suggested that mandated states' responses to domestic violence (i.e., focusing on the empowerment of the victim and their self-determination) may be more appropriate models (Barber, 2008). In addition, there are states in the United States with controversial penalties for failing to report and, in specific cases, mandated reporters can be sentenced to pay a fine or to a short jail sentence for failing to report (Payne, 2013).

In the UK, England's reporting rules were recently classified as "permissive reporting" (Donnelly, 2019). Under this system, "an individual uses their personal or professional judgment, based on individual circumstances, to determine whether or not to make a report about suspected or actual abuse or harm" (Donnelly, 2019, p. 247). However, health and social

care professionals are required to inform the Care Quality Commission (healthcare regulator) of any abuse incidents or allegations occurring in institutions (Age UK, 2019; Gilhooly et al., 2016). In other situations of suspected abuse—for example, in domestic settings—professionals should report to their line manager. However, if the person has mental capacity, they are advised to first discuss the situation with the older person. If the older person does not want to report, the professionals are required to decide whether to report the abuse or not, which may involve assessing whether there is a situation of coercion or duress (Age UK, 2019). On the other hand, Scotland's system "places a duty to report on public bodies or office holders who know, or believe, a person is an adult at risk of harm" (Donnelly, 2019, p. 147).

Elder Abuse Criminalisation. In the UK, there is no separate offence for EA; however, different EA behaviours may involve existing offences (Bows, 2020). On the other hand, EA was criminalised in the United States in the early 1990s. Despite initial enthusiasm for criminalisation, critics have arisen and authors such as Kohn (2012) suggest that criminalisation, like mandatory reporting, can have negative impacts on victims by appearing paternalistic. The argument is that, although criminalisation can protect victims of EA as well as improve the public's attitude towards the issue, by failing to engage victims in the process, it can also harm them. For example, it threatens to oppress them, perpetuates negative stereotypes about older adults, and undermines the delivery of victim services (Kohn, 2012). In addition, the introduction of a new crime brought challenges, and police chiefs highlighted a lack of training as a barrier when responding to EA cases (Payne et al., 2001). The benefits of prosecution are unclear in some cases (Jackson, 2016); in the United States, scholars highlight the difficulty of prosecuting financial abuse when the crime starts as something "voluntary" and proving that manipulation or coercion was involved. Hence, the introduction of a permissive presumption has been suggested (McClurg, 2013). There is evidence that multidisciplinary teamwork could help to prosecute cases of elder financial abuse (DeLiema &

Deevy, 2017; Navarro et al., 2013). However, Navarro et al. (2013) argue that prosecution should always be the last resort, as it is a costly and lengthy process that does not necessarily help the victim. Victims' preference (or lack thereof) for prosecution is likely to affect the outcome, and the need to balance older adults' autonomy with protection has been stressed by a number of U.S. scholars (Jackson & Hafemeister, 2011; MetLife, 2009). Indirect information about victims' views regarding these matters can be obtained from literature focused on victims' attitudes towards prosecution. Jackson and Hafemeister (2011) found that victims' views regarding prosecution were negatively affected by a close relationship with the perpetrator. Furthermore, victims' positive or negative views regarding this procedure were influential and prosecution was more likely when victims were supportive of it. Given that not all older people will find prosecution useful, a focus on harm reduction and prevention may be beneficial (Coombs, 2014; Lithwick et al., 2000; Navarro et al., 2013).

Other concerns regarding criminalisation are related to the fact that it may lack acceptability among victims when the perpetrator is a family member (Walsh et al., 2010). Despite the challenges of criminalisation, some UK organisations have campaigned for EA to become an aggravated offence under UK law, meaning that the severity of the crime would be increased as a result of considering factors such as age (Bows, 2020). Recently, Bows (2020) published a policy report where she did not recommend EA becoming a separate offence nor adding older age as a protected characteristic within hate crime legislation, concluding that:

> there are a number of valid concerns about the current state of policy and practice in relation to violence, abuse and crimes more generally against older people. Urgent action is needed to address each of these areas, but the current proposals to criminalise elder abuse through a new offence or extend hate crime legislation to include older age as a protected characteristic do not appear to be capable of achieving these goals. (p. 898)

Bows (2020) explained that there were conceptual ambiguities concerning EA that could challenge legal reform, and that evidence was limited to support that a specific criminal offence would increase prosecutions. Regarding extending hate crime legislation, Bows (2020) highlighted several challenges, including the problems of associating older adults with vulnerability. Instead, Bows (2020) posited that the aims of these proposals could be better tackled through policy and practice reforms.

Intervention Challenges. Unfortunately, both legal intervention and other intervention efforts are met with multiple barriers. In addition to the limitations caused by lack of funding and the challenges of inter-agency collaboration (Bows, 2018), the complex nature of EA and the relationship between abuser and victim further complicate matters (Dalley et al., 2017). In fact, it has been highlighted that "one of the greatest challenges in the field is to develop ways of supporting (…) victims without threatening their relationship with a close family member perpetrator" (Burnes, Lachs, et al., 2019, p. 888). For intervention to be successful, it is important to consider that the victim's attitude towards this process may have a specific impact. Given that victims can refuse to be assessed or to accept the intervention offered (Department of Health and Social Care, 2020), understanding ways of engaging them is essential. In Wales, Wydall and Zerk (2017) reported that victims' decisions to engage are dependent on the acceptability of the options offered. There is evidence that victims' wishes are important for the success of intervention, and research with victims in the United States has found that almost a third of cases were not investigated further by Adult Protective Services because of the victim's request (Jackson & Hafemeister, 2011). It has been highlighted for years that the refusal of services by the victim and/or perpetrator can be a primary obstacle to intervention (Lithwick et al., 2000; Neale et al., 1997). Regrettably, because of the general tendency of EA research to neglect victims' views, knowledge about victims' wishes in terms of intervention remains relatively limited (Burnes, Lachs, et al., 2019). However, recent research efforts are

starting to address this, and by reviewing the literature, it is also possible to obtain indirect information about victims' views from the perspective of professionals (Bows, 2018; O'Brien et al., 2011).

1.2.7.2. Help-Seeking and the Expectations of Intervention. The literature on help-seeking behaviour in EA identifies several barriers that are connected to intervention. These encompass fear of consequences for victims (e.g., residence placement, isolation) and for perpetrators (e.g., incarceration, homelessness). Sometimes victims anticipate intervention to be more negative than the abuse they are enduring (Enguidanos et al., 2014; Vrantsidis et al., 2016). Research finds that victims are not only afraid of their wellbeing being impacted if they seek help, but also the perpetrator's, and frequently want help for both themselves and the perpetrators (Jackson & Hafemeister, 2011). This is not surprising given the frequency of mental illness and substance abuse problems in perpetrators with whom they have close relationships (Labrum & Solomon, 2018; Storey, 2020), but unfortunately, help for the perpetrators is not frequently available (Wydall & Zerk, 2017). In a recent study in Australia (Vrantsidis et al., 2016), a number of victims, who had achieved an overall positive outcome after intervention, felt uncomfortable about the fact that they did not know anything about the perpetrator's wellbeing.

In terms of victims' fears for themselves, something frequently mentioned in the EA literature and in research with victims is the fear of being placed in a residential facility. This fear is connected to being afraid of losing the ability to remain in their houses or the community and becoming less independent, as well as the anticipated loss of social support (Bowes et al., 2008; Jackson & Hafemeister, 2015; Payne et al., 2001). Lack of housing options is something that has also been highlighted in Australia (Vrantsidis et al., 2016) and that may negatively impact intervention when it limits the available options for the victim and/or the perpetrator. Lithwick et al. (2000) highlighted that nursing home placement is unlikely to be an ideal

outcome for the victim and can be very traumatic, and this has been supported by more recent literature (Jackson & Hafemeister, 2015). However, fears that intervention may lead to institutionalisation may be justified. For example, research from the United States reported that referrals to Adult Protective Services were a significant predictor of nursing home placement (Lachs et al., 2002).

Attitudes towards care home and nursing home placement, both in the context of EA and more generally, have yet to be explored in the UK. Even though it is assumed that most older people will have a negative attitude towards placement in these institutions, research in China found that older people's attitudes towards care homes were generally more positive than in other age groups (Tang et al., 2009). In addition, a recent survey study in the United States looking at housing preferences of "baby boomers", aged 60-72, found that the preference to remain in their own homes if they had a physical or cognitive disability was not as common as in previous surveys, and was not unconditional (Sanders, 2019), and it seemed that the fear of living away from their communities or in a nursing home was also lower than expected. Thus, there might be different preferences in terms of housing when looking at different age groups (Sanders, 2019).

However, attitudes towards care home or nursing placement could be negative in the UK, given the occurrence of instances of institutional abuse, which are often reported in the media, and older people's desire to remain embedded in their communities. Qualitative research in Wales conducted with professionals working with older people found that they tend to place much more importance on their home as the primary living space where most activity happens as compared to other age groups (Wydall & Zerk, 2017). The same study found that, sometimes, care home placement may be one of the only options for professionals to ensure victims' safety due to lack of resources or options.

In addition, attitudes towards long-term care placement are likely to have worsened during the COVID-19 pandemic, given that, in many countries, a substantial percentage of deaths happened in this type of facility (Comas-Herrera & Zalakaín, 2020). Further to the association of these facilities with increased COVID-19 risk, many facilities went into lockdown and banned visitors in order to protect residents, which meant that older adults were often isolated from family members and other visitors (Stall et al., 2020). It is too early to understand the effect of these factors on older people's attitudes, but, for some, it may have increased their aversion to residential placement.

Victims' fears also concern the perpetrators of abuse, especially when they are family members, particularly adult children (Vrantsidis et al., 2016). A common theme is the fear of the perpetrator being incarcerated; however, fears include other types of harm to the perpetrator, such as loss of job or housing (Mackay, 2017). Fear of incarceration is a common theme in U.S. publications, and often more commonly reported than in studies in other countries. In addition, research has found that older Asian Americans feel that reporting the perpetrators to authorities would destroy perpetrators' lives (Moon et al., 2002). Fear of reporting was also highlighted by police chiefs as a problem encountered when responding to EA cases after EA was first criminalised in the United States (Payne et al., 2001). These fears and beliefs usually stand in contrast with the fact that perpetrators are unlikely to receive a custodial sentence, if the cases are prosecuted at all (Enguidanos et al., 2014; Jackson, 2016). It is not clear whether this fear is equally widespread in other countries, such as the UK, where rates of incarceration are lower (Wildeman & Wang, 2017) and, perhaps, distrust of authorities is not as intense, especially amongst minorities (Enguidanos et al., 2014; Paranjape et al., 2007).

From the findings highlighted above, it is possible that various concerns may prevent victims from disclosing abuse informally or formally, even though several of these concerns

may be more applicable or frequent in specific countries. The negative consequences that victims fear may or may not correspond with reality. Given that adult safeguarding policies advise respecting the victims' wishes as long as they retain capacity and aim to make safeguarding personal, these fears may not always be justified (Department of Health and Social Care, 2020). However, it may be that information about what is going to happen when a victim discloses or reports is not reaching victims. For this reason, researchers have stressed that older people need to be informed of available interventions and that reporting abuse will not automatically result in their being admitted to a nursing home or the end of their relationship with family members (O'Brien et al., 2011; Wydall & Zerk, 2017).

Victims' attitudes towards intervention, including fear of negative consequences, require further investigation, as intervention is something that service providers and policy makers can actively modify. Recognising the wishes of individuals is necessary to promote engagement (Clarke et al., 2016; Wydall & Zerk, 2017). Although barriers to help-seeking seem to be diverse according to the available research, and some, such as feelings of shame or helplessness, may be difficult to address in intervention, the intervention offered to victims is something that can be modified. Services need to be consistent with victims' needs; if victims believe that the result of intervention is going to be more negative than the abuse they are enduring, they may continue to tolerate the abuse, may not disclose, or may reject any intervention (Enguidanos et al., 2014). By tailoring services to victims' needs and wishes, older people could be more likely to be offered such services, and the offer of these tailored services could facilitate help-seeking and engagement with services. Understanding what victims fear and what they want in terms of intervention, and how these attitudes are affecting help-seeking behaviour, can also inform awareness campaigns. These campaigns should aim to make available not only information about EA, but also about what is likely to happen if victims seek help, with an emphasis on victims' agency. Designing interventions and policies according to

victims' needs goes far beyond making safeguarding person-led (Department of Health and Social Care, 2020), as it can aim to plan for victims' wishes before they reach services, and thus become more effective and ready to deal with specific cases.

As with help-seeking behaviour more generally, there is a need to bear in mind that some of the barriers related to intervention and problems highlighted are likely to be even more intense, or simply different, for minorities or within certain cultures. Even though most research with minority older people has been hypothetical in nature and may not generalise to victims' behaviour, the information it provides in terms of how different cultures perceive different behaviours is essential (Moon & Benton, 2000; Paranjape et al., 2007). In the same way that older people from different cultures perceive the same act in different ways, they can also understand intervention in different ways and be more or less likely to accept it or consider it appropriate. Additional barriers related to intervention, such as the fear of immigration services becoming involved, may also be present (Walsh et al., 2010; Zannettino et al., 2015). Minorities could be warier of authorities and fear the consequences of authorities' involvement, as found in research in the United States with older African American women (Paranjape et al., 2007). In addition, Chang's (2016) research with Chinese immigrants in the United States also highlighted barriers around services not being specific for the community, as these generally failed to build trust and accessibility. For these reasons, future research needs to be mindful of the diversity of the older adult population and explore a variety of experiences.

So far, as identified in the paragraphs above, the focus has been on what victims want to avoid when they seek help, either for themselves or for others. Less focus has been placed on what victims want out of intervention, even though this knowledge can be extracted from studies addressing their fears (e.g., if the victims fear institutionalisation, it is understood that they would prefer to remain at home; if they fear that the perpetrator will be incarcerated, they probably want non-custodial alternatives). It is also likely that victims seek help with different

goals in mind. In their qualitative study in the UK, Mowlam et al. (2007) interviewed victims and found that there were several types of action that victims wanted to achieve by seeking help. Victims sought help wanting to change the perpetrator's behaviour, place distance between themselves and the perpetrator, seek legal or formal redress, and seek informal support. More recently, Burnes, Hsieh et al. (2019) found that victims' goals for intervention concerned a variety of areas, including themselves and the perpetrator of abuse. Further knowledge about what victims want to happen when they seek help will be beneficial in understanding how to service victims and facilitate increased rates of help-seeking.

Improving the Understanding of Help-seeking and Attitudes Towards Intervention. Despite the lack of reporting being a major barrier to development in the field of EA, available research on victims' help-seeking behaviour remains limited by an emphasis on non-victim participants, as well as an emphasis on barriers. In addition, knowledge about help-seeking would not be complete if victims' attitudes towards third-party intervention were not considered, given that intervention (or an offer of intervention) is a likely consequence of their disclosures. Although knowledge about attitudes towards intervention has increased in recent years due to the increased inclusion of older people in research studies, knowledge remains scarce, particularly in the UK. There is more knowledge about what victims fear in terms of intervention than about what they want and how interventions can be tailored to respond to these needs. In addition, help-seeking and attitudes towards intervention are not only important as they pertain to potential victims, but also to those around them. Concerned persons may have certain conceptions about public services or what is going to happen if they seek help on behalf of the person who is suffering abuse. Thus, their expectations are likely to impact the likelihood of their seeking help on behalf of the victim.

1.3. Chapter Summary

After a general overview of the content of this thesis, Chapter 1 has introduced the topic of this thesis, moving from a broader focus about the nature of EA to a focus on available knowledge on help-seeking behaviours by victims and concerned persons. This chapter has justified the focus on victims and concerned persons, primarily because of the utility of understanding their views with an aim to improve policy and practice, but also because these groups' views have generally remained hidden in research and practice. This chapter has also provided a focus on intervention options available in the EA field, as well as victims' perceptions of available intervention. The rationale for focusing on formal intervention is that it is a likely outcome of seeking help, and thus expectations of what will happen are likely to influence victims' and concerned persons' decisions to seek help.

1.3.1. Research Aim

Based on the gaps identified, the general research aim of this thesis was to provide a comprehensive understanding of help-seeking behaviour in EA cases, by the victim or by other persons who seek help on their behalf. For the latter, the focus was on non-professional third parties, also called "concerned persons" (Breckman et al., 2017), because, compared to professionals, concerned persons have not often been the focus of research. For both victims and concerned persons, the aim of this research was to also explore their attitudes and wishes towards intervention, in order to inform policy and practice. To achieve this, this thesis encompassed three studies: a systematic literature review, an analysis of secondary data, and the gathering of primary data from concerned persons through interviews and a survey. These studies are reported in Chapters 3, 4, and 5.

CHAPTER 2- METHODOLOGY

This chapter outlines the research aims and structure of the thesis, as well as a discussion of research paradigms. It also includes a section about the conceptualisation of terms and variables that are common throughout the studies and chapters of this thesis. The detailed methodology for Study 3 is included herein; the methodology for Study 1 is presented in Chapter 3, and the methodology for Study 2 in Chapter 4. This chapter also presents the analytical approach of this thesis, and discusses issues relating to reflexivity, as well as ethical considerations.

2.1. Research Aims

The research aims of this thesis were:

a) To explore the characteristics of help-seeking behaviour (i.e., barriers, facilitators, help-seeking predictors, sources of help, and responses) from the perspective of victims of elder abuse, as well as their experience of accessing help.

b) To explore the characteristics of help-seeking behaviour (i.e., barriers, facilitators, sources of help, and responses) from non-professional concerned persons who support the victim of elder abuse, as well as their experience of accessing help.

c) To understand victims' and concerned persons' attitudes towards intervention for elder abuse, and the way in which they influence help-seeking behaviours.

Research aim a) is addressed in Chapters 3 and 4. Research aim b) is addressed in Chapter 5. Finally, research aim c) is addressed in Chapters 4 and 5. Each of these research aims are linked to the corresponding research questions in the specific chapters.

2.2. Thesis Structure

This thesis is the result of utilising a mixed methodological approach—a combination of quantitative and qualitative methods—to investigate the nature of help-seeking in elder

abuse (hereafter "EA") from the perspective of victims and concerned persons. This thesis is comprised of three studies: Study 1, a systematic review; Study 2, an analysis of secondary data; and Study 3, a survey and interview study:

- The methodology and findings for Study 1 are reported in Chapter 3.
- Some aspects of the methodology of Study 2—basic concepts and the justification for including several variables—are reported in the current chapter:
    - The rest of the methodology of Study 2 and the findings for that study that relate to victims are reported in Chapter 4.
    - The findings of Study 2 that relate to concerned persons are reported in Chapter 5.
- The majority of methodological details for Study 3 are reported in the current chapter.
    - The remaining methodological details are reported in Chapter 4, together with Study 3 findings that relate to victims.
    - The findings of Study 3 that relate to concerned persons are reported in Chapter 5.

For further guidance, Table 2.1 outlines how each study in this thesis relates to its research aims, empirical chapters (i.e., 3, 4, and 5), and what their focus is (i.e., on victims, concerned persons, or both).

Table 2.1

Relationship Between the Studies, Research Aims, and Chapters of the Thesis

Study	Aim(s)	Chapter(s)	Focus
1	a	3	Victims
2	a, c	4, 5	Victims, Concerned Persons
3	b, c	4, 5	Victims, Concerned Persons

2.3. Research Paradigms

The aim of this section is to specify the research paradigm chosen to learn about EA and help-seeking in a way consistent with the research aims and in order to answer the research questions of this thesis. The researcher's paradigms are important as they influence the approach to the project and the methodological choices made (Avramidis & Smith, 1999). They are "composed of certain philosophical assumptions that guide and direct thinking and action" (Avramidis & Smith, 1999, p. 27) and have been defined as "the basic belief system or world view that guides the investigator, not only in the choices of method but in ontologically and epistemologically fundamental ways" (Guba & Lincoln, 1994, p. 105). Epistemology is "a way of understanding and explaining how we know what we know" (Crotty, 1998, p. 3); in other words, it is the approach taken to learn about reality (Danermark et al., 2019). Meanwhile, ontology concerns questions about the nature of reality itself or the nature of being (Danermark et al., 2019). According to Wolgemuth et al. (2015, p. 352), it is often assumed that "research design decisions are paradigmatic; […] the theory of the research project influences all aspects of research". Many researchers adopt a single paradigm approach, but other researchers have adopted a multi-paradigmatic approach in their projects (Bogna et al., 2020). In the current thesis, the researcher adopted a single paradigm approach.

There are many research paradigms or positions, and authors have created various typologies or taxonomies; the same paradigms are sometimes referred to in different ways by different people (Avramidis & Smith, 1999; Bogna et al., 2020). Several influential paradigms are positivism—also known as logical positivism—post-positivism, constructivism, and the critical paradigm (Avramidis & Smith, 1999; Plano Clark & Creswell, 2008; Maxwell & Mittapalli, 2010). Paradigms are usually differentiated from one another by the different answers they provide to ontological, epistemological, and methodological questions (Avramidis & Smith, 1999). For example, positivism, which dates to the nineteenth century

and "bases knowledge solely on observable facts" (Plano Clark & Creswell, 2008, p. 11), adopts a realist-external ontology and an objectivist epistemology (Avramidis & Smith, 1999). Positivism received criticism, for example, for its reduction of ontology to epistemology (Fletcher, 2017), and post-positivism appeared in the 1950s as a reaction to this criticism, and as a way of addressing discredited aspects of positivism. Post-positivism recognised that research was influenced both by the values of investigators and by the theory, hypothesis, or framework that they used (Plano Clark & Creswell, 2008). In contrast to positivism, constructivism posited that researchers construct the meaning of their objects of study or investigation, and that individuals construct the meaning of the world (Gordon, 2009; Teddlie & Tashakkori, 2009). Thus, according to constructivists, who adopt a subjectivist epistemology, there are multiple realities (Avramidis & Smith, 1999). Finally, the critical paradigm posits that "all research is value-based [...] and the purpose is not simply to represent the world but to change it by empowering those people involved in the research" (Avramidis & Smith, 1999, pp. 28-29).

Post-positivism is usually associated with quantitative research, and constructivism with qualitative research, and there has been a challenge in associating mixed methods with a corresponding philosophical paradigm (Johnson & Gray, 2010; Maxwell & Mittapalli, 2010; Teddlie & Tashakkori, 2009). Further, some have argued that it was not appropriate to combine qualitative and quantitative methods because of the incompatibility of their associated research paradigms, and the "paradigm wars" between positivism and constructivism (Teddlie & Tashakkori, 2009). The idea behind this position is that research paradigms frame how one approaches learning about a subject, and that qualitative and quantitative researchers have an incompatible approach. However, not everyone agrees that a method should be associated with a specific fixed paradigm. In addition, mixed methods researchers have provided alternative positions to that of qualitative and quantitative researchers and have usually combined elements

of their associated paradigms (Johnson & Gray, 2010). One of the solutions to the argument of incompatibility was pragmatism, the major tenet of which being that quantitative and qualitative methods are compatible, and that methods should be combined based on their practical utility, shifting the focus away from paradigm wars or conflicts (Maxwell & Mittapalli, 2010; Plano Clark & Creswell, 2008; Teddlie & Tashakkori, 2009).

However, identifying the researcher's paradigm (or paradigms) is important and methods should not be chosen based only on practicality. An alternative for mixed methods researchers, with increasing popularity and identified benefits for research in social science, is critical realism (Fletcher, 2017; Maxwell & Mittapalli, 2010). Critical realism arose partly in response to the paradigm war between positivism and constructivism, and, though it combines elements of both, deviates from both in its understanding of epistemology and ontology (Fletcher, 2017). Critical realism has been compared to two other dominant perspectives: empirical realism and social constructivism (Danermark et al., 2019). On the one hand, empirical realism posits that science is only based on the things that are empirically experienced, and on the other, social constructivism understands that people's perspectives are always situated, and that knowledge is contextual (Danermark et al., 2019). Compared to these two positions, critical realism arises as "an alternative both to naïve realism and to radical constructivist views that deny the existence of any reality apart from our construction" (Maxwell & Mittapalli, 2010, p. 150). Critical realism "retains an ontological realism while accepting a form of epistemological relativism or constructivism" (Maxwell & Mittapalli, 2010, p. 150). It also posits that ontology cannot be reduced to epistemology (Fletcher, 2017).

This thesis has taken a critical realistic approach to the study of the research topic, which belongs to the social world. This research paradigm is appropriate for the nature of the topics being researched (EA and help-seeking), which can be understood to exist independently of people's perceptions (or human consciousness), but which are also influenced by social

knowledge about reality (Danermark et al., 2019). A discussion of how certain phenomena can be both perceived as real and as social constructs can be found in Hacking's (1999) discussion of child abuse and mental illness. In the present thesis, it is understood that EA can be measured by abusive behaviours that occur and may leave a mark or proof or may be witnessed. However, the researcher also recognises that what is abusive or not depends on people's perceptions, including victims', who may not believe they have been abused (Moon et al., 2002). Thus, different people (including researchers) may have different views of what EA is and may perceive and construct the same behaviours in different ways. Similarly, help-seeking may exist as a variety of behaviours (e.g., telling someone about the abuse, asking someone to help in dealing with the abuse) but is inevitably affected by the perceptions of those who engage in such behaviours, and those who are the recipients of the disclosure or request for help. Both actors may not consider the act as "help-seeking" and the same can be said about other third parties witnessing the behaviours.

A critical realist approach is also appropriate as it best fits a mixed methods approach, which has been considered beneficial for the purposes of this thesis (Maxwell & Mittapalli, 2010). As Maxwell and Mittapalli (2010) explain, "the main argument for combining qualitative and quantitative paradigmatic positions has traditionally been their complementarity—that they have different strengths and limitations and that using them together allows the researchers to draw conclusions that would not be possible using either methodology" (p. 148). Even though it has received more attention by social scientists in the last few decades, Maxwell (2016) identified that the combination of qualitative and quantitative methods has a longer history, and thus, that it has been considered helpful in a variety of fields, where these methods have been integrated successfully. The early works were characterised by "an intentional and systematic combining of qualitative and quantitative approaches and

methods, and a thorough integration of both sources of data in developing their conclusions" (Maxwell, 2016, p. 15).

A mixed methods approach has been previously recommended for studying specific aspects of EA (Dong & Wang, 2016). In this thesis, combining both qualitative and quantitative methods was appropriate, as different research questions were best answered using either qualitative or quantitative methods. More specifically, a quantitative approach suited the aim of analysing the relationships between help-seeking and other variables, as well as the explanatory variables of victims' self-reporting or disclosure. A qualitative approach, however, was also necessary in order to analyse variables for which little was known, as well as to be able to illustrate participants' experiences and perceptions and give concerned persons a voice.

Study 1 (the systematic review) employed qualitative methods, which were appropriate to synthesise the variety of findings reviewed. Quantitative methods were used primarily in Study 2, combined with qualitative analyses for certain variables. Study 3 involved qualitative analyses only. The goal of this combination of approaches was to triangulate information (i.e., corroborate results through different research strategies—qualitative and quantitative) and to provide completeness in relation to the research questions of the thesis. Not all the chapters have an equal balance between quantitative and qualitative methods, as explained further in Section 2.4. However, throughout the writing of the chapters of this thesis, the researcher aimed to integrate quantitative and qualitative sources of data in the discussion and conclusions.

2.4. Overview of Thesis Methods

The studies in this thesis have approached learning about help-seeking in EA by: 1) systematically reviewing the literature on EA victims' help-seeking; 2) analysing secondary data from a UK national helpline receiving calls from EA victims and third parties concerned about the abuse of an older adult; and 3) obtaining primary data from family members, friends,

neighbours, and acquaintances of EA victims about their support experiences using a survey and a semi-structured interview. These methods are explained below.

- A systematic literature review is described as “a type of research synthesis […] to identify and retrieve international evidence that is relevant to a particular question or questions and to appraise and synthesise the results of this search to inform practice, policy and in some cases, further research” (Munn et al., 2018, p. 144). In the case of this thesis, a systematic review was appropriate for the purposes of investigating what was known about the topic of help-seeking from the perspective of EA victims before conducting any further research. This method was helpful in identifying limitations of the studies reviewed, areas in need of further research, and for testing key review findings and conclusions in further studies of this thesis.
- The use of secondary data or “secondary analysis” has been described in different ways, but it largely refers to the use of data that have already been gathered by others (e.g., other researchers, an organisation) (Heaton, 2004). The use of these data can have limitations—for example, the researcher may not be able to gather data of interest or record certain variables—which may affect answering specific research questions. However, there are also common advantages: for example, the researcher usually has access to larger datasets and can address a variety of areas. In the case of this thesis, a secondary data method was chosen in order to have a large sample where associations between variables could be studied. The secondary data source was a national EA helpline. These data may represent a number of cases in which enquirers are trying to understand whether the situation they are experiencing or dealing with is EA (Weissberger et al., 2020), thus allowing for the representation of a diversity of enquirers’ views and thoughts regarding EA and intervention.

- Finally, surveys and semi-structured interviews were used in order to gather data directly from concerned persons. A semi-structured interview was more appropriate than an unstructured interview in order to answer the questions of Study 3, which were specific in nature and aimed to address the questions that could not be addressed in Study 2 due to the limitations of the use of secondary data. A semi-structured interview allows targeting of specific research questions yet leaves room for the interviewee to discuss any other aspects that they consider important and which the researcher may not have anticipated. Although an additional objective was to gather data from victims, this objective had to be abandoned. The survey, adapted from the semi-structured interview, was used in order to accommodate participants, based on feedback from initial recruitment. A further explanation of the rationale for choosing these methods as well as the development of materials (i.e., interview and survey) can be found later in this chapter (Section 2.6), which contains a full explanation of the design and implementation of Study 3.

Alternative Methods. Studying EA and help-seeking in the way that they have been investigated in this thesis may be an over-simplification. Both are complex experiences and phenomena that mean different things to different people. For example, as exemplified in Chapter 1 (Section 1.2.1) EA can mean different things to older adults, to victims, to practitioners, and to researchers. It can also mean different things to people across countries and cultures, and can have specific definitions in law that are non-existent in other countries or jurisdictions (Donnelly, 2019; Moon et al., 2002). Similarly, help-seeking can be understood in different ways by older adults, practitioners, and researchers. Hence, in the study of help-seeking in EA there are many actors and factors to focus on: victims, their family members, professionals, etc. All the actors will have their own perceptions of the factors studied, which will relate to their own constructions of events and reality. Compromises have been made, and

the focus has been on victims and concerned persons, because both have received less attention in research looking at help-seeking.

However, it is important to acknowledge and discuss other potential ways of investigating help-seeking in EA, and the rationale for not choosing these. For example, another way of looking at help-seeking in EA would have been to focus on professionals working with older adults and victims; nevertheless, an emphasis on professionals has been a frequent feature in previous research (e.g., Bows, 2018; Isham et al., 2020; Killick & Taylor, 2015; Spencer, 2009), and thus, the researcher understood that their views had been generally represented in research. As a result, the aim was to fill some of the gaps in research and give a voice to victims and concerned persons. This choice, and the choices described in the previous section, were all intentional. Other choices in this thesis were "forced" as a result of the researcher adapting to challenges that arose in carrying out the project as planned. One of the best examples of such a forced choice is that the researcher could not interview victims, as initially planned. This choice is further explained in this chapter and in Appendix A. Regardless, victims' views were represented in all three studies, albeit sometimes through the lens of others (i.e., the researchers of studies reviewed in Study 1, and concerned persons in part of Study 2 and in all of Study 3).

2.5. Conceptualisation

This section outlines the working definitions of some concepts common to all three studies. Concepts that are study-specific are discussed within their own study chapter.

2.5.1. Elder Abuse

The working definition for EA in this thesis is that adopted by the WHO (2020a), as outlined in the literature review (Chapter 1, p. 24). Thus, this thesis considers acts committed by people known to the victim and encompasses the five commonly accepted types of EA:

financial abuse or exploitation; physical abuse; psychological or emotional abuse; neglect; and sexual abuse (Pillemer et al., 2016). Given disagreements in the field as to what EA is, and the data indicating that older adults may hold a variety of perceptions, a flexible approach was adopted regarding the behaviours covered in definitions, especially when the victim was self-reporting. Because the purpose of this thesis was to provide an understanding of help-seeking in victims of EA and concerned persons, there was an openness to consider individual perceptions of EA.

However, situations that were clearly out of the scope of this definition, such as perceptions of societal ageism and other acts of discrimination, were not considered, and neither were general unsatisfactory experiences with services, unless these occurred in the context of seeking support for an abusive situation. Similarly, cases of EA needed to involve a specific perpetrator or perpetrators, for whom basic demographic characteristics and relationship with the victim were known. An exception was made in cases of institutional EA, given that, very commonly, there was a group of perpetrators (e.g., several members of staff) responsible for neglect, psychological, and/or physical abuse, and it was difficult to identify individual perpetrators. In terms of the age cut-off for the purposes of this thesis, a conservative age cut-off of 60 years was used, in concordance with the cut-off used by the World Health Organization (e.g., WHO, 2020a). This thesis did not include cases of self-neglect, given that they lack the interpersonal component of the other abuse types, and are not usually considered under EA in the UK (McDermott, 2010)

Elder Abuse and Intimate-Partner Violence. There are existing debates in the field as to whether intimate partner violence can be considered EA (Isham et al., 2020). One argument is that there is a difference between intimate partner violence that starts when the couple is young and continues into their late adulthood, which could be considered long-standing intimate partner violence, and cases of abuse perpetrated by a partner that start once

they are older because of age-related vulnerabilities of one (or both) of the individuals (Yan & Chan, 2012). These two types of intimate partner violence are likely to differ and this may have implications for help-seeking behaviour. However, the studies in this thesis were not designed to exclude cases of intimate partner violence “grown old”. The rationale was two-fold.

First, it was expected that it would be generally difficult to discern whether violence perpetrated by the partner started before the victim was 60, because of the type of information collected by the charity Hourglass in Study 2. Second, the main objective of this thesis was to understand help-seeking behaviour in EA cases and with respect to EA services. Given that a victim of long-standing intimate partner violence could still be the recipient of EA intervention or general services for older adults, aiming to exclude these cases was likely to limit the field’s understanding of the wide range of cases that are classified as EA and/or may be dealt with by EA services. This approach was consistent with that of other scholars in the field researching help-seeking behaviour in EA (e.g., Yan, 2015). Nevertheless, in order to improve the understanding of intimate partner violence in older age, there was an attempt to identify, where possible, cases of long-standing intimate partner violence. In addition, in Study 3, participants could indicate their own perception of EA, and whether they identified the case as EA. Thus, concerned persons’ perceptions of the abuse, and potential identification of long-term intimate partner violence, are included.

A Note on Terms. There exists discussion not only about the meaning of “elder abuse”, but also about the use of “elder abuse” itself. Other terms used include “elder mistreatment”, “elder maltreatment”, or “older adult mistreatment” (e.g., Lithwick et al., 2000). There also exist several problems with the use of the words “elder” and “elderly”, and gerontological associations and some charities have expressed their preference for the use of “older adults” or “older people” because they emphasise the individual and not the group (e.g., Gerontological Society of America, n.d.). In addition, “elder” may have a specific meaning in certain countries

or communities. For example, for Indigenous communities in Canada it has a different connotation that is not necessarily related to age (Lithwick et al., 2000); thus, “seniors” is more commonly used. In line with recent changes in gerontological research and with older adults’ own preferences, the word “elderly” was not used anywhere in this thesis.

There is also criticism about the use of “abuse” itself, which can for some be associated with primarily physical abuse (Lithwick et al., 2000). However, the thesis was written using the term “elder abuse” for one primary reason. Most of the research literature is written referring to “elder abuse”, and elder abuse is still the most prevalent term used to refer to the specific type of interpersonal violence which is the focus of this thesis; that is, perpetrated by a trusted family member, friend, neighbour, or professional (WHO, 2020a). Hence, using “elder abuse” aids in the recognition and understanding of what the researcher is referring to, both for the participants and for the wider research community. While the “abuse of older adults” or the “mistreatment of older adults” could be less specific and refer to different types of abuse, which may or may not be perpetrated by somebody trusted by the victim, “elder abuse” is commonly used to refer to the definition found in the previous section.

2.5.1.1. Elder Abuse Types. This section outlines the definitions of different EA types considered in the studies in this thesis, and the type of behaviours considered within each type of EA (see Table 2.2). It is worth mentioning that definitions of EA were more strictly applied in Study 2, due to the large sample size, as compared to Studies 1 and 3, where smaller sample sizes were expected. Given that, in Study 2, the researcher was considering whether the cases fit inclusion criteria, this inclusion was based on whether the case fit within the definitions. In the primary data research study (Study 3), participants were not given definitions of EA types, only of EA. Thus, participants, not the researcher, were identifying their situation as EA.

The definitions used can be found in O'Keeffe et al. (2007, pp. 18-19), which is the report of the most recent national prevalence of EA in the UK. In addition, for Study 2, the primary researcher and the research assistant (RA) used these definitions as a reference during coding, along with examples extracted from the website of Hourglass (at the time, Action on Elder Abuse) for the different types of abuse. The same exact examples are no longer available due to changes in the organisation's website; thus, they are included herein for reference.

Table 2.2

Definitions of Abuse Types and Examples

Abuse Type	Definition (O'Keeffe et al., 2007)	Examples From O'Keeffe et al. (2007) or Hourglass' Website
Financial abuse	The unauthorised and improper use of funds, property or any resources of an older person.	Stealing of money, possessions or property, the use of fraud, or the misuse of power of attorney.
Psychological abuse	The (…) use of threats, humiliation, bullying, swearing and other verbal conduct, and/or any other form of mental cruelty that results in mental or physical distress.	Insulting the victim, calling the victim names, threatening the victim, undermining or belittling the victim, and preventing the victim from seeing others that they care about. Actions considered as coercive control (Barlow et al., 2020).
Physical abuse	The non-accidental infliction of physical force that results in a bodily injury, pain, or impairment.	Slapping the victim, grabbing, pushing or shoving the victim, threatening the victim with a knife, gun, or other weapon, locking the victim in their room, or giving the victim drugs or too much medicine to control them.
Sexual abuse	Direct or indirect involvement in sexual activity without consent.	Talking to the victim in a sexual way that makes them feel uncomfortable, touching them in a sexual way against their will.
Neglect	Repeated deprivation of assistance needed by the older person for important activities of daily living.	Neglect may be intentional or unintentional (e.g., because a caregiver cannot cope or is not getting sufficient help).

2.5.2. Help-Seeking

As introduced briefly in Chapter 1 of this thesis, “help-seeking” was approached as a broad process, which includes the following:

- Disclosures (i.e., talking about an EA victimisation with any third-party and with a variety of purposes) to informal (e.g., friends) and formal (e.g., police) third parties,
- requesting help from those third parties, and
- engaging with the help offered.

Thus, help-seeking was defined in a broader way as compared to previous definitions in the field of EA and other fields of interpersonal violence which conceptualised help-seeking as the act of talking about the abuse (e.g., Naughton et al., 2013; O’Keeffe et al., 2007). Herein, the act of talking about the abusive situation with a third party was referred to as “disclosure”, and this thesis considers disclosure as part of help-seeking. In agreement with previous research in other fields of interpersonal violence, the approach taken in this thesis differentiates, where possible, between informal disclosure to any person and disclosure to a formal source, given that there may be qualitative differences between these two processes (Sylaska & Edwards, 2014). The latter encompasses disclosures to formal sources (to a volunteer organisation or charity, to the local authority or safeguarding services, or any other official organisation) and official reporting to the authorities (e.g., raising a safeguarding alert or reporting an incident to the police). Hence, herein “help-seeking” is a broader term and encompasses more processes than talking about (i.e., disclosing) the victimisation.

2.5.2.1. Aspects of Help-Seeking. All the studies in this thesis focused on several main aspects related to the process of help-seeking:

1. Barriers to help-seeking: understood as anything (e.g., a circumstance, a feeling, or a belief) that makes it harder for a person to seek help. For example, fear of negative consequences arising from seeking help.
2. Facilitators to help-seeking: understood as anything (e.g., a circumstance, a feeling, or a belief) that makes it easier for a person to seek help. For example, the existence of a good support network.
3. Reasons or circumstances that lead to help-seeking: for example, a particular event and/or similar circumstance that leads to seeking help (e.g., the perpetrator being away from the victim's home).
4. Sources of help-seeking: understood as the persons, professionals, or services that a person seeks help from. These can be informal or formal sources of help.
5. Responses from sources of help: understood as the immediate response obtained from sources of help after help-seeking, verbally or non-verbally, as well as the helpfulness of the response. Following a conceptualisation in the field of intimate partner violence (Sylaska & Edwards, 2014), these could be positive/helpful (e.g., believing the victim or validating their experience) or negative/unhelpful (e.g., not believing the victim or blaming them).
6. Outcomes from sources of help: the success in stopping the abusive situation or improving the situation (Comijs et al., 1998) as a result of seeking help from others, including outcomes that worsened the situation (Mowlam et al., 2007).
7. Predictors of help-seeking: variables that can be associated to increased rates of help-seeking (Burnes, Acierno, & Hernandez-Tejada, 2019).
8. Reasons for seeking help: understood as the goals for seeking help (i.e., what a person wants to achieve as a result of seeking help) (Mowlam et al., 2007).

9. Attitudes towards third-party intervention: understood broadly as the expectations of help from third parties, as well as the wishes towards help obtained from third parties, particularly, referring to the help in relation to the abusive situation. These wishes can also refer to the perpetrator of abuse or others involved (Burnes, Hsieh, et al., 2019).

The examination of aspects 2 and 3 as listed above was initially approached together in this thesis, and the systematic review (Study 1) only considered "facilitators" in its research questions. However, upon finding that most studies reporting facilitators were referring to a concept more akin to that described in aspect 3 of the list, both facilitators and circumstances leading to seeking help were considered. Across studies and chapters, a distinction was made when presenting and discussing the findings.

2.5.3. Concerned Persons

The term "concerned persons", first used by Breckman et al. (2017), was used to refer to those persons who know about a victim of EA, and who might decide to seek help on behalf of the victim or try to support the victim but do not interact with the victim in a professional capacity. This encompasses family members, friends, neighbours, and acquaintances. In addition, individuals who know the victim in a professional context, such as a shopkeeper or a bus driver, but who would not be expected to know about EA as a result of their professional background or who have no duty of care towards the older adult, are considered. Because the objective was to understand the behaviours of those who have not received the training necessary to know how to report a case of EA, these individuals were a better fit to the category of "concerned persons" than that of professionals, such as a social worker, a charity worker, or a healthcare worker, whose experiences have been explored in detail in research (e.g., Alt et al., 2011; Bergeron & Gray, 2003; Killick & Taylor, 2009; Thompson-McCormick et al., 2009). However, no exclusion was made for cases in which a person interacting with a victim in a non-professional capacity may have a professional background that would make them more

familiar with EA or the functioning of services. For example, a person working with a charity that deals with domestic abuse and who is supporting their friend, a victim of EA, would be considered a "concerned person".

2.5.4. Variables That may Influence Help-Seeking

Several variables that may influence or relate to help-seeking were studied in Chapters 4 and 5. These variables referred to the victim and perpetrator of abuse, the abuse itself, and the victim-perpetrator relationship. They were included based on previous research findings or due to the research literature identifying them as variables that may influence help-seeking and that should be investigated. It has been previously argued that, given that EA occurs within the context of a relationship, these characteristics should be incorporated in the study of barriers and facilitators to help-seeking (Burnes, Acierno, & Hernandez-Tejada, 2019). Several variables included in Studies 2 and 3 were derived from the findings in Study 1. Similarly, some of the variables included in Study 3 were derived from the preliminary findings in Study 2, after analysing a randomly generated sample representing 10% of cases in Study 2.

The following tables include an explanation and/or definition of the variables included, along with corresponding justifications and research references, where relevant. The first table (2.3) includes variables related to the victim and perpetrator. According to the theories considered in this thesis, victim variables may influence help-seeking as predisposing factors (Andersen, 1965) or as background factors (Ajzen, 2011). Some victim variables (e.g., physical or mental health problems) can also be considered as part of the "need" factor in Andersen's Behavioral Model of Health Services Use (Andersen, 1965). That means that these variables could be morbidities that prompt a person to seek help. Perpetrator variables can be considered as part of the victim's meso-system according to the Ecological Systems Theory (Bronfenbrenner, 1979).

Research has previously noted that some of the factors that may make a person more vulnerable to abuse may also make it harder for them to seek help (e.g., dependency on others; Chokkanathan et al., 2014). Similarly, as reviewed by Storey (2020), previous research has hypothesised that substance abuse problems, a risk factor for EA, may limit the victim's ability to seek help. Another example of a variable that can both raise vulnerability for abuse and make it harder to report is isolation (see Fraga Domínguez, 2020 for a related discussion in the context of COVID-19). Thus, some of the variables that were studied in this thesis are factors that have recently been identified as risk factors for elder abuse in a comprehensive systematic review (Storey, 2020).

Culture and related factors such as race/ethnicity, acculturation, and immigration status were identified as important factors that may influence recognition of abuse and help-seeking behaviours in Chapter 1. However, there was not enough information in Study 2 to test these in the logistic regression models or the chi-square tests, and the other studies had small sample sizes that could not be the subject of quantitative analysis. Thus, these variables were not included in the table below. Nonetheless, cultural factors and factors related to immigration status are explored in other ways in Chapters 3 and 4.

Table 2.3

Victim and Perpetrator Variables That may Influence Help-seeking

	Definition (if Applicable) and Justification for Inclusion (in Bullet Points)	
Name	Victims	Perpetrators
Gender	• Pritchard (2007) states that male victims may have a harder time disclosing due to being seen as perpetrators rather than victims, and norms regarding disclosure while growing up.	• The perpetrator being female has been previously associated with general service utilisation (Barker & Himchak, 2006) by EA victims.

Name	Definition (if Applicable) and Justification for Inclusion (in Bullet Points)	
	Victims	Perpetrators
Age group [a]	Divided in younger age group and older age group (under 80 and over 80 years old). • Increased age may decrease the victim's ability to disclose (Burgess et al., 2008).	
Physical health problems [b]	Poor physical health or medical problems, which are vulnerability and risk factors for EA (Beach et al., 2005; Dong, 2015; Eisikovits et al., 2004; Johannesen & LoGiudice, 2013; Lachs & Pillemer, 2015). • In general, increased vulnerability and disability may decrease the chance of disclosing (Burgess et al., 2008). However, poor self-rated health status has been associated with increased service utilisation (Barker & Himchak, 2006).	
Physical disability [b]	"Limitation on a person's physical functioning or mobility" (De la Torre-Luque et al., 2017, p. 423). • Increased vulnerability and disability may decrease the chance of disclosing (Burgess et al., 2008).	
Intellectual disability [b]	"Intellectual disability is a disability characterized by significant limitations both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behaviour, which covers a range of everyday social and practical skills" (American Association on Intellectual and Developmental Disabilities, 2020, para. 1). • Increased vulnerability and disability may decrease the chance of disclosing (Burgess et al., 2008).	
Mental health problems [b]	Diminished psychological health and mental health problems, such as depression and anxiety, which are vulnerability and risk factors for EA (Acierno et al., 2010; Jackson, 2016; Johannesen & LoGiudice, 2013; Labrum et al., 2015). • Increased vulnerability may decrease the chance of disclosing and may hinder victim's ability to seek help (Burgess et al., 2008; Henderson et al., 2002).	
Dementia [b]	"Dementia is a syndrome in which there is deterioration in memory, thinking, behaviour, and the ability to perform everyday activities" (WHO, 2020c, para. 1). Causes can be Alzheimer's disease, Lewy body dementia, frontotemporal disorders, and vascular dementia (National Institute on Aging, 2017).	

Name	Definition (if Applicable) and Justification for Inclusion (in Bullet Points)	
	Victims	Perpetrators
	• Dementia has been associated with a lower likelihood of disclosure, particularly in advanced stages (Burgess et al., 2008). • On the other hand, cognitive impairment has been associated with increased service utilisation in EA victims (Barker & Himchak, 2006).	
Previous victimisation	Previous abuse experienced or witnessed, other than the current episode of EA (Storey, 2020).	Previous abuse experienced or witnessed during the perpetrator's childhood or adolescence (Storey, 2020).
Substance abuse problems [b]	Problems related to the use of illegal substances or misuse of legal substances, such as alcohol or prescribed medication (Storey, 2020). • The victim abusing substances may reduce their ability to seek help (Storey, 2020)	• The perpetrator's substance abuse problems have been associated with EA victim's service utilisation (Barker & Himchak, 2006).
Antisocial attitudes [c]		Not taking responsibility for behaviour, and antisocial behaviour, such as a history of criminal or violent behaviour (Storey, 2020).

[a] This factor is only examined for victims.
[b] The definition for victims and perpetrators is the same.
[c] This factor is only examined for perpetrators.

The following table (2.4) includes variables relating to the EA, which may influence help-seeking behaviour. They are included because they have been found to relate to help-seeking in EA (e.g., Burnes, Acierno, & Hernandez-Tejada, 2019) or to help-seeking by other interpersonal violence victims (e.g., intimate partner violence, Sylaska & Edwards, 2014), or

have otherwise been identified as risk factors. Variables related to the EA would be considered a "need" factor as per the Andersen's model (Andersen, 1965) or the reason for seeking help.

Table 2.4

Variables Related to the Abuse

Name	Definition and Justification for Inclusion (in Bullet Points)
Abuse types	The different abuse types identified in Table 2.2, as per the definitions in that section. • Researchers have reported differences in the perception of different abuse types and also in the reporting intention or the actual reporting by victims (Amstadter et al., 2011; Markovik et al., 2014; Naughton et al., 2013).
Poly-victimisation [a]	"Multiple co-occurring or sequential types of elder abuse by one or more perpetrators, or one type of abuse perpetrated by multiple others with whom the older adult has a personal, professional or care recipient relationship in which there is a societal expectation of trust" (Ramsey-Klawsnik & Heisler, 2014, p. 15). • Co-occurrence of multiple types of abuse has been found to predict reporting by EA victims (Burnes, Acierno, & Hernandez-Tejada, 2019).
Use of isolation	Isolation of the victim is a common behaviour in abuse perpetrators, who may alienate the victim from others (Dalley et al., 2017). The perpetrator is isolating the victim when, for example, they prevent them from seeing other members of the family or even talking to them. In more extreme cases, they may have taken away the victim's telephone to prevent them from making calls. • The abuser's behaviour, including isolation, may impact a victim's willingness or ability to seek help (Newman et al., 2013). Isolating behaviours may make it harder for victims to reach out to anyone about the abuse.
Use of threats	Utterances or behaviour that threatens physical, psychological, or social harm in some manner, such as threatening statements. • They could impact the victim's decision to seek help by causing fear or through intimidation (Newman et al., 2013).
Chronicity	The abuse has been going on for at least six months or is described as long-standing.

[a] The two different aspects of the definition (i.e., multiple types of abuse perpetrated or one type of abuse perpetrated by multiple others) were studied separately.

Finally, the victim-perpetrator relationship has been deemed to be influential in help-seeking (e.g., Jackson & Hafemeister, 2015) (see Table 2.5). It would be considered part of the victim's relationships in the meso-system (Bronfenbrenner, 1979).

Table 2.5

Variables Related to the Victim-Perpetrator Relationship

Name	Definition and Justification for Inclusion (in Bullet Points)
Victim-perpetrator relationship	The victim-perpetrator relationship, distinguishing between different types of family members, friends, and professionals (Jackson & Hafemeister, 2015). • The specific relationship between victim and perpetrator has been generally identified as a factor which may influence help-seeking in EA (Acierno et al., 2020; Gibson, 2013; Jackson & Hafemeister, 2015; Pickering & Rempusheski, 2014).
Dependency	Victim's dependency on the perpetrator or perpetrator's dependency on the victim, for the following: care, financial, social, emotional, for housing (Jackson & Hafemeister, 2014; Pillemer et al., 2007). • The victim's dependency on the perpetrator has been associated with decreased reporting by victims (Burnes, Acierno, & Hernandez-Tejada, 2019). • The perpetrator's financial dependency on the victim has been associated with increased service utilisation (Barker & Himchak, 2006).
Co-habitation	The victim and the perpetrator living together (Jackson & Hafemeister, 2011; Johanessen & LoGiudice, 2013; Naughton et al., 2013).

2.6. Methodology Study 3

Study 3 was subject to several changes and amendments as the thesis progressed. Please see Appendix A for the researcher's reflection on recruitment challenges and related changes to the structure of this thesis.

2.6.1. Participants

Participants (N = 19) were individuals who had sought help on behalf of a victim or supported this victim in some way in a non-professional capacity. Of those, 17 participants

completed only the survey, and one was only interviewed. Another participant was interviewed and then completed the survey. They data from this participant were merged and further information can be found in Chapter 4 (p. 171). Participants expressed an interest in participating upon learning about the study through social media or through contact with an organisation in the eligible countries (UK, Ireland, United States, Canada, Spain, Australia, and New Zealand). More information on the selection of eligible countries can be found in Section 2.6.2.1. Recruitment was also conducted through snowball sampling; for example, participants may have heard about the study from other participants or from organisations.

2.6.2. Procedure

2.6.2.1. Recruitment. The researcher obtained ethical approval for Study 3 and for several amendments to the original study protocol (further information can be found in Section 2.8). Recruitment started in September 2019 and finished in June 2020. There were several stages of recruitment, responding to changes in the procedure, all of which are explained chronologically in this section. In addition, limitations related to the sampling strategy are discussed.

Recruitment From September 2019. Potential participants were initially targeted by posting information about the study on social media (e.g., Twitter, LinkedIn, Facebook), and only residents in the UK were targeted. To facilitate the sharing of information, the researcher prepared a summary of the project in a flyer format. The researcher also created a website that included the study information to share with potential participants so they could review the information about the study in their own time. Both the flyer and the link to the website were posted on social media (e.g., Twitter, LinkedIn, Facebook), and shared with different organisations in the UK to enquire whether it could be posted on their websites or shared with users, workers, etc. The researcher commenced recruitment in September 2019, upon amendment to the original form of recruitment (i.e., with an organisation as gatekeeper). The

researcher contacted several relevant organisations in the UK with information about the study—e.g., flyer, link to the website. A sample of the method of contacting can be found in Appendix B. These organisations were targeted because they provided services in the UK in which they could interact with the target population, and several organisations were charities (e.g., Women's Aid). A number of organisations did not reply, and several replied that they could not help with recruitment due to a lack of resources or because they felt the target population did not overlap with the population they serviced. Six weeks after sending the first email, the researcher sent a reminder to organisations that had not replied. Seeing the challenges to this form of recruitment, the researcher, together with her supervisors, developed alternative ways of recruitment. Specifically, the researcher printed leaflets and created a list of venues where she could ask to drop these leaflets (e.g., libraries, GP surgeries). There were several barriers to distributing leaflets as some places did not want to accept them (e.g., due to rules about posting leaflets or because of the sensitivity of the topic).

Recruitment From November 2019. In November, due to recruiting challenges, recruitment was opened to other English-speaking countries outside the UK (i.e., United States, Canada, Ireland, Australia, and New Zealand). These countries were chosen because they had commonalities in the way they addressed EA (e.g., a shared understanding of EA, population awareness, an understanding of mental capacity, and services to deal with EA). These were countries with which the researcher was familiar through having reviewed the literature on EA. Given that the study was designed to be conducted remotely, there was not an initial barrier to sampling from other countries. In addition, because EA is a global issue, learning from the experiences of individuals in different countries can be helpful for researchers. It is common for studies conducted remotely to end up reaching a wider population than intended (Bates & Carthy, 2020). However, the researcher decided to limit recruitment to a certain number of

countries to ensure that the debriefing information presented as part of the study contained resources for each of the countries included.

After an amendment to the original ethics protocol was approved, the researcher contacted organisations in all of the countries included to enquire whether information about the study could be shared with colleagues and users, in the same way as in the UK. Several responded positively and shared the information within their organisations.

Recruitment From February 2020 and use of a Survey. A further ethics amendment took place in February 2020. Based on the challenges of recruiting and anecdotal feedback from organisations contacted about the barriers to participation in an interview (e.g., due to time differences and concerns about technology), the interview was adapted to fit an online survey format. The estimated completion time was 30 minutes. The survey was also translated to Spanish so that Spanish-speaking individuals in the United States could participate, as well as participants in Spain, the home country of the researcher. Information about this survey was shared via the same routes as information about the interview (see Appendix B for a sample email). A new set of updated leaflets were printed. Unfortunately, after printing those, the situation with COVID-19 rapidly escalated, leading to national lockdowns, and the researcher was not able to distribute the leaflets.

Recruitment From March 2020 and Impact of COVID-19. The pandemic had an impact on recruitment, adding more barriers to contacting organisations and charities to ask for help, as they were overburdened trying to support older people and other communities in the extraordinary circumstances, often with decreased numbers of staff (Elman et al., 2020). Similarly, with the limits to recruitment and study participation imposed by social distancing guidelines, many researchers amended their studies to take place remotely. As a result, there

was an increase in the number of research studies being promoted and discussed in social media.

Because the study dealt with sensitive issues and the public was worried about their health and that of their loved ones, as well as adapting to lockdowns, it is likely that their worry affected their willingness to participate in this research study, which involved remembering distressing events in their lives. For these reasons, recruitment was negatively affected by the pandemic, and the researcher had to be more flexible about sample size. A further reflection on the impact of COVID-19, as well as the changes that the researcher made in the thesis structure, can be found in Appendix A.

Limitations to the Sampling Strategy. There are limitations to the sampling strategy described in the previous paragraphs, particularly as it pertains to the inclusion of participants from different countries in a study with a small sample size. When a decision was made to sample participants from different countries, the primary aim was to increase the sample size, given initial challenges recruiting solely in the UK. The researcher wanted to strike a balance between remaining committed to the original topic of study (i.e., exploring the help-seeking experience of concerned persons) and making the research study possible.

However, the final sample size was relatively small ($N = 19$), and the heterogeneity of the sample in terms of countries of origin presents limitations. For example, legislation regarding EA is different across the four countries included in the final sample (UK, United States, Canada, Australia) and even across states within a country, including whether it is considered a crime, or the services most likely to intervene (Dong, 2015; Podnieks et al., 2010). This diversity posed challenges in terms of integration of findings that may reflect very different experiences and circumstances. Nonetheless, the researcher chose several countries with similarities in how they intervened in EA cases to make integration easier. If the final

sample had been larger, it may have been possible to compare the findings for different countries, and this should be explored in future research.

Participation via Interview. Upon contact via email or social media by potential participants willing to take part in the interview, the researcher replied with a standard email/message thanking them for reaching out, acknowledging their experience (if discussed in the email/message), and suggesting times for a quick phone call to go over the study details. The researcher proceeded to contact participants over the phone at the times outlined and explained the study characteristics and what it involved. Potential participants were given time to ask questions. If they were still interested in participating, the researcher arranged a time to contact them to conduct the interview. The researcher followed this procedure so that they had time to think about the study, and what it involved, carefully, and to make an informed decision about participating (Mowlam et al., 2007). Since the initial contact happened over email, the researcher again provided the link to the research study website, so they had time to access it again and read it carefully. This information matched the information sheet that was used by the researcher.

For interview participation, at the time indicated, the researcher called the potential participant. Informed consent was obtained before proceeding to conduct the interview. To ensure that the person had the capacity to consent, the researcher asked whether there was anybody in the person's life who made decisions on their behalf. If they had said yes, the researcher would have followed several steps, which can be found in Appendix C. Interview participants indicated that there was nobody in the participant's life who made decisions on their behalf; thus, these further steps were not necessary.

Since there was nobody in the participants' lives making decisions for them, the researcher proceeded to explain again the details of the study and asked the participants to pay

attention and repeat them back at the end. The researcher then used a checklist to ensure that the basic details of the study procedure had been understood and repeated. If details had been missing, the researcher would have asked further questions. If they still had not remembered the details, the researcher would have asked whether they could speak at a different time when they were clearer about the study and what it entailed. These two steps were not necessary in the interviews conducted for the study. Further details on how the researcher would have proceeded otherwise can be found in Appendix C.

Once the researcher ensured that the person had understood and remembered the basic details of the study, she proceeded to audiotape the person giving consent. The researcher explained again why this was important, as there was no possibility for written consent and the researcher needed to ensure that the person was giving consent willingly. The researcher asked the person to provide their full name or a pseudonym, then asked several questions regarding the person's understanding of the study, and finally asked whether the person agreed to participate. As consent to record the whole interview was obtained, the researcher recorded the consent, stopped the recording, and started again, identifying the recording only by a number. These data were stored separately in order to preserve anonymity. To record the interview over the telephone, the telephone was set to hands free and the researcher's personal laptop recording function was used. This way of recording meant that sometimes the sound quality was low, so the researcher aimed to take notes as she went along and transcribe the interviews within a reasonable timeframe so it was easier to find words in the notes that were not audible in the recording. The researcher explored alternative ways of recording but none of them offered sufficient sound quality, and the use of external telephone conversation recording apps was discarded, due to privacy risks.

During the interview, participants were allowed to take breaks, and the researcher offered them regularly. After conducting the interview using a semi-structured interview guide,

the researcher debriefed the participant. Participants were provided with a participant number and reminded that they could withdraw their participation within two months by contacting the researcher. Given that the two interview participants were resident in the UK, the researcher directed them to Hourglass' (a UK EA charity) helpline should they have any questions or need further support. The researcher also included the contact for two other helplines (Age UK and Silverline) in the debriefing form in case participants felt they may need different help, and also because of the wider availability of these other two helplines (see Appendix D). Even though these helplines are aimed at older people, they also target older people's loved ones, such as family members, who were the target of this study. The debriefing form was emailed so that the participant had the information on paper. Country-specific debriefing information was available for use with non-UK participants.

Participation via Survey. The procedure above could not be implemented during survey participation, and thus, did not apply to this type of participation. To reflect the conditions of the interview participation, participants were allowed to take breaks and come back to the survey at a later time. They were also provided with an ID (automatically generated by the survey software utilised) so that they could withdraw their participation within two months.

2.6.2.2. Materials. Study 3 involved a semi-structured interview and a survey. The survey was built and distributed using the survey software supported by Qualtrics. More information about how the survey was designed is included in the current section.

Interview Guide. A semi-structured interview guide was built based on previous literature, the results of the systematic review (Study 1) and the preliminary analyses from Study 2. Gaps in the literature were identified after conducting Study 1, a systematic literature review regarding EA victims' help-seeking behaviour. Thus, the interview guide was designed

to fill those research gaps. Additionally, the interview guide was supported by previous published interview guides with this population exploring similar topics (Jackson & Hafemeister, 2011; Mowlam et al., 2007). The interview guide was also created considering the themes identified during the coding of a randomly generated 10% of Hourglass' helpline cases, and the preliminary quantitative analyses performed on that subsample. In addition to these themes, the researcher paid attention to any variables of the data collection tool that were difficult to gather from the free texts, such as the specific responses that victims obtained when they disclosed abuse. The interview guide included some modifications in order to be used both with victims and concerned persons, as it was originally built to allow for interviewing victims, with the help of a charity. Thus, some of the decisions and steps described in the following paragraphs are more relevant to interviews with victims. Generally, interview participants, including those who have been victimised, find their participation beneficial (e.g., empowering) (Wolgemuth et al., 2015); thus, this was considered an appropriate method for approaching this population.

The interview guide consisted of five main sections:

1. Participant's demographic characteristics and victim's demographic characteristics.
2. The abusive situation.
3. The process of seeking help.
4. Attitudes towards intervention.
5. Help received.

Most of the questions were open-ended, but some were closed-ended (some dichotomous, some with several categories), with the purpose of obtaining case characteristics. The full interview guide can be found in Appendix E. For some of the case characteristics, the researcher classified the responses during the interview or following the interview (e.g., type(s) of abuse, place where the abuse occurred, relationship with the perpetrator), instead of

presenting the interviewee with categories. The researcher did this to allow the interviewee to answer in the way that felt more natural, without interrupting the story about their experience of abuse and help-seeking. However, where necessary, after the interviewee's initial description, the researcher followed up or enquired about different abuse types, given the commonality of poly-victimisation (Heisler, 2017).

Piloting. Piloting of interview guides is recommended for studies, especially when dealing with sensitive topics (WHO, 2001). It has also been found that certain words may not resonate with older adult participants and that the use of language is important (Age UK, 2018). The researcher based the interview guides on existing interview guides with EA victims as well as on her initial observations during the data collection for Study 2. Nonetheless, piloting the interview materials was still considered necessary. Piloting the interview guide with older participants from the general population was considered risky because they could disclose an abusive situation which they had not yet discussed with anybody other than the researcher. For this reason, the materials were piloted with professionals experienced in interacting with victims and other enquirers concerned about EA victims. The interview guide and other recruitment materials (information sheet, process for obtaining informed consent, and debriefing) were piloted with six members of the helpline staff of the charity Hourglass. These participants were chosen because they were experienced helpline workers who had frequent contact over the phone with the target population of the researcher's study. Because of their contact with both older adult victims and, more frequently, concerned persons, they were well positioned to provide feedback on these matters.

The piloting took place in January 2019 over three days. The researcher spoke to each member of staff individually for a period of 30 to 90 minutes in Hourglass' headquarters. The researcher first explained the purpose of their participation in the piloting of the materials. After participants had the chance to ask questions about the piloting procedure and the study, they

signed an informed consent. Participants were then provided with the materials that were intended for use in the study and were instructed to review the materials carefully, considering potential improvements in terms of language, wording, clarity of explanations, and any changes in terms of appropriateness of the procedures for the target population. The objective was to answer the following questions:

1) Are the interview materials (including the interview guide, information sheet, consent, and debriefing procedures) appropriate for the target population?

2) Is the procedure for obtaining consent and informing victims appropriate for the study?

3) Could there be any improvement to the wording or concepts used so that they resonate better with the target population?

4) Is there anything else that requires modifications before using the interview with the target population?

After the participants read each study material, the researcher asked questions aimed at gathering their feedback regarding the resources. Participants suggested some improvements in terms of language or wording based on their experiences interacting with victims of EA and other helpline enquirers. They also suggested some minor modifications for the process of obtaining informed consent. All the information was written down by the researcher, who used these observations to improve the study materials prior to ethical review. In addition, several participants had suggestions for the researcher in terms of conducting the interviews and reacting to several situations that could arise with the target population, based on their professional experience. The researcher gathered these as well and considered their implications for study implementation. Participants were debriefed and thanked for their time and their contribution to the study.

Survey Guide. The survey guide, used after the ethics amendment approved in February 2020, was based on the semi-structured interview guide and followed the same structure and sections (see Appendix F). Where appropriate and to reduce the amount of information presented to participants, the researcher used Qualtrics' settings so that questions were only displayed when relevant based on previous answers. To follow the same principles of the interview, participants could skip any question (except for the consent questions) and still proceed with the interview. Based on the sensitive nature of the questions and the relative length for an online survey (approximately 30 minutes), participants could also take a break from the survey and come back to it within a week. This was specified in the information page of the survey. To reduce the time completion—estimated by the survey software—several questions that were open-ended in the interview were amended into closed-ended questions. However, comment boxes and "other" options were available throughout, so that participants would not feel constrained.

2.7. Reflexivity

Reflexivity is an important element of the research process and can be framed around the idea of awareness—of the researcher's influence on the research process, and of the research process' influence on the researcher and participants (Gilgun, 2008). It is important that the researcher acknowledges and is aware of their position with respect to the research topic. Letherby et al. (2013) argue that "the values and subjectivity of the scientists […] are integral elements in its claims to objectivity and expertise, accountability, and value" (p. 6). In this case, the researcher can be considered as an outsider, as a person who does not have lived experience of abuse and who is younger than the majority of the population being studied. This outsider perspective has an influence on the way that the topic is approached, as well as on the participants' perceptions of the researcher.

Importantly, there is research indicating that views about what constitutes EA are different in different countries and cultures (e.g., Dong & Wang, 2016; Moon et al., 2002). Thus, the researcher's own cultural background and norms may influence how the situations studied are perceived and approached (Darawsheh, 2014). This is particularly relevant as the researcher was studying populations in countries where she did not grow up (i.e., outside of Spain), and thus, did not share a common background with the populations studied. This may have led to a lack of understanding of the nuances of participants' experiences. In addition, in Study 3, this may have contributed further to participants' perceptions of the researcher as an outsider. The researcher benefited from the supervision of researchers with knowledge of the systems in the UK and other countries, which allowed her to develop a further understanding of the population and topics being studied.

In order to be systematic, specific definitions and examples of what are generally considered abusive behaviours were used. However, it still likely that the researcher's perceptions may have influenced inclusion of studies or cases (in Study 1 and 2, respectively), as well as interaction with participants in the interviews conducted in Study 3. In Study 2, the researcher used a notebook to record thoughts and impressions as she coded the data. This helped the researcher examine her own perceptions of the cases that she read, as well as identify and reflect on instances of bias. Understanding reflexivity as a continuous process that can be helpful at different points in the doctoral research process, the researcher recorded her thoughts regularly, during study design, initial coding of the data, and qualitative data analysis (Darawsheh, 2014). During qualitative data analysis, the researcher recorded thoughts, reflections, and coding decisions as memos using qualitative data analysis software, and revisited these throughout the process of data analysis and write-up.

In Study 3, the researcher was aware that, when interviewing participants, she could influence the participants' responses through her own framing of the questions and the reaction

she had to participants' responses (Darawsheh, 2014; Gilgun, 2008). In relation to the framing of the questions, the researcher adhered to the interview schedule, which was designed based on previous research with a similar population (Mowlam et al., 2007). Regarding her reaction to responses, the researcher was informed by her previous professional experience and training interviewing people with depression in a randomised clinical trial. Thus, she took steps to remain as neutral as possible throughout, clarifying that she was interested in the participants' experiences, all the while establishing rapport with participants and respectfully and sensitively acknowledging their experiences. For the survey, the researcher had less influence on participants' responses during their participation. However, the researcher's details and identity were still available to participants, who may have perceived the researcher as an outsider investigating a phenomenon she had no direct experience with.

Being aware of her perspective as an outsider, throughout the course of her doctoral studies, the researcher aimed to become more familiar with the topic and ensure that the approach to it was informed and respectful. In order to do this, the researcher not only thoroughly engaged with the literature but also attended events related to EA, where she interacted with researchers and professionals from different disciplines with direct experience supporting victims, as well as with individuals who had been directly affected by EA. Acknowledging the international nature of her PhD studies, she attended events in different countries where possible. These activities were invaluable when designing studies, communicating with other researchers, with practitioners, and with participants. Importantly, the thorough engagement with the data in Study 2 facilitated the implementation of Study 3, as by then the researcher was familiar with the stories of many older adults and concerned persons affected by abuse. This process illustrates the ways in which the research process can influence the researcher (Gilgun, 2008).

A related reflection on the researcher's approach to this thesis and the challenges experienced in the implementation of Study 3 can be found in Appendix A.

2.8. Ethical Considerations

Given the sensitivity of the topic, ethical considerations were an important element during the design and implementation of studies.

In Study 2, specific ethical considerations concerned the safe storing of the data and the anonymisation of cases for the purposes of working with a secondary researcher to obtain inter-rater reliability. This study involved the use of secondary data and confidentiality was covered by a separate agreement with Hourglass, at the time called Action on Elder Abuse. This included a volunteer confidentiality agreement and a service agreement.

In Study 3, research procedures and interview guides were carefully developed by consulting previous research in the field with similar populations (e.g., Jackson & Hafemeister, 2011; Mowlam et al., 2007). In addition, materials were piloted with staff experienced with dealing with the target population to avoid language that was insensitive, with a special emphasis on the interview guide.

Study 2 and the piloting of materials with Hourglass' staff (Study 3) were self-certified by the researcher, under supervision. The piloting of staff involved interaction with participants, but these participants were not considered an at-risk population, which does not require a full ethical review by Royal Holloway's Ethics Committee. Study 3 was submitted for full ethics review and received approval by the ethical committee at Royal Holloway, University of London. Three amendments were submitted and approved, to allow for changes in the recruitment procedures.

Several other measures were taken during the design of Study 3 in order to be employed during implementation because of the sensitive issues raised by the research. First, to account

for pre-existing vulnerabilities, participants were informed that they could take breaks at any point they liked, refuse to answer any questions, and stop the interview if they were feeling discomfort. Because the interviews were conducted over the phone, the researcher paid attention to participants' tone of voice to identify potential signs of distress. The researcher was informed both by training specific to older adults suffering from depression and by her experience interviewing older and younger adults with major depressive disorders over the phone. The researcher also checked regularly during the interview if participants needed any breaks. Participants could be offered the possibility to finish the interview at a later date if they were feeling too distressed to continue; however, this was not necessary. Participants were informed about the study twice before they participated, in order to allow more time to think about their vulnerabilities in relation to the study and to make an informed decision (Mowlam et al., 2007).

In order to account for distress that participants could experience as a result of participating in the study, the interview guide was developed focusing more on the support experiences rather than on the abusive experience itself. The researcher paid particular attention to signs of distress during the most sensitive questions. During debriefing, participants were advised to call Hourglass if they felt distressed after the interview or if they required further support. Hourglass does not provide intervention, but they are a specialist charity aware of other services that may help victims and concerned others, such as befriending services, or other helplines (Podnieks et al., 2010). The researcher also provided the contact for two alternative helplines in case participants expressed any concerns regarding Hourglass during the interview and/or to accommodate different participants' needs. Specifically, the researcher provided the contact numbers for Age UK Advice line and the Silver Line, both of which are free helplines for older adults or their family members, with the latter being available 24 hours every day of the year. Participants were reminded in the debriefing form that if they were in a

situation of immediate harm, they should contact the police. For participants outside the UK, the researcher prepared alternative resources, including at least one helpline or number that could direct them to the appropriate helpline in the region. The local police number was also provided. This contact information was displayed on the last page of the survey, along with the rest of the debriefing information.

Management of Safety Concerns

During their participation, participants could have disclosed that they or somebody else found themselves in a situation of extreme immediate harm or were being harmed and were not able to act to protect themselves. Interview participants were informed that if they disclosed any such situation, the researcher would contact the charity Hourglass to seek advice. If such disclosure occurred and there was a real risk of immediate harm, the researcher would also ask the participant to please call the police emergency number. However, there was no such disclosure. More information about the protocol for dealing with such concerns can be found in Appendix C. As another safety precaution, the researcher also instructed the participants to let her know if at any point they were no longer in a private place and needed time to find a private place or wanted to arrange a call for a different day. Before starting the interview, the researcher also checked with the participants whether they wanted to choose a word or phrase that they could use in case somebody arrived and the participant did not want to disclose the motive of the call.

CHAPTER 3- STUDY 1: SYSTEMATIC REVIEW ON VICTIMS' HELP-SEEKING

3.1. Introduction

As outlined in the introduction of this thesis, the objective of Study 1 was to synthesise the findings relating to help-seeking behaviour among elder abuse (hereafter "EA") victims, and to be able to understand what is known and ignored regarding these behaviours. Thus, the focus of this study was exclusively on victims' behaviour and experiences. The current study was informed by a scoping review of the literature, presented in Chapter 1, which integrated the findings of studies focused on a variety of participants and perspectives (e.g., EA victims, older adults, older adults' family members and caregivers, and a range of professionals). After identifying a gap in the literature regarding EA victims' help-seeking behaviour, Study 1 was designed to analyse and synthesise the findings from the literature specific to victims' views. A related objective was to use the study findings to inform further empirical studies in this area, particularly for this thesis. This study served as a basis for Studies 2 and 3, which also focused partly on EA victims.

3.2. Literature Review

Among the published EA research, there is recognition that disclosure rates and formal reports of victimisation are low (Bergeron & Gray, 2003; Burnes, Lachs et al., 2019; Killick & Taylor, 2009). As a result, it is estimated that only a small proportion of cases are known to formal services (Cooper et al., 2008; O'Keeffe et al., 2007). This suggests not only that the prevalence rates might be underestimated but also that assisting victims is a challenge. Indeed, major barriers to assisting EA victims are underreporting, victims' rejection of intervention, and lack of service utilisation (Barker & Himchak, 2006; Burnes, Lachs et al., 2019; Naughton et al., 2013). These factors are critical to address, not least because when abuse remains hidden there is a potential for escalation (Storey & Perka, 2018).

Due to EA being perpetrated primarily behind closed doors and by family members (Jackson, 2016), there is an assumption that victims face many obstacles when disclosing EA. However, much of the evidence is anecdotal or has not been gathered from victims themselves, and knowledge of barriers to help-seeking is limited. Research on barriers to help-seeking for EA has mostly used samples of older adults from the general population who have not been victimised, vignette methodologies, or focus group discussions (Chokkanathan et al., 2014; Gibson, 2013). Others have focused on a specific cultural minority residing in the United States (e.g., Lee et al., 2014). Understanding victims' perspectives of EA is essential to addressing underreporting, but knowledge in this area is limited and lacks specificity.

The understanding that victims are unlikely to disclose has resulted in policies to increase professional detection of warning signs and on developing mandatory reporting statutes to protect victims (Barber, 2008; Gibson, 2013). Professional training for frontline staff can support the identification and reporting of EA, and there are over 15 available tools to screen and assess EA (Spencer, 2009). Although increasing professional reporting is necessary, this has led to a lack of focus on the victims' perspective and fails to acknowledge the many victims who may not display identifiable signs of abuse or be in contact with professionals due to isolation—a risk factor for EA (Lachs & Pillemer, 2015). Unfortunately, this practice is consistent with general research trends that neglect the views of older people (Burnes, Lachs et al., 2019; Erlingsson, 2007; Killick et al., 2015; Mysyuk et al., 2016). Although some victims will not be able to disclose abuse because of physical or cognitive barriers, a considerable number of older people could do so, and thus, research should focus on identifying and understanding methods of increasing victims' help-seeking (Barber, 2008; Brank et al., 2011; Richmond et al., 2020).

The current study, a systematic literature review, aimed to provide a synthesis of the published and unpublished research on EA victims' help-seeking behaviour to inform

practitioners and guide future empirical work, including Studies 2 and 3 in this thesis. To the best of the researcher's knowledge, there was no published review on help-seeking behaviour among EA victims. Before any further research was conducted, it was prudent to identify the common themes in the literature, any gaps in the topics covered, and any limitations of the research studies previously conducted. The main areas of interest for this systematic literature review were help-seeking barriers, facilitators, sources of help-seeking, outcomes or responses to seeking help, and the characteristics of victims who were more likely to seek help.

3.3. Research Questions

The primary question that this systematic review aimed to answer was: What are the characteristics of help-seeking behaviour among EA victims?

Specifically, the review addressed the following research questions:

1. What are the barriers that prevent help-seeking among victims of EA?

   1a. Are there any abuse characteristics associated with increased barriers to help-seeking?

2. What are the facilitators of help-seeking behaviour among victims of EA?

   2a. Are there any abuse characteristics associated with increased help-seeking behaviour?

3. From whom do victims of EA seek help?
4. What are the responses of third parties to EA victims' help-seeking and how do they influence further attempts to seek help?
5. What characterises victims who are more likely to seek help?

3.4. Methodology

3.4.1. Definition Parameters

Due to inconsistency of definition in the field and the lack of specificity of some studies when addressing EA, an inclusive approach was adopted. Although the most commonly accepted definition specifies that EA be perpetrated by someone the victim knows and trusts, because of the scarcity of research with EA victims identified during the scoping review, studies that included analysis of both stranger and known perpetrator abuse were incorporated. However, studies that examined help-seeking behaviour exclusively as a result of stranger victimisation were outside the scope of this review. The context of stranger or known abuse perpetrator is made explicit in the discussion of the results of this review.

The age cut-off that defines an older person is also a source of disagreement in the literature (Addington, 2013; Bows, 2018). For the purposes of this systematic review, a conservative age cut-off of 60 years was used, in concordance with that used by the WHO (e.g., WHO, 2020a) and which was adopted in the other thesis studies. Lower age cut-offs were considered if the use of such a cut-off was justified within the articles reviewed on the basis of cultural differences or lower life expectancy (e.g., Indigenous population in Australia; Dow et al., 2018); however, no relevant studies with such justifications were identified.

Within this review, help-seeking behaviour was broadly understood as informal or formal disclosure of EA victimisation, the latter also referred to as "reporting" (e.g., Jackson & Hafemeister, 2015). Studies involving EA victims in which help-seeking for the abuse was not a primary focus were excluded (e.g., examination of the degree to which a service, such as meals-on-wheels, was utilised by victims; Barker & Himchak, 2006). Help-seeking or disclosure had to be conceptualised as resulting from the abusive situation (e.g., talking to a family member or professional about the mistreatment or filing a report). The self-report of abuse to researchers in the context of a prevalence study was not considered help-seeking.

Further, studies were excluded if they only provided figures on the prevalence of self-reported abuse within a sample of victims without any further discussion of help-seeking. Where possible, there was an aim to differentiate between informal and formal disclosure to account for the possibility of distinctions between these two modes of disclosure, which have been found in samples of intimate partner violence victims (Sylaska & Edwards, 2014).

3.4.2. Search Process

The approach to this systematic literature review was informed by the Preferred Reporting Items for Systematic reviews and Meta-analyses (PRISMA) Statement (Moher et al., 2009). The details of this systematic literature review's protocol were registered on PROSPERO (International prospective register of systematic reviews; Booth et al., 2011; registration number CRD42018097012).

Comprehensive literature searches of several bibliographic databases relevant to the field of EA were conducted to identify published and unpublished research. The following databases were searched: ProQuest Dissertations & Theses Global (via Proquest), PubMed (via NCBI), PsychINFO (via EBSCOHOST), Scopus (via Elsevier), and Web of Science (via Clarivate Analytics). Searches included articles available in the databases from the start of the databases up to and including 5 July 2018, when the searches were conducted. Search terms included those referring to the phenomenon of EA (i.e., *elder abuse, elder mistreatment*, *elder neglect*, *mistreatment of older adults*) and those used to describe help-seeking behaviour (i.e., *help-seeking*, *disclosure*, *reporting*). To broaden the search, several terms were truncated, e.g., disclos*. The search term relating to disclosure was limited to the title/abstract in all the databases, to prevent the databases from retrieving irrelevant articles (e.g., many articles include *disclosure* statements).

Furthermore, with the aim of identifying "grey" literature other than dissertations/theses—which were targeted by the search on ProQuest Dissertations and Theses Global—and conference proceedings—included in Web of Science—additional searches were conducted. These searches were carried out in Google Scholar, the OpenGrey repository, the Grey Literature Report database, and the World Health Organization Institutional Repository (IRIS). In order to narrow the results obtained through Google Scholar, all possible combinations of the key search terms were added to the Advanced Search option, restricting the terms to the title. Additionally, the researcher searched the websites of several organisations (in English and Spanish) working with older clients (e.g., Age UK in the United Kingdom, Senior Rights Victoria in Australia) and reviewed their resources/publications section to retrieve relevant publications.

As a result of these searches, 2,037 published and unpublished sources were retrieved. After duplicates were removed using referencing software, there were 1,388 articles remaining for screening. The search process is illustrated in Figure 3.1.

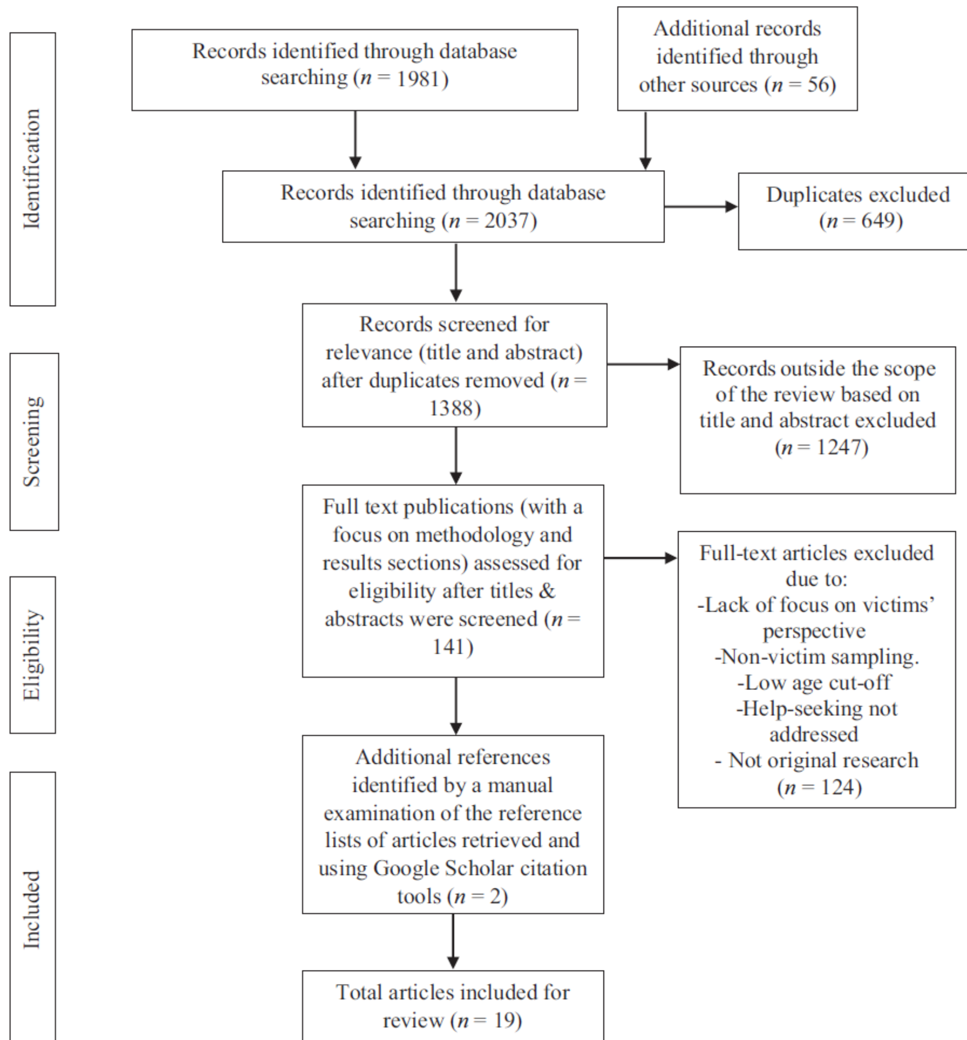
3.4.3. Inclusion and Exclusion Criteria

Titles and abstracts of the 1,388 sources retrieved were screened against inclusion criteria:

- Original empirical published or unpublished research data relating to victim-focused help-seeking behaviours in the context of EA, regardless of the specific definition used.
- Research focusing on victims aged 60 and older, unless a rationale was provided for a lower age cut-off (e.g., cultural differences, lower life expectancy).
- Articles in English or Spanish.

Figure 3.1

Search Process



Note. Adapted from: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and MetaAnalyses: The PRISMA Statement. *PLoS Med* 6(7): e1000097. https://doi.org/10.1371/journal.pmed1000097

Titles and abstracts of the retrieved sources were compared to the inclusion criteria and 1,242 were eliminated. Full texts of the remaining articles (*n* = 146) were reviewed against the following exclusion criteria:

- Addressed reporting from the perspective of professionals who suspect or are aware of EA cases.

- Conducted solely with non-victim populations.
- Conducted with victim and non-victim populations that failed to present the results for victims separately.
- Conducted with an age cut-off below 60 (without justification based on culture or life expectancy) that failed to present the results for the older victims separately.
- Not original research (e.g., opinion papers, book reviews).
- Failed to address help-seeking or disclosure in any detail (e.g., exclusively reporting the disclosure rates in the study).

Citations and reference lists of the remaining 17 articles were reviewed in detail to identify further sources. This review yielded two additional sources for a final sample of 19.

3.4.4. Quality Assessment

Two quality assessment tools were utilised: one for quantitative and one for qualitative and mixed methods studies. The objective of the quality assessment was not to exclude low quality studies, but to evaluate the quality of the available research on the topic to inform future research and the interpretation of the findings. For qualitative and mixed method studies, the Critical Appraisal Skills Program was used (CASP) (2018), which provides a 10-question checklist to systematically appraise a qualitative piece of research. For the quantitative studies, an adaptation of the National Institutes of Health (NIH) tool for cohort, observational, and cross-sectional studies was employed (National Institutes of Health, 2016). From the original 14 questions, the adaptation (see Appendix G) excluded questions 6, 7, 10, and 13 on the basis that they were irrelevant to the identified studies, which were cross-sectional in nature and lacked a temporal dimension in their measurement. Further, question 12 was omitted because it was not relevant to the quality of the studies reviewed. For the remaining nine questions, exposure variables were defined as the assessment of EA victimisation (in descriptive studies)

and/or the assessment of other independent variables in relation to help-seeking, which was considered the outcome or dependent variable.

3.4.5. Results Extraction

Data were extracted based on the aims of the current study to identify the following: a) barriers to help-seeking behaviour among victims of EA; b) facilitators of help-seeking behaviour among victims of EA; c) sources of help-seeking; and d) responses of others to victims' help-seeking behaviour. Because of the lack of research in this area, any other variables highlighted by research as relevant to the understanding of help-seeking behaviour in this population were considered. Similarly, particular attention was paid to the methodology and sampling of the studies to identify trends and gaps that could inform future research. When the source presented findings for other topics without relating them to the focus of this review (e.g., the consequences of abuse; barriers regarding access to service from the perspective of professionals), only the results relevant to the review were extracted. Thematic analysis was conducted to inductively explore common themes across the studies organised by the four first areas of interest (Braun & Clarke, 2006). In addition, any other variables addressed by research in relation to help-seeking were synthesised. Results regarding the characteristics of victims who are more likely to seek help are presented separately as both the quality and quantity of these data did not warrant thematic analysis. Quantitative content analysis was used to ascertain frequencies of the specific group of barriers mentioned across studies (Elo & Kyngäs, 2008).

3.5. Results

3.5.1. Quality Assessment

The results of the quality assessment of quantitative and qualitative studies can be found in Tables 3.1 and 3.2, respectively. In general, quantitative studies adequately outlined a research question, population and selection of participants, and measurement of outcome and exposure variables. However, all studies failed to provide an adequate sample size justification

and two failed to report the participation rate. Overall, most qualitative studies included the different components assessed by the CASP tool. The most common aspect that studies failed to address was the relationship between the researcher and participants in both the formulation of research questions and the data collection process.

3.5.2. Overview of the Studies

An overview of the studies included in the review can be found in Table 3.3. Among the 19 sources included, 10 were qualitative (or mixed methodology) and nine were quantitative. Sample sizes (excluding non-victim participants) ranged from six (Chokkanathan et al., 2014) to 457 participants (Tamutiene et al., 2013). In most studies, information was obtained directly or indirectly from victims (n = 17). However, two studies included participants who were professionals reporting on their experience working with EA victims (Bows, 2018; Wydall & Zerk, 2017) and one of the studies with victim participants also included Adult Protective Services workers and third-party adults (Jackson & Hafemeister, 2015). Conceptualisations of abuse varied but most focused on abuse by a known and trusted person. However, four studies explicitly included, or did not exclude, stranger abuse (Acierno et al., 2020; Bows, 2018; Mowlam et al., 2007; Naughton et al., 2013). Many studies did not specify their conceptualisation of help-seeking, but those that did generally framed it as informal or formal disclosure to others, or taking action to change the situation or prevent the reoccurrence of the abuse. In some cases, help-seeking focused exclusively on reporting to the police or other authority (e.g., Acierno et al., 2020). In addition, a study focused on reporting or talking to somebody about the most serious incident of abuse (Tamutiene et al., 2013). Studies typically set an age cut-off of 60 or 65 years, with a cut-off of 66 years in O'Keeffe et al. (2007). Studies spanned 15 different countries (one study included data from five different countries; Tamutiene et al., 2013). The two most common countries were the UK (n = 4) and the United States (n = 3).

Table 3.1

Quality Assessment of Quantitative Studies

Reference	Research Question	Study Population	Participation Rate	Participants Selection	Sample Size	Exposure Variation	Exposure Measurement	Outcome Measurement	Confounds
Acierno et al. (2020)	Y	Y	Y	Y	N	NA	Y	Y	N
Amstadter et al. (2011)	Y	CD	Y	Y	N	NA	Y	Y	NA
Comijs et al. (1998)	Y	Y	Y	Y	N	NA	Y	N	NA
Gil et al. (2017)	Y	Y	Y	Y	N	NA	Y	Y	N
Markovik et al. (2014)	Y	Y	NR	CD	N	Y	CD	CD	NA
Naughton et al. (2013)	Y	Y	Y	Y	N	Y	Y	Y	CD
O'Keeffe et al. (2007)	Y	Y	Y	Y	N	NA	Y	Y	NA
Ribot et al. (2015)	Y	N	Y	Y	N	NA	N	N	NA
Tamutiene et al. (2013)	Y	Y	NR	Y	N	Y	Y	Y	N

Note. Y = yes; N = no; CD = cannot determine; NR = not reported; NA = not applicable.
Adapted from the NIH tool for cohort, observational, and cross-sectional studies (National Institutes of Health, 2016).

Table 3.2

Quality Assessment of Qualitative Studies and Mixed Methodology Studies

Reference	Research Aims	Qualitative Methodology	Study Design	Recruitment Strategy	Data Collection	Relationship Researcher Participants	Ethical Issues	Rigorous Data Analysis	Findings Clear Statement	Value of Research
Bows (2018)	Y	Y	Y	N	Y	N	Y	Y	Y	Y
Chokkanathan et al. (2014)	Y	Y	Y	N	Y	N	Y	Y	Y	Y
Jackson and Hafemeister (2015)	Y	Y	N	Y	Y	Y	Y	CT	Y	Y
Lafferty et al. (2013)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mowlam et al. (2007)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mysyuk et al. (2016)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Souto et al. (2015)	Y	Y	Y	N	Y	Y	Y	Y	Y	Y
Vrantsidis et al. (2016)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Wydall and Zerk (2017)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Yan (2015)	Y	Y	N	Y	Y	N	Y	Y	Y	Y

Note. Y = yes; N = no; CT = cannot tell.
Based on the Critical Appraisal Skills Program (CASP, 2018).

Table 3.3

Description of Reviewed Studies

Reference	Country	Sample	Help-Seeking Definition	Objective	Main Findings
Acierno et al. (2020)	United States	131 victims of financial and emotional abuse	Reporting to police or other authority.	To examine differences in reporting between known and stranger perpetrators.	*Barriers*: did not want perpetrator to get in trouble, did not want publicity, did not want others to know, afraid to look foolish, feared reprisal, did not know how to report.
Amstadter et al. (2011)	United States	254 victims of emotional, physical, and sexual abuse	Reporting to police or other authority.	To examine incident and perpetrator characteristics (including reporting) of EM.	Emotional mistreatment less likely to be reported than physical and sexual mistreatment.
Bows (2018)	UK	23 practitioners working with older survivors of sexual violence	Reporting, disclosing or accessing services.	To examine the impact of age in accessing support services.	*Barriers*: emotional challenges, physical impairments, sociocultural challenges, lack of awareness.
Chokkanathan et al. (2014)	India	Six victims of physical abuse by family members	Seeking both formal and informal sources of help.	To understand the barriers that prevent help-seeking.	*Barriers*: service-related, religious, family-related, perpetrators' threats, individual.
Comijs et al. (1998)	Netherlands	99 victims of verbal, physical or financial aggression	Taking action to prevent abuse reoccurrence.	To understand the reasons for and consequences of abuse.	*Sources of help*: 13.3% asked relatives/friends; 17.8% asked professionals. *Outcomes*: 28.8% actions successful (diminishing abuse); 46.6% abuse never happened again; 24.4% unsuccessful.
Gil et al. (2017)	Portugal	133 EA victims	Disclosing the incident to an official agency or talking about it with a known person.	To understand help-seeking behaviour rates, sources, and barriers to seeking help.	35.5% sought help (police forces, informal social network, other professionals). *Barriers*: incident too trivial, importance of family, fear of reprisal/being left alone/institutionalised, financial dependence on perpetrator, shame.

Reference	Country	Sample	Help-Seeking Definition	Objective	Main Findings
Jackson and Hafemeister (2015)	United States	71 APS workers, 55 victims of PFE, HFE, and neglect, 32 third-party adults	Reporting (formally to some authority).	To capture the circumstances under which EA is detected and reported; and the temporal relationship between both processes.	*Barriers:* long-standing victim-perpetrator relationship, social isolation, difficulty labelling behaviour as abuse, desire to protect perpetrator. *Facilitators*: lack of emotional attachment, feelings of betrayal, ongoing positive relationship with professional, fear for personal safety.
Lafferty et al. (2013)	Ireland	Nine EA victims	Help-seeking (unspecified).	To examine the support experiences of abused older people.	*Barriers:* unawareness of abuse or services, lack of confidence, embarrassment, frightened of others knowing, accessibility issues. *Sources:* variety of formal and informal sources.
Markovik et al. (2014)	Macedonia	307 EA victims	Reporting (unspecified).	To explore the phenomenon of EM.	Unreported in 77.3% of cases. Psychological abuse and neglect least likely to be reported.
Mowlam et al. (2007)	UK	36 EA victims + three relatives	Taking action.	To explore mechanisms and barriers to reporting.	*Barriers*: individual, understanding of role and remit of agencies, concern about consequences. *Facilitators*: fear for safety, encouragement from others.
Mysyuk et al. (2016)	Netherlands	17 EA victims	Informal and formal help-seeking.	To understand the perceptions and experiences of victims.	*Barriers*: hopelessness, self-blame, afraid of consequences, shame, perpetrator dependency. *Facilitators*: abuse reached unbearable point.
Naughton et al. (2013)	Ireland	120 EA victims	Disclosure to anybody.	To examine the relationship between EA awareness and help-seeking behaviour.	Awareness not associated with help-seeking Help sought in 45% of cases (family members, police, friend/neighbour, health professionals).
O'Keeffe et al. (2007)	UK	54 EA victims	Seeking help or advice from anyone.	To describe EM in the UK.	Action taken in 70% of cases (family member/friend, health professional, social worker, other professionals).

Reference	Country	Sample	Help-Seeking Definition	Objective	Main Findings
Ribot et al. (2015)	Cuba	88 EA victims	Help-seeking (unspecified).	To characterise victims' help-seeking behaviour.	*Barriers*: shame, fear of retaliation or worsening abuse, lack of knowledge about organisations. *Sources:* most often a relative.
Souto et al. (2015)	Brazil	11 female victims of psychological abuse by relatives	Attempts to change their current situation.	To understand psychological domestic violence.	*Barriers:* wanting to remain in their homes, protection of the perpetrator. *Sources:* family members, police, neighbours.
Tamutiene et al. (2013)	Austria, Belgium, Finland, Lithuania, Portugal	457 EA female victims	Talking about or reporting most serious incident.	To examine the determinants of help-seeking behaviour.	*Barriers:* incident too trivial, lack of trust in others' ability to help, not wanting to involve anybody, not wanting perpetrator to be imprisoned, feelings of shame/guilt, fear of not being believed/retaliation. *Facilitators:* higher intensity and density of abuse.
Vrantsidis et al. (2016)	Australia	28 EA victims	To generally act.	To understand the older person's experience of abuse.	*Barriers:* ambivalence, parental love and duty, concerns about the perpetrator. *Facilitators:* feeling supported, fear for their safety.
Wydall and Zerk (2017)	UK	50 practitioners	Accessing services.	To explore perceptions of barriers to help-seeking.	*Barriers:* socio-cultural, negative stereotypes about services, desire to remain in their communities.
Yan (2015)	China	40 EA victims	Disclosure to anybody.	To explore factors associated with help-seeking.	*Barriers:* culture, belief in fate, lack of knowledge about EA, lack of an effective support network. *Facilitators:* seriousness of abuse, fear for safety.

Note. EM = elder mistreatment; EA = elder abuse; APS = Adult Protective Services; PFE = Pure Financial Exploitation; HFE = Hybrid Financial Exploitation.

Many of the quantitative studies were descriptive, often part of a broader project that focused on prevalence and asked victims whether they had sought help, queried the sources of help, or asked about the reasons for not seeking help. A minority of the quantitative studies involved an analytic component and tried to identify the association between certain variables and help-seeking (e.g., Naughton et al., 2013). Qualitative studies usually aimed to understand the experience of EA from the perspective of already identified victims (or professionals working with victims), and the method was most often an in-depth interview.

Rates of help-seeking were reported in 10 studies. For abuse committed by a person known to the victim, help-seeking behaviour was engaged in by 11% (Acierno et al., 2020) to 70% (O'Keeffe et al., 2007) of identified victims. The variability in findings may be explained by the definition used for help-seeking since the former study conceptualised it as reporting to the police/other authorities, whereas the latter considered individuals who had "sought help or advice from anyone" about the abuse (p. 127). Rates of help-seeking also varied by the type of EA (Amstadter et al., 2011) and the country examined (Tamutiene et al., 2013).

3.5.3. Barriers to Help-Seeking

Barriers to help-seeking were reported in 14 studies, arising from either specific questions posed by the researchers, or as part of in-depth interviews regarding the victim's experience. There were difficulties in comparing barriers across studies (different sample sizes, some studies offering options a priori and some coding inductively). Hence, barriers are presented according to themes in the order in which they were most commonly mentioned in the studies analysed (i.e., a quantitative content analytic approach informs the prioritisation of presentation of inductive thematic analysis themes).

Fear of Consequences for Self or the Perpetrator. Fear of the consequences of seeking help—either for the victims themselves or the perpetrators— was reported in 12 out of the 19 studies. For example, victims were afraid of being institutionalised, of retaliation or

worsening of the abuse, and of becoming abandoned, isolated, or ostracised by their communities (Acierno et al., 2020; Chokkanathan et al., 2014; Gil et al., 2017; Mowlam et al., 2007; Mysyuk et al., 2016; Ribot et al., 2015; Tamutiene et al., 2013). Despite the fear of retaliation, only Chokkanathan et al. (2014) reported specific threats made by the perpetrator to prevent victims from disclosing the abuse. In addition, victims mentioned the fear of harming the perpetrator or losing or worsening their relationship with them; this was sometimes paired with a desire to protect and help the perpetrator (Acierno et al., 2020; Chokkanathan et al., 2014; Jackson & Hafemeister, 2015; Mowlam et al., 2007; Mysyuk et al., 2016; Souto et al., 2015; Tamutiene et al., 2013; Vrantsidis et al., 2016). Other fears included "making a fuss" (Mowlam et al., 2007, p. 35), being blamed, a general fear of authorities, and the fear of others knowing what was happening to them (Acierno et al., 2020; Lafferty et al., 2013: Yan, 2015).

Individual Feelings and External Circumstances. Several of the barriers mentioned were internal (e.g., emotions) and external circumstances that were perceived to make help-seeking more difficult (*n* = 11). Victims mentioned shame and embarrassment, self-blame, low self-confidence and self-esteem, physical frailty, socioeconomic dependency, the stigma associated with seeking help, and feelings of ambivalence (Acierno et al., 2020; Bows, 2018; Chokkanathan et al., 2014; Gil et al., 2017; Lafferty et al., 2013; Mowlam et al., 2007; Mysyuk et al., 2016; Ribot et al., 2015; Tamutiene et al., 2013; Vrantsidis et al., 2016). Some victims also alluded to anxiety and mentioned bereavement as a barrier to action (Bows, 2018; Mowlam et al., 2007). Other barriers included feelings of helplessness and that the abuse was beyond their control (Mysyuk et al., 2016; Yan, 2015).

Knowledge About Services and Their Adequacy. A common barrier (*n* = 10) was the lack of knowledge regarding where to seek help (Acierno et al., 2020; Bows, 2018; Chokkanathan et al., 2014; Gil et al., 2017; Lafferty et al., 2013; Mowlam et al., 2007; Ribot et al., 2015; Yan, 2015). Victims also reported doubts about the capacity of services to help

them and a lack of trust in professionals, as well as service inadequacy, and accessibility barriers (Bows, 2018; Chokkanathan et al., 2014; Lafferty et al., 2013; Mowlam et al., 2007; Tamutiene et al., 2013; Wydall & Zerk, 2017).

Family Barriers. Family was another theme across studies (n = 8), especially in the context of abuse perpetrated by relatives. Victims associated seeking help with negative consequences for their family and placed emphasis on their relationship with the perpetrator and other relatives. In addition, some victims alluded to the perpetrators' dependency on them and, in the case of adult-child perpetrators, their parental duty (Chokkanathan et al., 2014; Gil et al., 2017; Jackson & Hafemeister, 2015; Mowlam et al., 2007; Mysyuk et al., 2016; Vrantsidis et al., 2016; Wydall & Zerk, 2017; Yan, 2015).

Characteristics of Social Networks. Characteristics of social networks, across family and community, were identified in six studies. Victims reported a general lack of effective social support, isolation, and in some instances that their only relationship was with the perpetrator (Chokkanathan et al., 2014; Jackson & Hafemeister, 2015; Yan, 2015). Victims also anticipated denunciation by their communities and disbelief by others if they disclosed the abuse, and some believed that people they knew could not help them (Chokkanathan et al., 2014; Mysyuk et al., 2016; Tamutiene et al., 2013; Wydall & Zerk, 2017; Yan, 2015).

Perception of Abuse. Although infrequently mentioned (n = 5), the perception of the abuse (or lack thereof) was understood as a barrier. There was a lack of awareness among victims that abuse was occurring, difficulties labelling abusive behaviour as abuse, and the perception that the abuse was not serious enough to disclose (Gil et al., 2017; Jackson & Hafemeister, 2015; Lafferty et al., 2013; Mowlam et al., 2007; Tamutiene et al., 2013). In contrast to this, Naughton et al. (2013) found that awareness of the term *elder abuse* was not associated with disclosure.

Cultural, Generational, or Religious. Cultural, generational, or religious beliefs influenced disclosure, and a desire to remain in their homes and communities, and maintain privacy, was reported (*n* = 5; Bows, 2018; Chokkanathan et al., 2014; Souto et al., 2015; Wydall & Zerk, 2017; Yan, 2015). In addition, Vrantsidis et al. (2016) reported, in their study in Australia, that a sense of parental obligation was particularly strong among participants from Culturally and Linguistically Diverse backgrounds.

Characteristics Associated With Increased Barriers to Help-Seeking. Findings indicate that emotional/psychological abuse and neglect might be the least reported types of EA (Amstadter et al., 2011; Markovik et al., 2014; Naughton et al., 2013). Specific barriers may arise when seeking help for abuse perpetrated by close family members (e.g., adult children, grandchildren, spouses/partners), as help-seeking was less common for this abuse compared to that perpetrated by other relatives, a neighbour, or by a paid home help/caregiver (Gil et al., 2017; Tamutiene et al., 2013). Barriers to reporting also differed by perpetrator identity where "not wanting to get the perpetrator in trouble" (p. 223) was a more common barrier against reporting family, friends, and acquaintances compared to strangers (Acierno et al., 2020). Delay in reporting increased when the perpetrator was a close family member (Mysyuk et al., 2016). This was in agreement with the finding of Jackson and Hafemeister (2015) that the time between detection or awareness of the abuse and reporting to authorities depends on the nature and quality of the relationship between the victim and perpetrator. Finally, in most cases of poly-victimisation victims cited a lack of information (98%) or shame (94%) as barriers in reporting (Gil et al., 2017), suggesting a difference in the barriers present in cases where multiple types of abuse are co-occurring.

3.5.4. Facilitators of Help-Seeking

In contrast with the research attention devoted to barriers, facilitators of help-seeking were reported in only six of the studies reviewed. Facilitators included having a good network

(both formally and informally), a lack of emotional attachment to the perpetrator, and a feeling of betrayal by a trusted person (Jackson & Hafemeister, 2015; Mowlam et al., 2007; Vrantsidis et al., 2016). Most commonly, however, studies addressed the circumstances that led victims to seek help. Victims sought help when they perceived the abusive situation was critical in terms of intensity, seriousness, or frequency, when there had been a recent escalation, and/or when they feared for their immediate personal safety or that of the perpetrator (Jackson & Hafemeister, 2015; Mowlam et al., 2007; Mysyuk et al., 2016; Tamutiene et al., 2013; Vrantsidis et al., 2016; Yan, 2015).

Characteristics Associated With Increased Help-Seeking Behaviour. Help-seeking was facilitated by several abuse characteristics. For example, the victims of a study in the Netherlands stated that financial abuse was easier to talk about because it is more publicly discussed and experienced by others, making it less shameful to seek help (Mysyuk et al., 2016). This is consistent with the findings of Acierno et al. (2020), who compared perpetrator identity (family/friends/acquaintances vs. strangers) with reporting rates to authorities and found that financial abuse (but not emotional abuse) was more likely to be reported if perpetrated by a stranger. In connection to the impact of abuse, Tamutiene et al. (2013) found that several of the consequences of EA (anger, depression, tension, sleeping difficulties, concentration difficulties, difficulties in relation with others) correlated positively with seeking help. However, the type of analysis used does not allow inference of causality.

3.5.5. Sources of Help-Seeking

The sources from which victims sought help were addressed in some detail in 10 studies. Victims sought help from a variety of formal and informal services. Formal sources of help included health professionals (general practice, community nurses), specialised services (centres for domestic violence, specialist support groups), social workers, legal professionals (solicitors, prosecutors), the police, voluntary services, and local councils (Comijs et al., 1998;

Gil et al., 2017; Lafferty et al., 2013; Mysyuk et al., 2016; Naughton et al., 2013; O'Keeffe et al., 2007; Souto et al., 2015; Yan, 2015). Informal sources of help included relatives, friends, and neighbours (Comijs et al., 1998; Lafferty et al., 2013; Mysyuk et al., 2016; Naughton et al., 2013; O'Keeffe et al., 2007; Ribot et al., 2015; Souto et al., 2015).

In terms of preference for informal or formal sources, Naughton et al. (2013) and Tamutiene et al. (2013) found that victims favoured contacting informal sources, though there were variations in preferences between countries in the latter study. Other studies did not identify differences; however, Mysyuk et al. (2016) stated that informal help was sought when victims experienced psychological abuse and neglect and when perpetrators were family members, and formal help was sought in poly-victimisation cases. In terms of specific sources of professional help, seeking help from the police was identified as a "last resort" for perceived experience of serious abuse (both Souto et al., 2015, p. 48; and Yan, 2015, p. 2700). Results from other studies indicated that each victim often seeks help from different sources (Mowlam et al., 2007; Vrantsidis et al., 2016). When victims did not seek help from external sources, some stated that they dealt with the abuse themselves (Gil et al., 2017; Mysyuk et al., 2016; Tamutiene et al., 2013). For victims who sought help, Mysyuk et al. (2016) reported that they had endured abuse for a period ranging from a couple of weeks to six or seven months.

3.5.6. Responses to Help-Seeking

Like facilitators, the responses of others to victims' help-seeking received less attention. Responses to help-seeking were only reported in six studies and reflected mostly the degree of success in stopping the abuse or improving the victim's situation; there was little reported on the specific responses that victims obtained from third parties. Some victims were successful in seeking help, but others' attempts were unsuccessful or had mixed results (Comijs et al., 1998; Naughton et al., 2013; Souto et al., 2015). In one study, victims highlighted that the responses of others helped them to realise that abuse was taking place, and informal sources

were mentioned as a bridge to formal resources (Lafferty et al., 2013). A positive response was obtained from both family and statutory services by most victims, and some victims found reporting helpful (Lafferty et al., 2013; Tamutiene et al., 2013). Other responses to victims were rather negative—for example, when frontline workers were unaware of how to help victims, or when neighbours were aware but did not want to be involved—and this lack of success resulted in feelings of hopelessness (Souto et al., 2015; Yan, 2015). This finding is of critical importance given that other studies have found that several attempts to report or seek help may be required before victims receive help or decide to pursue the help that is offered (Mowlam et al., 2007; Vrantsidis et al., 2016).

3.5.7. Victim Characteristics

There was a limited number of studies that attempted to identify which victims were more likely to seek help (*n* = 4). Among these, victims with poor mental health-related quality of life, those in the younger (60-69 years) and older (80+ years) age groups, and those who were separated or divorced were most likely to seek help (Gil et al., 2017; Naughton et al., 2013). However, Tamutiene et al. (2013) found no significant differences in relation to several demographic characteristics (age, marital status, education, income, or subjective evaluation of health status or quality of life). Finally, Amstadter et al. (2011) reported that women were more likely to report emotional and physical abuse than men, whereas the latter were more likely to report sexual abuse, although no statistical analyses were provided.

3.6. Discussion

This systematic review aimed to synthesise the available research knowledge relating to EA victims' help-seeking behaviour. The results indicated that EA victims faced barriers to help-seeking across multiple levels (internal, external, socio-cultural, systemic) and sought help out of fear for their personal safety or because social networks facilitated the help-seeking process (e.g., Mowlam et al., 2007; Yan, 2015). Victims disclosed abuse experiences to formal

and informal sources and received both helpful and unhelpful responses (Lafferty et al., 2013; Souto et al., 2015; Yan, 2015). Similarly, they perceived and experienced both positive and negative outcomes from their help-seeking efforts (Comijs et al., 1998). Psychological abuse, neglect, and any type of abuse perpetrated by family members were particularly difficult to report (Acierno et al., 2020; Naughton et al., 2013). There were victims who decided not to seek help, with percentages ranging from 30% to 89% (Acierno et al., 2020; O'Keeffe et al., 2007). When victims did choose to seek help, this was not always immediate, and they sometimes required several attempts to pursue any help offered (Mowlam et al., 2007). This description of the nature of help-seeking is consistent with the idea that disclosure is not a discrete process (Truong et al., 2019).

In the following paragraphs, the findings of this systematic review are discussed and integrated with theories presented in Chapter 1 of this thesis, as well as with other findings in the literature related to help-seeking in EA that are not part of this review because they did not fulfil the criteria (e.g., they were conducted with non-victim population). Where relevant, the findings of Study 1 and the implications are linked with further literature published since the database searches for this systematic review were conducted (5 July 2018). However, since no systematic search was conducted after the original searches, the discussion of further research may not be exhaustive. Following this initial discussion, implications for practice, policy, and further research are outlined.

3.6.1. Theoretical Implications

Several findings in this study can be integrated with the theories described in Chapter 1 of this thesis, as well as with other research on help-seeking that was not included in the current study. In terms of theories, findings relate to the Theory of Planned Behaviour (TPB) (Ajzen, 1985), Andersen's Behavioral Model of Health Services Use (Andersen, 1968), and the Ecological Systems Theory (Bronfenbrenner, 1979).

The barrier themes identified in this systematic review can be integrated in several of the components of the TPB. According to the TPB, an important determinant of help-seeking behaviour in EA is subjective norms, an individual’s perceptions of social approval or disapproval for seeking help (Ajzen, 1985). In studies looking at the influence of culture on help-seeking, researchers have pointed to the need to address the stigma of help-seeking because of cultural norms regarding seeking help or experiencing abuse in some communities. For example, in Lee et al. (2014) participants—Chinese and Korean immigrants in the United States— believed that “expressing needs for support or complaining about adversity was seen as a weakness and a source of disharmony” (p. 259), and they reported that this belief made it particularly difficult to seek help. Outside of the study of culture, the stigma associated to seeking help may also vary by gender, with previous literature indicating that older males have been raised to attach stigma to the process of seeking help and likely to have grown up in a time of perceived male strength, which could make engaging in this process more difficult (Barber, 2008; Kaye et al., 2007).

In the context of the studies reviewed, some of the groups of barriers identified, as well as specific barriers within these groups, fit within the “subjective norm” component of the TPB (Ajzen, 1985), such as barriers related to social networks and family, and those that are generational, cultural, or religious. In terms of social networks, sometimes victims anticipated denunciation by their communities (Mysyuk et al., 2016) if they disclosed abuse. Some of the victims’ perceptions of social approval for seeking help were determined by generational factors, such as norms regarding disclosure, or religious factors, which also featured in some of the studies (Bows, 2018; Chokkanathan et al., 2014; Yan, 2015). Another factor that could determine an individual’s perception of behaviour can be the beliefs regarding family and the characteristics associated with it, which play a particular role in EA perpetrated by family members. Victims sometimes placed special emphasis on their relationship with the perpetrator

and other family members and made reference to their parental duty, which may be more emphasised in those from Culturally and Linguistically Diverse backgrounds in Australia (Chokkanathan et al., 2014; Jackson & Hafemeister, 2015; Vrantsidis et al., 2016; Yan, 2015).

Another TPB component is “attitudes”, which are an individual’s positive or negative evaluation of performing the behaviour and result partly from the perceptions of the likely consequences of performing said behaviour (Ajzen, 1985). In the case of help-seeking in the studies reviewed, there was evidence that some EA victims did not seek help out of fear of what could happen if they did (e.g., negative consequences for themselves, such as being institutionalised, or for the perpetrator, such as them getting in trouble). The theme of fear is consistent with barriers to informal disclosure in intimate partner violence victims, who also feared the reactions of sources of disclosure (Sylaska & Edwards, 2014).

Some other barriers, such as those related to the characteristics of formal services available to the victims, their social networks, and the victim’s perception of these systems, are also related to the theories reviewed in Chapter 1 of this thesis. Specifically, they are likely to affect help-seeking behaviour through “perceived behavioural control” (Ajzen, 1985) or as enabling factors (Andersen, 1968). In this regard, as evidenced by one of the specific barriers in this systematic review, victims lacked knowledge regarding where to seek help. Victims also reported doubts about the capacity of services to help them, lacked trust in professionals, or thought that the services were inadequate or too difficult to access (Acierno et al., 2020; Bows, 2018; Chokkanathan et al., 2014; Gil et al., 2017; Lafferty et al., 2013; Mowlam et al., 2007; Ribot et al., 2015; Tamutiene et al., 2013; Wydall & Zerk, 2017; Yan, 2015). Outside of the studies reviewed, it is worth mentioning that other research highlights that, in certain minority populations, distrust in the system and in authorities can be major barriers to seeking and obtaining help (Paranjape et al., 2007). Regarding social networks, victims were isolated, lacked effective support, or thought that others could not help, or else were limited by the

perpetrator being their only significant relationship (Chokkanathan et al, 2014; Jackson & Hafemeister, 2015; Yan, 2015). Finally, victims' "perceived behavioural control" (Ajzen, 1985) may also be affected by feelings of low self-confidence, helplessness, low self-esteem, physical frailty, socioeconomic dependency, anxiety, or feelings that the abuse is beyond the victim's control (Acierno et al., 2020; Mowlam et al., 2007; Mysyuk et al., 2016).

The general barriers and facilitators identified can also be understood utilising the Ecological Systems Theory (Bronfenbrenner, 1979). Some of the barriers highlighted in the previous paragraphs occur in the micro-system, such as victim's feelings regarding help-seeking, their perception of the abuse, or their relationships with their immediate network (e.g., the perpetrator, their social support). There are also barriers within the meso-system; for example, those related to formal services responsible for the victim's care and wellbeing; and exo-system, for example, victims who were affected by the lack of accessible services for EA in their country. Further research conducted by Adib et al. (2019) also identified barriers that fit into the victim's micro-system (e.g., personal attitude towards the abuse, dependence on others) and the exo-system (e.g., inefficiency of social and legal support systems). In general, the identification of barriers at different levels (e.g., victim, family, community, cultural and societal attitudes) is consistent with research on disclosure in other types of interpersonal violence (e.g., child sexual abuse, Alaggia, 2010; Alaggia et al., 2019; Sorsoli et al., 2008).

Another aspect in one of the theories reviewed was predisposing factors (Andersen, 1968) or an older person's characteristics that may make it more likely for the victim to seek help. This study found that there was little knowledge about predisposing factors in the studies reviewed. The few findings included in this review were mixed (Gil et al., 2017; Naughton et al., 2013; Tamutiene et al., 2013). Some of the characteristics associated with victims' help-seeking in this review were poor mental health-related quality of life, younger (60-69 years) and older (>80 years) age groups and being separated or divorced. However, further research

has been conducted recently by Burnes, Acierno, and Hernandez-Tejada (2019) looking at the factors that predicted victims' help-seeking. They found that victims' help-seeking in their sample was more common when the victims were experiencing physical abuse or poly-victimisation, and when the perpetrator had prior police trouble. This is consistent with the review findings that victims sought help when the situation became more serious or when they feared for their safety (Mowlam et al., 2007; Tamutiene et al., 2013; Yan, 2015). On the other hand, help-seeking was less likely when the victim was dependent on the perpetrator and when the perpetrator had a large friendship network (Burnes, Acierno, & Hernandez-Tejada, 2019).

3.6.2. Implications for Practice and Policy

The reviewed research has implications for practitioners and policymakers. Awareness of EA could be improved among older adults, professionals, and the general population. Despite efforts to raise awareness through campaigns (Naughton et al., 2013), some victims remained uninformed of what EA is and lacked knowledge about the services they could access. Awareness campaigns that rely on the attendance of older adults in community centres and similar settings might miss those most at risk because of isolation or physical problems preventing them from attending. These campaigns should employ methods most likely to reach and resonate with older adults (Krug et al., 2002). There should be a continued effort to extend the information about EA to the general population, because victims seek help from informal sources and might do so before contacting formal services (Lafferty et al., 2013). A good example of a wide-reaching way of increasing awareness is the Friends Against Scams initiative by the National Trading Standards Scams Team (Baxter et al., 2017), which provides information about protection from scams and encourages recipients to share this knowledge with others within their communities and social networks. The effectiveness of this type of initiative could be tested in the context of awareness for abuse perpetrated by persons known to the victim.

Awareness among professional services could also be enhanced to ensure that, should victims disclose abuse, they are responded to in a helpful and positive manner that facilitates further help-seeking behaviour. Findings revealed that good social support networks and positive relationships with professionals were facilitators of help-seeking, and that a lack of trust in professionals and the impression that help was inadequate were barriers to help-seeking (Jackson & Hafemeister, 2015; Yan, 2015). To assist professionals, who are often overburdened, training should be provided on how to adequately support and refer victims and they should be directed to pay increased attention to cases where the older person lacks social support (Jackson & Hafemeister, 2015). Increased training and available solutions should help in creating spaces where victims are more likely to disclose concerns and where professionals feel supported to respond.

Professionals who suspect EA need to be ready to explore the many barriers that victims may face, particularly victims' fears regarding the consequences of disclosure and their attitudes toward services. Although some of the barriers will be more difficult to address and modify positively (e.g., fear of a negative reaction by the perpetrator or the community), others (e.g., lack of knowledge about services) are more likely to be altered positively. One method to achieve professional awareness is through the use of a barriers checklist in their work with older people, proposed by Chokkanathan et al. (2014) with the aim of ensuring continued service engagement. For example, a question from Chokkanathan et al.'s checklist relating to services would be "What is the older adult's awareness level of the services?" (p.74). This type of checklist could also inform mandatory reporting training for professionals (where appropriate, given legal requirements), so that not only are risk factors for abuse and the detection of abuse emphasised but also knowledge regarding the reasons why, or the situations in which, victims might attempt to hide the abuse.

Policies should aim to create environments where victims feel safe to disclose abuse without fear of consequences. This could be achieved by implementing victim-centred interventions based on an assessment of the clients' needs and wishes, including the exploration and limiting of interventions that a victim perceives as negative to encourage engagement with services. This is the course of action of services like the Elder Abuse Resource and Support Team in Canada, where the older person's wishes are a priority during the assessment and management of cases (Storey & Perka, 2018). For example, victims might not seek help if doing so will lead to moving away from their communities and becoming isolated or if they perceive the outcome of intervention to be worse than the abuse they are enduring (Enguidanos et al., 2014; Wydall & Zerk, 2017). Special attention should be paid to cases in which the perpetrator is a descendant of the victim, as the review findings suggest that these are complex cases in which victims might want to protect and help the perpetrators because of parental duty or general feelings of responsibility (Vrantsidis et al., 2016). In these circumstances, interventions need to be negotiated with the older person and victims need to be aware that seeking help will not automatically result in harm to them, the perpetrator, or their families (Wydall & Zerk, 2017). To achieve this, appropriate resources must be provided, such as affordable housing and interventions not only for the victim but also for the perpetrator where there may be mental health or substance abuse problems (Fraga Domínguez et al., 2020; Labrum & Solomon, 2018; Vrantsidis et al., 2016).

3.6.3. Research Implications

This systematic review has identified several gaps in the research with EA victims' help-seeking behaviours. First, there is a need to better understand some areas of help-seeking, such as facilitators and characteristics associated with help-seeking, as well as the experiences of victims who seek help and the responses they obtain from informal and formal sources of disclosure. The lack of information about facilitators in the studies reviewed was likely due to

an emphasis on the barriers that EA victims face when disclosing the abuse; however, it poses challenges to prevention and intervention efforts. The few studies that searched for and identified facilitators were often describing the circumstances that led victims to seeking help or that prompted the decision to seek help. Worryingly, some EA victims only sought help when the abuse was perceived as unbearable or they feared for their safety (Yan, 2015). More research is needed to understand reasons why victims seek help and how victims can be supported to disclose earlier. Even if an informal disclosure does not lead to a formal disclosure, victims may be able to consider the options available to them and feel supported as a result of talking about their experience with someone else (Truong et al., 2019; Vrantsidis et al., 2016). Delayed disclosure is not uncommon in interpersonal violence. However, the longer the victim waits to report, the more abuse they will have to endure, and the more severe the consequences will be. Similarly, the intervention required by both the victim and the perpetrator will need to be more resource intensive. Early intervention is likely to be the least costly, not only in terms of victims' health but also financially, given the associated medical costs of EA (Rosen et al., 2019).

Importantly, further research needs to be based on the voices of victims and should explore situations that could have facilitated earlier help-seeking. Future research should attempt to differentiate between facilitators to help-seeking (e.g., factors or mechanisms that enable or make help-seeking easier, such as adequate informal or formal support) and the circumstances or events that prompt help-seeking (e.g., escalation or fear for safety). Although these are frequently presented together in other fields of research (e.g., child sexual abuse disclosure; Winters et al., 2020), it would be more helpful to differentiate them as much as possible. This would provide a further understanding of unique facilitators, which may be more susceptible to positive modification (e.g., increasing social or professional support).

Another area with fewer research findings was victim characteristics associated to help-seeking. More research is needed to understand which victims are more and less likely to seek help and across abuse types so that interventions can be targeted accordingly (Sylaska & Edwards, 2014). This information can also be used to inform awareness campaigns, which can then be targeted more intensely at the groups least likely to disclose. Since this systematic review was conducted, research by Burnes, Acierno, and Hernandez-Tejada (2019) in the United States has provided some information about victims most likely to seek help (e.g., those suffering physical abuse or poly-victimisation); however, further research in a variety of countries is still a priority.

Another gap was the lack of information regarding responses to victim's informal disclosure or reporting. This is unfortunate, given that help-seeking behaviour is not a straightforward process and it has been found that sometimes satisfaction with outcomes is only achieved after various forms of action are taken (Mowlam et al., 2017; Vrantsidis et al., 2016). It may also be the case that some victims will not be ready at first to accept help or to report to formal services, but may feel ready at a later point, and the initial reactions they receive from others may influence further help-seeking behaviour. Thus, informal responses the older person receives from family, or reactions from any other sources, need to be investigated. Consistent with the TPB (Ajzen, 1985), feedback obtained after performing a behaviour (i.e., seeking help) will impact a person's intention to seek help again. Just as a negative response can have devastating consequences, a positively perceived reaction can be highly beneficial for victims of abuse (Truong et al., 2019).

There is also a need to investigate barriers and facilitators to help-seeking in relation to case characteristics (relating to the victim, victim-perpetrator relationship, and the abuse). One of the findings of this systematic review is that the barriers and facilitators to help-seeking published throughout the literature have been rarely studied in relation to victim, abuse, and

victim-perpetrator relationship characteristics. The scope of studies, particularly due to small sample sizes, has precluded the testing of barriers in relation to other case characteristics, and many studies did not address facilitators. An understanding of which barriers are more likely to occur and in which abuse cases—e.g., depending on victim characteristics, abuse type(s), and also on the relationship between victim or perpetrator—could inform prevention strategies. This more specific knowledge could also help professionals who have frequent contact with an older population at risk of abuse, to understand which barriers they may be facing depending on their client's background and personal circumstances, and how to better interact with victims to promote engagement (Truong et al., 2019). For example, for the purposes of targeting interventions, it is important for practitioners to know what barriers a victim might experience depending on the abuse they suffered or if the perpetrator is a family member as opposed to a professional. An exception in the systematic review was Acierno et al. (2020), which addressed relationship type and identified that there were different barriers associated to abuse perpetrated by a family member versus a stranger. However, most EA definitions do not include abuse perpetrated by a stranger, so it would be helpful to understand barriers associated to family vs non-family member perpetrators who are not strangers, such as friends, acquaintances, or professionals.

Although a variety of barriers were reported at different levels, fear of consequences of seeking help was the most consistently reported across studies (12 out of 14 studies mentioning barriers). Consistent with the TPB (Ajzen, 1985), a person's expectation of the likely consequences of performing a behaviour (seeking help) has an effect on the person's intention to perform that behaviour. In the studies reviewed, negative expectations of what would happen (e.g., institutionalisation, isolation, retaliation) made victims fearful of seeking help and impeded help-seeking. The findings are consistent with the research highlighted in Chapter 1 about the importance of understanding victims' views of intervention and expected outcomes

of help-seeking. More research on this area is needed focusing on what victims would want to get out of intervention, and not only what they would like to avoid.

Finally, because of the characteristics of the studies involving victims, these studies have not generally involved victims who have cognitive limitations or may lack capacity, largely due to the ethical concerns of doing so (Dalley et al., 2017). Thus, most of the results do not reflect an understanding of help-seeking behaviour in cases where the victim may suffer from dementia or other cognitive limitations. These cognitive impairments may not always prevent a victim from disclosing abuse, but may be a barrier in others' believing them, or may be used by perpetrators to attack the victim's credibility (Walsh et al., 2010). In some cases, the victim may express what has happened through behavioural cues of distress instead of disclosure (Burgess & Phillips, 2006). Thus, more research on the experience of help-seeking in cases of dementia is necessary to advance the field.

3.7. Limitations and Strengths

The current study is limited by the inclusion criteria, which may have resulted in excluding relevant data on older adults' help-seeking that were not presented separately for victims from non-victims. However, these criteria were necessary to provide a synthesis of the behaviours of victimised older adults alone. Although the goal was to be comprehensive, help-seeking could have been addressed indirectly in some studies that were eliminated. Citation searches and the review of reference lists were undertaken to limit the possibility of failing to include relevant studies. The inclusion of studies from different countries means that the illegality of EA and the availability of services is bound to vary, and this is likely to affect victims' views regarding seeking help. Similar to the field of intimate partner violence, the studies reviewed are limited by their reliance on cross-sectional designs and self-report (Sylaska & Edwards, 2014), and the purposive sampling of several of the studies included limits their generalisability.

Another limitation of the studies reviewed was the generally small sample sizes. Although the samples ranged from six to 457 EA victims, there were more studies on the smaller side of the spectrum (i.e., 13 of the 19 studies had sample sizes smaller than 100). This made it more difficult to answer several research questions of the study in detail, as the data were simply not available in the studies. However, several of the studies reviewed were part of national prevalence studies. Thus, even though the subsamples that they used for the publications in order to report on help-seeking may not be as large, the original study sample was a random sample of the population of a specific country. Hence, the generalisability of those samples is likely to be adequate. Finally, due to the different types of methods used in studies, there were issues related to the synthesis of the data. For example, some studies enquired about barriers directly, by asking participants to choose if they had experienced any barriers from a specific list, while others extracted those barriers from interviews with older adults. This made it difficult to ascertain which barriers were relatively more frequent or important in studies. There are also limitations in the sample selection of the included studies in terms of their ability to represent diverse populations. For example, two included only female victims and seven specific types of abuse (e.g., physical, emotional). However, most studies were inclusive of all the types of abuse commonly considered in the field of EA and included female and male participants.

A strength of this review is the geographic variation of studies, gathering data from 15 countries and five continents, which is unusual considering the general location bias in EA research, with studies primarily conducted in the United States or Western countries in general (Daly et al., 2011; Storey, 2020). This allows us to see that commonalities exist in terms of victims' help-seeking behaviour in different countries and cultures and also in people with different religious beliefs. Study samples were typically varied in terms of age, gender, race/ethnicity, and socioeconomic status, but generally, people who experienced cognitive

difficulties were excluded from sampling and this reduced the understanding of help-seeking in this population. This exclusion is important because cognitive limitations are factors that make older adults vulnerable to abuse (Johannesen & LoGiudice, 2013; Pillemer et al., 2016; Storey, 2020). Finally, most studies focused on community-dwelling older adults, and thus, the findings may not be applicable to adults suffering abuse while in residential facilities. However, abuse happens in these facilities (Yon et al., 2018), and there may be specific issues that affect victims trying to seek help in these settings, which should be the focus of future research.

3.8. Conclusions

The current study is, to the author's knowledge, the first systematic review conducted focusing on literature specifically relating to EA victims' help-seeking behaviour. The final studies reviewed include findings from different countries and continents, with different sampling and ways of researching help-seeking. The findings presented in the study can contribute to existing theories on help-seeking and have important implications for practitioners and researchers. The findings have been integrated with theories of help-seeking and related to existing conceptualisations of the process of help-seeking. These considerations are further explored in the following chapters of the thesis. For practitioners, the synthesis of knowledge about barriers to help-seeking can help in their interactions and conversations with potential victims. Further, the evidence that negative responses to disclosure can lead to victims' hopelessness should be emphasised in professional's training. Finally, for researchers, this study carefully presented the gaps of the studies reviewed and outlined several areas that need further attention. Importantly, these gaps were considered in the design and implementation of the two subsequent studies presented in this thesis.

CHAPTER 4- VICTIMS' HELP-SEEKING

4.1. Introduction

This chapter discusses findings from Studies 2 and 3 of this thesis. These studies were informed both by the general literature on help-seeking by victims, and by the results of the systematic literature review focused on victims' help-seeking behaviour (Study 1). A review of the general literature identified that findings regarding victims' help-seeking behaviour were difficult to identify and synthesise. Based on this identification, Study 1 focused on victims and found that facilitators to help-seeking, responses obtained when seeking help, and characteristics of those victims more likely to seek help, had received limited attention. While barriers had received detailed attention, due to the generally small sample sizes of those studies, these had not been examined in relation to characteristics relating to the abuse suffered, the victim, and the victim-perpetrator relationship, hence limiting the research and practical implications. As another limitation, the studies synthesised did not generally focus on victims with cognitive limitations or those in long-term care placements (i.e., care homes or nursing homes).

Based on these literature findings, the aims of Studies 2 and 3 were to address some of these limitations and examine victims' help-seeking behaviour further. The extent to which the findings from Study 1 about barriers to and facilitators of help-seeking could be applied to the victims in Study 2 were explored, and which barriers and facilitators were most frequent. Other aims were to examine barriers and facilitators in relation to case characteristics, to study predictors of disclosure, and to gather data about victims' attitudes towards intervention. In Study 3, the aim was to examine some areas that could not be explored in detail in Study 2, such as the specific responses victims obtained when they disclose abuse, their satisfaction with the external help received, and their attitudes and wishes regarding third-party

intervention, including outcomes for the perpetrator. Both studies also focused on concerned persons' perspectives and experiences; these findings are discussed in Chapter 5.

4.2. Literature Review

Research relating to help-seeking and reporting in EA has been limited by a focus on professional reporting and, where applicable, on mandatory reporting policies (Bergeron & Gray, 2003; Kohn, 2012). This research has dealt mostly with challenges around detection and barriers to reporting that professionals may experience, leading to the development of many detection tools that place the onus on the professional, rather than on the victim (Gallione et al., 2017; Spencer, 2009), thus assuming that the victim cannot or will not report. Research conducted from the perspective of non-professionals has frequently employed samples of (older) people from the general population using a vignette methodology and asking participants to report their behaviour in a hypothetical situation (e.g., Pickering & Rempusheski, 2014).

This thesis' literature review has outlined the limitations of the vignette methodology approach. Importantly, the use of the non-victim population, while justified due to the difficulties of conducting research with vulnerable populations, limits the generalisability of the findings to victims of EA (Gibson, 2013). The literature review chapter also specified that there is research conducted with EA victims as participants. However, the systematic review (Study 1) identified that available research on help-seeking behaviour from the perspective of victims is limited by the focus on barriers. In addition, the generally small sample sizes (up to 457 victim-participants among the studies included in the systematic review) challenged the analysis of victim characteristics, victim-perpetrator relationship, and abuse characteristics in relation to variables related to help-seeking, which were infrequent. There was also limited knowledge about predictors of help-seeking, i.e., which victims are more likely to disclose

abuse. Even though some recent literature has been published (e.g., Burnes, Acierno, & Hernandez-Tejada, 2019), research of this kind with a primary focus in the UK is still lacking.

4.3. Research Questions

Based on the research gaps identified, the studies presented in this chapter aim to improve the understanding of help-seeking by victims, primarily in a UK context, but also in other countries in Study 3 (the United States, Canada, and Australia). Specifically, these studies focused on barriers, facilitators, sources of help, responses received when seeking help, the characteristics of victims who seek help from a helpline, predictors of victims' informal and formal disclosure, and victims' attitudes towards and experiences with third-party intervention.

In both these studies, those who have allegedly suffered EA will be referred to as "victims" and those have allegedly perpetrated EA will be referred to as "perpetrators".

The research questions and sub-questions these studies aimed to answer were:

1. What are the characteristics of help-seeking from the perspective of EA victims?
    a. What are the barriers victims face when seeking help?
        i. Are there any barriers caused by the perpetrator's behaviour?
    b. What are the facilitators (e.g., social support) that enable help-seeking and/or the circumstances (e.g., escalation) that prompt a decision to seek help?
    c. To whom do victims disclose the abuse?
        i. Do victims confront the perpetrator?
    d. What responses do victims obtain from disclosure recipients and what is their degree of success in improving their situation?
2. Are help-seeking variables (barriers, facilitators) associated to other characteristics connected to the victim, the abuse, and the victim-perpetrator relationship?

3. What are the differences in case characteristics (victim, abuse, victim-perpetrator relationship, perpetrator) when victims of EA contact sources of help, as compared to when third parties contact on behalf of the victim?
    a. Are there any case characteristics that predict a victim enquirer to a helpline?
    b. Are there any case characteristics that predict victims contacting informal vs formal sources?
4. What do victims want to achieve by seeking help (for example, from contacting a helpline)?
5. What are victims' attitudes towards third-party intervention?
    a. What would victims like to happen to the perpetrator, and what is the relationship that victims would like with the perpetrator?
6. What are the most common sources of signposting according to advice by an EA helpline?
    a. Are there any differences in the advice provided when the enquirer is a victim vs a third party?
    b. Are there any differences in the advice provided based on the abuse type suffered by the victim?

Research questions 1-3 and 6 belong to general aim a) as outlined in Chapter 2, while research questions 4-5 link with aim c) (p. 81).

4.4. Methodology

This chapter draws on data from Studies 2 and 3 of this thesis. The design and procedures for each of these studies are described. However, basic concepts, variables included, and other details are explained in Chapter 2 and the reader should refer to those. In addition, for Study 3, the most detailed aspects of the method, including the amendments to recruitment, are discussed in Chapter 2.

4.4.1. Methodology Study 2

4.4.1.1. Design. Study 2 involved a secondary analysis of cross-sectional data. The data encompassed all the records entered in an EA helpline's dataset between 22/5/2017 and 22/5/2018. Some records could be linked to a previous contact with the helpline, which could have occurred during the target period. For example, a record in April 2018 could be subsequent to a previous enquiry made in August 2017. In these cases, the information from any further enquiry (in the example, April 2018) was added to the information about the first record (in the example, August 2017) of that same case in the dataset. If there was information about a repeat enquiry in the system, but this information was obtained outside of the target period (before May 2017 or after May 2018), the record was not updated. More details about the management of repeat enquiries can be found in Appendix H.

Data Source. The data source was the records of Hourglass' free helpline. Hourglass, formerly called Action on Elder Abuse (AEA) and founded in 1993, is the only EA-dedicated charity in the UK (Hourglass, n.d.; O'Keeffe et al., 2007; Podnieks et al., 2010). As a reference in dealing with the abuse of older people, it is common for other organisations to refer people with EA concerns to the charity's helpline for advice. Indeed, the helpline's telephone number appears quoted in several organisational websites in their "safeguarding" sections or factsheets (e.g., Age UK, 2019). At the time of accessing the data for this study, Hourglass was not usually conducting case intervention and they primarily provided advice through their helpline. They also campaigned and organised training events related to EA, and had launched an Elder Abuse Recovery Service in areas of England (Sussex and Essex), with the aim of helping victims recover from EA in the community assisted by staff and volunteers. As a result of their recent rebranding, the organisation has broadened their focus to include the general promotion of safer ageing (Hourglass, n.d.).

Hourglass' helpline operates from Monday to Friday during working hours (9:00 to 17:00, excluding bank holidays). The helpline, supported by staff and volunteers, has been operational since 1998 (Action on Elder Abuse, 2008; Bennett et al., 2000) but cases have been recorded and managed using an electronic system only since 2017. Its main objective is to offer advice to people suffering from EA and others (e.g., family members, friends, professionals) who are seeking advice on behalf of EA victims, and signpost them to appropriate services. In a small percentage of cases, staff and volunteers may follow up with the enquirer or provide further assistance via telephone or email. Since the launch of the electronic database, each time the helpline workers receive an enquiry, they register it in said database. Helpline workers start by adding a free text describing the enquirer's situation, the help needed, and the advice provided. Following this free text, helpline workers are required to fill out fields with information about the enquirer (e.g., victim or non-victim enquirer), the victim (e.g., gender, age), the abusive situation, the help needed, the barriers to action, the advice given, and the outcomes.

4.4.1.2. Procedure. The researcher received access to the helpline records of the charity Hourglass (at the time called AEA) through a written agreement, and signed a confidentiality agreement with the charity as a volunteer. The researcher followed the process for ethical approval with her university, by completing and recording a self-assessment form, which determined no further review was needed (see Appendix I). The focus of the study were all enquiries (i.e., calls, emails, and letters) during the period of 22/5/2017 to 22/5/2018 (N = 2,538). The coding of data started in October 2018 and was completed in May 2019.

Inclusion Criteria. The helpline receives many out-of-remit enquiries. Therefore, as advised by the charity and confirmed by the researcher during preliminary pilot coding, the researcher developed inclusion criteria for the study. The objective was to include EA cases with sufficient information to answer the research questions:

1) Firstly, the case had to be considered EA (criterion 1), as understood by the charity Hourglass and the working definition of this thesis (WHO, 2020a), which was coined by said charity (Action on Elder Abuse, 1995). Three different categories were created to account for different situations: “no abuse”, “suspicion”, and “abuse”.

   - “No abuse” was appropriate when the concerns described did not fit within the thesis’ definition of EA, or where there was insufficient information to decide whether the situation constituted EA.
   - “Suspicion” was appropriate when the person contacting the helpline suspected abuse (e.g., “having a hunch”) but had no proof, had not witnessed abuse, and had not been told by the victim or anybody about said abuse.
   - “Abuse” was appropriate when the enquirer had enough confidence of the abuse occurring. This category did not require substantiation given that these are enquiries to a helpline and that the EA concerns may not have been investigated.
     - o If an older adult was self-reporting, there was a lower threshold for coding abuse, even if the language used was cautious. This decision was made because victims face barriers when seeking help and may not always be ready to describe the events in detail during their first disclosure (Fraga Domínguez et al., 2021; Truong et al., 2019). However, older adults’ concerns clearly unrelated to the WHO definition (e.g., abuse perpetrated by a stranger) were excluded.
     - o To guide decision-making in cases with more limited information, attention was paid to the helpline’s recommended actions. For example, the researcher checked whether the helpline advised that their situation was out of remit and directed them to contact organisations that do not

deal with EA or if, on the other hand, they directed them to EA-related organisations. This procedure is consistent with a recent U.S. study focused on helpline enquiries (Weissberger et al., 2020).

2) Second, to ensure that the cases included were sufficiently detailed, the case had to contain information about several key variables (criterion 2). These were: a) the type(s) of abuse alleged, b) the victim's gender, c) the victim-perpetrator relationship (e.g., adult child), and d) the enquirer's identity (victim vs. non-victim). In terms of variable c), a case was not excluded if it did not specify the type of relative; however, it had to be clear that the perpetrator was not a stranger.
3) The case also needed to contain information about one of the aspects of help-seeking (outlined in this section in pages 164 and 165).

The following steps were followed with the data, depending on the fulfilment of different criteria:

a) If cases did not fulfil criterion 1 (EA case) or 2 (information about key variables), they were excluded, and the reason for exclusion was noted (n = 868).
b) If cases fulfilled criterion 1 (EA case) and 2 (information about all the key variables) but not 3 (information about help-seeking) (n = 17), they were left as a general sample.

4.4.1.3. Materials

Data Collection Tool. A data collection tool was developed to obtain case characteristics from the enquiries' free texts. The tool can be found in full in Appendix J. This tool was created based on previous literature, the systematic review reported in Chapter 3, and the gaps identified in this review. The aim of the data collection tool was to gather information in order to answer the research questions. After developing an initial tentative tool, the researcher coded 30 cases (10 located at the beginning of the database or chronological period,

10 in the middle, and 10 at the end) to identify any potential changes needed. Any notes during this initial coding were used to improve the tool by deleting variables (that could not be coded, given the type of information usually recorded) and expanding the tool where appropriate by creating new variables.

The process of coding was iterative; the data collection tool was modified after data collection started. After coding the first 254 cases (a randomly generated 10% of the total sample), decisions were made to include additional variables, based on themes noted by the researcher. For example, during initial coding, the researcher noted that many cases included a pattern of isolating behaviours displayed by perpetrators, which seemed to affect help-seeking efforts negatively. As a result, a dichotomous variable referring to the presence or absence of "isolating behaviours" was included in the data collection tool. Afterwards, the researcher reviewed cases already coded to account for the newly added variables.

The data collection tool consisted of several sections, relating to characteristics of the following:

1) Enquirer (e.g., relationship with the victim)
2) Victim (e.g., gender)
3) Abuse (e.g., abuse type)
4) Victim-perpetrator relationship (e.g., dependency)
5) Perpetrator (e.g., gender)
6) Help-seeking

The type and meaning of variables coded from the first five sections are specified in Chapter 2. The final section covered information about help-seeking variables from the perspective of the victim and the non-victim enquirer, referring mostly to barriers, facilitators, responses and outcomes, sources of help, and, finally, any attitudes towards intervention of the

victim or the non-victim enquirer as reported in the case. In the coding sheet, the barriers and facilitators from the perspective of victims were derived from the list of barriers and facilitators identified in the systematic literature review (Chapter 3). Any other barriers or facilitators identified in the enquiries' free texts were gathered as free text variables. This procedure applied both to barriers or facilitators from the perspective of the victims and any barriers or facilitators to help-seeking from the perspective of concerned persons. Victims were the focus of Study 1, a systematic review; thus, barrier themes are derived from the findings in that study. Findings relating to concerned persons are presented in Chapter 5.

The variables were:

1. **Barriers.** Any barriers to previous or current help-seeking from the perspective of the victim or non-victim enquirer: pre-identified categories derived from the systematic review for victims (e.g., fear of consequences), free texts for barriers not fitting within these categories or subcategories, and free text for non-victims.
2. **Facilitators and circumstances.** Any facilitators to previous or current help-seeking from the perspective of the victim or non-victim enquirer: pre-identified categories derived from the systematic review for victims (e.g., victim's fear for safety), free texts for facilitators not fitting within these categories, and free text for non-victims. Circumstances leading to help-seeking were also coded within this category (please see Section "2.5.2.1. Aspects of help-seeking" for further clarification).
3. **Sources of help.** Prior attempts at seeking help and source of help of the victim and/or non-victim enquirer:
    - Specific source in free text (e.g., police, friend).
    - Type of source: categorised as "formal", "informal", or "both".
4. **Responses.** Prior responses from the sources of help contacted by the victim and/or non-victim enquirer:
    - Specific responses in free text.
    - Response type: categorised as "positive", "negative", "neutral", or "mixed".
5. **Outcomes** of these help-seeking behaviours, understood as the success in stopping or improving the abusive situation:

- Specific outcomes in free text.
- Outcome type, categorised as "the abuse ceased", "the situation improved", "the situation worsened", or "no change".

6. **Helpline goals.** Enquirer's goals in contacting the helpline (i.e., help needed).
7. **Helpline outcomes.** Immediate outcomes of contacting the helpline, understood as the advice offered to enquirers.
8. **Confrontation.** Prior confrontation of the perpetrator:
   - Anyone confronted: yes/no.
   - Who confronted the perpetrator: victim, non-victim enquirer, both, other, or unknown.
   - Perpetrator's response/reaction in free text.
9. **Attitudes towards intervention.** Victim and non-victim enquirer's attitudes towards intervention: free text.

The data collection tool was designed to gather a combination of quantitative and qualitative (e.g., attitudes towards intervention) data. Most of the quantitative variables were categorical, and many were dichotomous yes-no variables.

Hourglass' Data. Some of the data recorded by Hourglass were utilised. These were data which could not be gathered from the free texts and that were useful to describe the sample. Due to these data not being gathered by the researcher and the unavailability of inter-rater reliability data, caution should be exercised when interpreting these data. The following variables are used:

- The enquirer's nation: England, Wales, Scotland, Northern Ireland.
- The type of contact: telephone, email, letter, other.
- How they heard about the helpline: Age UK, internet, Silverline, previous contact, other[1].

[1] Age UK is an organisation working with older people in the UK. The Silverline is a free helpline for older people, their families, and friends, open 24 hours a day every day of the year.

- The victim's race/ethnicity.
- The victim's and perpetrator's age.

Data about victims' and perpetrators' ages were only utilised when such data could not be gathered from the free text. Where data about the victims' or perpetrators' ages could be found in both, priority was given to the free text; thus, the data collection tool variables were used. Given that, in many cases, data about ages were present in both Hourglass' database fields and on the free text, Intraclass Correlation Coefficient (ICC_1) (Bartko, 1966) (mixed effects, absolute agreement) was employed. The results were .986 for the victim's age and .998 for the perpetrator's age, suggesting excellent agreement (Koo & Li, 2016). This provides confidence in using Hourglass' variables, where ages were not provided in the free texts.

Several Victims and Perpetrators. In cases of multiple victims and perpetrators, the researcher decided to gather information about up to two victims and/or perpetrators. Information about any further victims or perpetrators was not recorded due to the fact that these were uncommon, and that in most cases with more than two perpetrators, information about those perpetrators was limited (e.g., being described as "family members" or "care home workers"). The primary victims and perpetrators coded as the "main victim" and "main perpetrator", were the ones that were the centre of the enquiry. This was defined as the older adult (or perpetrator) who was suffering (or perpetrating) most of the abuse, who was mentioned first, or who had the closest relationship with the perpetrator (or victim), in this order. For the secondary victim or perpetrator, basic information (i.e., gender, age) is presented in this chapter.

While piloting the first 254 cases, the researcher noticed that in some cases with two victims where the victims were in an intimate relationship there was no clear primary victim as they were both mentioned at the same time, suffering similar abuse, and their relationship with the perpetrator was equally close (e.g., parents as victims, with a son/daughter as

perpetrator). To balance these cases, the researcher made a note and alternated who was recorded as primary depending on gender. That is, if in the first case coded, the primary victim was a female, and her male spouse was coded as second victim, in the next case, the primary victim would be the male.

Other Details. Other details about coding, including the focus of the data gathering, the process for identifying repeat enquiries, and the treatment of unknown data can be found in Appendix H.

Inter-Rater Reliability. To ensure that the coding was done reliably, a research assistant (RA) independently coded 10% of the sample. The primary researcher trained the RA on the data collection tool and several practice cases were coded together to ensure consistency. The RA signed a volunteer confidentiality agreement with the charity Hourglass. Afterwards, she received a sample of 254 fully anonymised cases, which were randomly generated from the original sample using SPSS. This procedure meant that the RA was given cases that were coded by the primary researcher at different stages during the data collection process. After the RA coded the first 20 cases, she met with the primary researcher to discuss questions, ensure that the coding was being performed consistently, and that there was agreement on the meaning of the different variables. The secondary researcher started the coding in February 2019 and completed it in July 2019.

Inter-rater reliability was calculated using Cohen's Kappa for categorical variables (Cohen, 1960) and Intraclass Correlation Coefficient (ICC_1) for continuous variables (Bartko, 1966) (mixed effects, absolute agreement). When Cohen's Kappa could not be calculated, because one of the variables was a constant (i.e., 100% of cases were coded as "Yes" or "No"), percent agreement was calculated instead. For the purposes of several analyses in this study, some variables (e.g., barriers or facilitators that did not fit into pre-defined subcategories of

barriers) were checked to separate whether the barriers concerned the victim, the non-victim enquirer, or both. This separation was only done by the primary researcher; thus, inter-rater reliability could not be calculated.

Inter-Rater Reliability Findings. Inter-rater reliability was generally good or very good with a Kappa result above 0.60 (Altman, 1999). Full results for all the variables in the data collection tool can be found in Appendix H (Table H1). In Table 4.1, the average result per group of variables (e.g., victim, perpetrator) can be found. Percent agreement ranged from 97.1% to 100%. The results of percent agreement, where applicable, can also be found in Appendix H (Table H1). ICC_1 was calculated for continuous variables (e.g., victim's age, number of victims) and was good to excellent for all the variables (Koo & Li, 2016).

Table 4.1

Inter-Rater Reliability Average Results by Category

Section	Kappa	ICC_1
Case and enquirer characteristics	.82	.99
Victim characteristics	.82	1
Perpetrator characteristics	.87	.99
Victim-perpetrator relationship characteristics	.70	
Abuse characteristics	.74	.80
Previous help-seeking and facilitators	.68	
Barriers	.74	
Advice	.78	

4.4.1.4. Data analysis. Study 2 involved both quantitative and qualitative analyses. In the discussion, and to a lesser extent, in the findings section, quantitative and qualitative findings were integrated narratively (Bryman, 2007). The purpose was to triangulate information (i.e., corroborate results through different research strategies) and to provide completeness, by obtaining a more comprehensive answer to the complex research questions posed by the study.

Quantitative analyses were performed using SPSS version 21. To answer some of the research questions, descriptive statistics were calculated, including frequencies. Chi-square tests of independence were used to calculate whether certain case characteristics (relating to the victim, abuse, or victim-perpetrator relationship) were related to the presence of different barriers and facilitators. To explore whether certain variables predicted a victim's self-report in the context of contacting the helpline, logistic regression was employed. Variables were tested in different models, by type of variable: a model with victim variables, a model with abuse variables, a model with variables relating to the victim-perpetrator relationship, and a model with variables related to the perpetrator. The variables that were statistically significant within those models were then tested in an overall model. In addition, to understand differences between formal and informal disclosure, another set of logistic regression models were tested, following the steps described above. In this case, the outcome variable was not whether the victim had reported to the helpline, but a variable that classified the victims as having previously disclosed the abuse informally or formally (either to the helpline or to other services). For this analysis, cases where the victim had not reported or had reported to both sources were excluded.

In addition, to examine other variables that did not fit into pre-identified themes or subthemes or variables for which no themes existed (e.g., attitudes towards intervention), qualitative content analysis was used. For these qualitative analyses, NVivo 11 and NVivo 12 were used to organise and code the data. This approach concerned barriers or facilitators that did not fit into pre-identified subcategories, responses to confrontation, and attitudes towards intervention. Qualitative content analysis is appropriate for summarising larger data sets such as the one in this study and can help to generate categories of content (Drisko & Maschi, 2016). Coding was performed using a combination of deductive and inductive approaches. This combination was appropriate for the type of data in this study, where for many variables, pre-

identified categories (i.e., derived from research) existed and were deductively generated. However, within these categories, the content was inductively analysed.

For these analyses, the researcher became familiar with the data by reading it carefully before assigning codes. Subsequently, the researcher identified common themes and created subthemes. These themes and subthemes were revised as needed iteratively, and the approach to coding was data-driven. To enhance credibility, the researcher used memos to document and review decisions (i.e., to merge codes or create overarching themes). These memos were also used to reflect on the researcher's impressions of the data and the data analysis process, which facilitated researcher's reflexivity throughout (Korstjens & Moser, 2018; Shenton, 2004). To illustrate themes and subthemes, examples are provided; however, to preserve anonymity, quotes are not included. Because the codes were primarily descriptive, the amount of bias is minimised. Given the large sample size, and to illustrate how many cases referred to specific themes or subthemes, frequencies are reported (Drisko & Maschi, 2016).

4.4.2. Methodology Study 3

4.4.2.1. Design and Participants. Participants were individuals who had sought help on behalf of a victim or supported a victim in some way in a non-professional capacity. Participants expressed an interest in participating upon learning about the study through social media, contact with an organisation, or from a friend or acquaintance. Participants were eligible if 1) they had supported or sought help on behalf of a victim of EA—aged 60 or older, given the general cut-off used by the WHO (Yon et al., 2017); 2) they had an informal relationship with the victim (i.e., they were not in a professional relationship with them); and 3) had supported or sought help on behalf of the victim in one of seven eligible countries: UK, Ireland, United States, Canada, Australia, New Zealand, or Spain (see Chapter 2).

Participants were 19 concerned persons who self-identified as having supported an EA victim. One of those participants was interviewed and the rest filled out the survey. One of the survey participants was both an interviewee and survey participant, and was interviewed several months before filling out the survey, as indicated by themselves when taking part on the survey. The two interviews were audio-recorded and transcribed verbatim. Participants, with ages ranging from 21 to 71 (M = 53.9, SD = 13.7), were residents in one of five of the eligible countries: five resided in the UK (26%)—four in England and one unknown—six in the United States (32%), four in Australia (21%), three in Canada (16%), and one in New Zealand (5%). The victims resided in one of four countries, as the New Zealand resident had helped an EA victim resident in the UK. Participants were primarily female (n = 18, 95%) married (n = 8, 42%), and relatives of the victim (n = 17, 90%).

4.4.2.2. Procedure. Recruitment started in September 2019 and finished in June 2020. Potential participants were targeted by posting information about the study on social media (e.g., Twitter, LinkedIn, Facebook) and by sharing the information with different organisations in the UK and abroad, some of which agreed to post the information on their websites or share with users and/or workers. To facilitate the sharing of information, the researcher prepared a summary of the project in a flyer format and created a website with the study information so that potential participants could easily review it. Participants had the opportunity to share their experiences via telephone interview or survey. The two interview participants were interviewed in October 2019 and the last survey participant filled out the survey on 27 June 2020.

Telephone Interview. For interview participation, at the time indicated, the researcher called the potential participant and obtained informed consent before proceeding to conduct the interview. To ensure that the person had the capacity to consent, the researcher employed several checks (see Chapter 2). The researcher audio-recorded the participant's consent to participate and the interview in separate files, to preserve anonymity of data. After conducting

the interview using a semi-structured interview guide, the researcher debriefed the participant and directed them to Hourglass' helpline or other organisations for any questions or further support.

Survey. The survey mirrored the interview procedure, although it was not possible to conduct the checks for capacity explained in Chapter 2. To mirror the conditions of the interview, participants could take breaks while filling out the survey. They were also provided with an ID (automatically generated by Qualtrics) so that they could withdraw their participation up to two months after survey completion.

4.4.2.3. Materials. The study involved a semi-structured interview and a survey adapted from this interview. This type of interview was more appropriate than an unstructured interview in order to answer the study questions, which were specific in nature and aimed to address the questions that could not be addressed in Study 2 due to the limitations of the use of secondary data. The use of a semi-structured interview allows targeting of specific research questions yet leaves room for the interviewee to discuss any other aspects that they consider important and which the researcher may not have anticipated.

Interview Guide. The semi-structured interview guide was built based on previous literature and the preliminary analyses and themes resulting from 10% of the database used in Study 1, based on Hourglass' helpline enquiries. The interview was piloted with six workers from Hourglass (at the time AEA) in January 2019 over three days. More details about interview design and full details of the piloting process can be found in Chapter 2.

The interview guide consisted of five main sections:

1. Participant and victim demographic characteristics
2. The abusive situation, including information about the perpetrator, and their relationship with the victim

3. The help-seeking process
4. Attitudes towards intervention
5. Help received

Most questions were open-ended, but some were closed-ended (some dichotomous, some with several categories), with the purpose of obtaining case characteristics. The full interview guide can be found in Appendix E.

Survey. The survey (see Appendix F) was created using Qualtrics based on the interview guide and followed the same structure and sections. Some questions were only displayed when relevant based on the previous answers. To follow the same principles of the interview, participants could skip any question (except for consent questions) and still proceed with the survey. Based on the sensitive nature of the questions and the length of the survey, participants could take a break from the survey and come back to it within a week. This was indicated in the information page of the survey. To reduce time to completion, some of the interview's open-ended questions were amended to closed questions.

4.4.2.4. Data Analysis. To describe the sample and report the categorical variables, frequencies and percentages are reported. Due to the small sample size, it was not possible to conduct further quantitative analysis. The rest of the variables were analysed using a combination of qualitative content analysis and thematic analysis. The approach used for the qualitative content analysis process was akin to the one described in Study 2 (see Section 4.4.1.4). Qualitative content analysis was considered appropriate for the data in Study 3 in order to generate themes or categories that summarised the content in the data and also highlight key content (Drisko & Maschi, 2016). The coding was both deductive and inductive, in that the original questions posed to participants and associated variables (e.g., satisfaction with services) guided the coding of the responses provided. Within a given area (e.g., reactions to the concerned person helping the victim), previously generated deductively, the researcher read

all the data several times to become familiar with it. She then proceeded to inductively generate and assign codes to the data (e.g., "worry about abuser's retaliation"), supported by qualitative analysis software (NVivo 11 and 12). From these codes, she searched for and identified common patterns and generated themes or categories (e.g., "negative or unsupportive reaction"), which were further defined and revised iteratively. Afterwards, the content within these themes and categories (i.e., participants' responses) was read to ensure that the themes accurately reflected their meaning and enhance credibility (Korstjens & Moser, 2018). Examples and/or quotes were chosen to illustrate the meaning of the themes and categories and are reported as relevant in the findings section. Because of the quality of the survey responses in terms of detail and the fact the data was provided in response to targeted questions, coding happened at a primarily descriptive level, which is common in qualitative content analysis, and may diminish the amount of bias (Drisko & Maschi, 2016).

In addition, focusing on the two interviews, which were more in-depth than the survey responses and contained richer data, thematic analysis was used to further engage with these data and reflect the participants' experiences. This was considered a less descriptive approach to qualitative analysis, involving a higher level of interpretation (Braun & Clarke, 2020). The objective was to identify common themes in these participants' experiences of seeking help on behalf of an EA victim, and this objective guided the coding of the data. The analysis followed the orientation of reflexive thematic analysis (Braun & Clarke, 2020), characterised by the researcher's reflective engagement with, and interpretation of, the data. Because this analysis focused on concerned persons' perspectives, findings are reported in Chapter 5 (Section 5.6.3). More details about the process for thematic analysis, including transcription, are also reported in Chapter 5 (Section 5.4.2).

4.5. Findings Study 2

4.5.1. The Sample

After applying exclusion criteria, out of 2,538 entries in the system, 1,623 (64%) met inclusion criteria. The reasons for excluding 915 cases can be found in Table 4.2.

Table 4.2

Reasons for Case Exclusion

	Cases	
	n	%
Not EA as per definition	207	22.6
Not enough information to determine if EA	192	20.9
No information about key variables	135	14.7
Concerning a person younger than 60	110	12.0
Seeking information about a telephone number	75	8.2
Describing systemic abuse	50	5.5
Suspicion of abuse	39	4.3
Test case (i.e., database system testing) or duplicate	32	3.5
Repeat enquiry, added to previous case	30	3.3
Other	28	3.1
No help-seeking variables information	17	1.9

There were 1,640 cases with information about all the key variables, but 17 of those did not include information about help-seeking; thus, they were excluded, consistent with the inclusion and exclusion criteria. Cases with and without help-seeking recorded were compared in several variables (victim and perpetrator age, victim and perpetrator gender, and abuse types) by using independent T-tests and Chi-square analyses. The samples did not differ significantly from each other in victim's age; $t(781) = .791$, $p = .429$. The perpetrator's age test could not be calculated due to the high amount of missing data in this variable. There was no evidence of a significant association between the variable "help-seeking behaviours information" and the victim's gender ($p = .779$), perpetrator's gender ($p = .927$), psychological abuse ($p = .245$), and financial abuse ($p = .485$). The Chi-square analyses for physical abuse, neglect, and sexual abuse cannot be interpreted due to the violation of assumptions.

Number of Victims and Perpetrators. Among the 1,623 cases included, a minority of these mentioned more than one victim (*n* = 119, 7%), with an average of 2.0 victims (*sd* = 0.1) in cases with multiple victims. More cases involved at least two perpetrators (*n* = 363, 22%), with an average of 2.1 perpetrators (*sd* = 0.5) in cases with multiple perpetrators. The most common relationship between victims was that of partners/spouses (*n* = 101, 85%). Multiple perpetrators were most commonly siblings (*n* = 82, 23%), partners/spouses (*n* = 80, 22%), or colleagues (*n* = 60, 17%; e.g., in a care/nursing home). Another co-perpetrator relationship was a parent and an adult child (*n* = 49, 14%), and several relationships were unknown (*n* = 24, 7%). The central analyses focus on the primary victim and perpetrator.

Other Enquiry Characteristics. Most enquiries were made via telephone (*n* = 1,550, 96%), although some were email (*n* = 70, 4%) and letter (*n* = 3, 0.2%) enquiries. The helpline recorded the way enquirers heard about the service in 756 cases (47%). Most of those enquirers had heard about the helpline online (*n* = 438, 58%), followed by Age UK (*n* = 109, 14%). Most enquiries were made from England (*n* = 1,270, 78%), with a minority from Scotland (*n* = 52, 3%), Wales (*n* = 51, 3%), and Northern Ireland (*n* = 21, 1%) (0.4% outside of the UK, 14% unknown).

4.5.2. Case Characteristics

4.5.2.1. Enquirer's Characteristics. Most enquirers were discussing the abuse of someone else (*n* = 1,434, 88%). Of those, most were relatives of the victim (*n* = 1,077, 76%, 11 cases missing) and female (*n* = 1,020, 73%; 37 cases missing). The full list of relationships and more details about non-victim enquirers are provided in Chapter 5.

4.5.2.2. Victim and Perpetrator Characteristics. Characteristics for the main victim and main perpetrator can be found in Table 4.3. Primary victims were predominantly female and aged 80.9 years on average (*SD* = 8.9), with ages ranging from 60 to 102 years. In a sample

encompassing secondary victims (*n* = 1,742), victims were still predominantly female (*n* = 1,149, 66%). Primary perpetrators were most commonly male and aged on average 51.9 years (*SD* = 17.3), with ages ranging from 14 to 93 years. When the sample also included secondary perpetrators (*n* = 1,986), these were also most commonly male (*n* = 833, 51%; 339 cases unknown).

Table 4.3

Primary Victim and Primary Perpetrator Characteristics

		Victim		Perpetrator	
		Cases		Cases	
		n	%	*n*	%
Gender [a]					
	Female	1093	67.3	682	48.7
	Male	529	32.6	719	51.3
	Other	1	0.1		
Relationship status [a]					
	Single	24	4.8	43	11.8
	Married	295	58.5	56	70.5
	Living with partner	20	4.0	31	8.5
	Widowed	137	27.2	2	0.6
	Divorced	28	5.6	31	8.5
Deceased		77	4.7		
Physical health problems		351	21.6	21	1.3
Physical disability		121	7.5	7	0.4
Intellectual disability		9	0.6	6	0.4
Mental health problems		105	6.5	80	4.9
Dementia		320	19.7	7	0.4
Lacks capacity according to enquirer		104	6.4		
Assessed by professional as lacking capacity		83	5.1		
Antisocial attitudes				352	21.7
Substance abuse problems		12	0.7	91	5.6
Previously victimised		39	2.4	10	0.6

[a] Percentages are provided for valid cases.

Victim's race/ethnicity was obtained through Hourglass' records; however, it was only recorded in 181 cases (11%). In these cases, victims were predominantly White-British (*n* = 126, 70%). Other victims were Asian of different backgrounds (*n* = 32, 18%), Black of African or Caribbean background (*n* = 11, 6%), and White-Irish or White of any other background (*n* = 11, 6%).

4.5.2.3. Abuse Characteristics. The abuse type and characteristics can be found in Table 4.4. The abuse reported was predominantly financial or psychological, and in more than a third of cases there was co-occurrence or poly-victimisation (Heisler, 2017). Among these cases, the average number of types of abuse suffered was 2.2 (sd = .4) and the abuse types most likely to co-occur were financial and psychological. The abuse types most likely to co-occur with others were psychological (n = 251, 31%) and physical (n = 41, 21%). Most cases were perpetrated in the victim's own home and ongoing at the time of the enquiry, with only a few one-time incidents. Finally, most cases (n = 1256, 78%) mentioned at least one type of impact for the victim, frequently financial.

Table 4.4

Abuse Characteristics

		Cases	
		n	%
Abuse type	Financial	994	61.2
	Psychological	803	49.5
	Neglect	369	22.7
	Physical	196	12.1
	Sexual	27	1.7
Abuse poly-victimisation	Any co-occurrence	653	40.2
	Financial and psychological [a]	413	63.2
	Psychological and neglect [a]	123	18.8
	Psychological and physical [a]	120	18.4
	Financial and neglect [a]	119	18.2
Abuse location [b]	Victim's home	1211	80.3
	Care home/nursing home	174	11.5
	Hospital	52	3.6
	Sheltered accommodation	37	2.5
	Other	32	2.1
Other abuse characteristics	Abuse ongoing [b]	1420	89.0
	One-time incident [b]	59	3.8
	Chronicity	364	22.4
	Perpetrator isolation	186	11.5
	Use of threats	50	3.1
	Substantiated	14	0.9
	Long-standing IPV	18	1.1
	Bi-directional [c]	7	0.4

		Cases	
		n	%
Impact on victims	Financial	746	46.0
	Psychological	488	30.1
	Physical	412	25.4

[a] Percentages are provided for cases of poly-victimisation.
[b] Percentages are provided for valid cases.
[c] In these cases, the person who was framed as the main recipient of abuse by the enquirer and the helpline, was coded as the victim.

4.5.2.4. Victim and Perpetrator's Relationship. The victim-perpetrator relationships and other related variables can be found in Table 4.5. The perpetrators were primarily family members, and there was frequent co-habitation. Victims were dependent on the perpetrators for care, and the perpetrator was the victim's main caregiver in more than half of those cases ($n = 229$, 53%).

Table 4.5

Relationship of the Perpetrator With the Victim

		Cases	
		n	%
Victim-perpetrator relationship	Family member	1193	73.5
	Adult child	760	46.8
	Partner	188	11.6
	Grandchild	59	3.6
	Nephew/niece	46	2.8
	Sibling	30	1.8
	Stepchild	13	0.8
	Aunt/uncle	1	0.1
	Other family member	67	4.1
	Family member unspecified	29	1.8
	Professional	206	12.7
	Friend	137	8.4
	Neighbour	54	3.3
	Other	33	2.0
Victim and perpetrator co-habitation		505	31.1
Victim's dependency on the perpetrator	Any	630	38.8
	For care	436	26.9
	Perpetrator is victim's Power of Attorney	160	9.9
	Socially or emotionally	130	8.0
Perpetrator's dependency on the victim	Any	84	5.2
	Housing	50	3.1
	Financially	40	2.5

4.5.3. Victims' Help-Seeking

4.5.3.1. Research Question 1a. What are the barriers victims face when seeking help? In 1032 cases (64%) one or more barriers were identified that made it harder for the victim to seek help. Some of these were classified as belonging to the themes and subthemes of barriers identified in the systematic review (Study 1; coded as "pre-identified barriers") and some were coded as "new barriers". Any new barriers that were not part of pre-identified themes were analysed using qualitative content analysis. The most common barrier themes can be found in Table 4.6. Victims may experience more than one barrier. Moreover, a specific barrier may fit into two different themes (e.g., barriers related to formal services and barriers related to culture).

Table 4.6

Victims' Barriers by Themes Identified in Systematic Review

	Cases	
	n	%
Social network	457	44.3
Individual feelings	321	31.1
Formal services	305	29.6
Fear in relationship to help-seeking	209	20.2
Fear for themselves	149	14.4
Fear for the perpetrator	61	5.9
Perception of abuse	166	16.1
External circumstances	128	12.4
Family	61	5.9
Cultural, generational, or religious	39	3.8

Note. Barriers were not exclusive, so the sum of percentages exceeds 100.
The percentages are calculated with respect to the cases where there were barriers reported (n = 1,032).

The following paragraphs report the frequencies for the different subthemes within each barrier theme. In addition, new subthemes (i.e., that did not fit within the pre-identified subthemes) are discussed. Some of the new subthemes, may overlap with existing subthemes. For example, a subtheme within barriers related to the social network was "lacking effective social network". Some of the new subthemes may fit within this category, but they describe something specific that is not reflected (e.g., concerned persons who cannot help because they

are fearful of the perpetrator). This would be a new subtheme because it expands on existing subthemes.

Social Network. The most common pre-identified subtheme was that the victim was isolated. The rest of subthemes can be found in Table 4.7.

Table 4.7

Victims' Social Network Barriers by Subtheme

		Cases	
		n	%
Subthemes of barriers identified in systematic review	Victim is isolated	230	50.3
	Victim lacks effective social support	93	20.4
	Victim's only significant relationship is with the perpetrator	17	3.7
	Victim believes social network cannot help	6	1.3
	Victim anticipates denunciation from the community	1	0.2
New subthemes of barriers (presented in Table 4.8)		206	45.1

Note. Barriers were not exclusive, so the sum of percentages exceeds 100.
The percentages are calculated with respect to the cases where there were barriers reported (n = 457).

There were other social network barriers not fitting within these subthemes (n = 206, 45%). In Table 4.8, the content of the new subthemes is defined, along with subcategories, where appropriate.

Table 4.8

Victims' New Social Network Barriers by Subtheme

Barrier Subtheme	*n*	%	*Subcategories* (*n*) or Explanation/Meaning
Existing social network cannot or does not want to get involved. There is an existing social network, but they cannot or are not willing to help.	87	19.0	• *Social network cannot support due to other care or work commitments, ill health, or living abroad* (62). • *Social network does not want to get involved* (15). • *Social network cannot help or visit because of the perpetrator (e.g., their threats or violence)* (10).

Barrier Subtheme	*n*	%	*Subcategories* (*n)* or Explanation/Meaning
Victim has problems communicating with others or seeing others, primarily—but not exclusively—due to perpetrator's influence.	73	16.0	• *Problems or inability to see or be in contact with others who want to support or could support (i.e., family or friends), primarily caused by the perpetrator* (41). • *Isolated by the perpetrator, the victim pushes others away or socialises less than before the abuse onset* (13). • *The victim can see others but cannot talk to them in private because the perpetrator is always with them or does not allow private visiting* (8). • *The victim has no telephone to communicate. Perpetrator may have taken telephone away. In other cases, they cannot communicate due to language barriers* (6). • *The victim cannot talk to other people because the perpetrator intercepts calls or monitors any form of contact* (5).
Victims' attitudes towards informal help generally or specific informal sources of help.	46	10.1	• *The victim rejects the help of others or does not want them to intervene/interfere* (17). • *The victim does not trust their informal network, has pushed them away or is not speaking to them* (13). *In some cases, this is because of the perpetrator's false allegations (e.g., that the supporters are the actual perpetrators).* • *The potential supporters and the victim have not been in touch for some time or are estranged* (11). • *The victim does not want to "bother" their social network or is embarrassed to tell them* (3). • *The victim does not want others' involvement for other reasons* (2).
The victim has moved to a new area where they have no support.	12	2.6	The move may have been caused by the perpetrator or the victim has moved voluntarily to be with the perpetrator.
The victim is not able to leave the house or move around freely outside, which makes it hard to communicate with others.	10	2.2	In some cases, this is because the perpetrator locks the victim in the house during the day or because they do not give them access to finances, which makes them unable to go out.

Barrier Subtheme	*n*	%	*Subcategories* (*n*) or Explanation/Meaning
The victim thinks the perpetrator is their only reliable network or values the perpetrator above others.	7	1.5	This happens in cases where there are other people supporting.
The victim is lonely, has no family, or no people to talk about what is happening.	6	1.3	

Note. n = 457.

Individual Feelings or Perceptions of Personal Circumstances. There were several individual feelings around the victim's personal circumstances that made it harder to seek help; most commonly, the victim's physical frailty. Other barrier subthemes, including new subthemes from the present study, can be found in Table 4.9.

Table 4.9

Victims' Barriers Related to Individual Feelings or Circumstances by Subtheme

		Cases	
		n	%
Subthemes of barriers identified in systematic review	Physical frailty	120	37.4
	Ambivalence regarding help-seeking	63	19.6
	Feelings of shame or embarrassment	20	6.2
	Feelings of anxiety	17	5.3
	Feelings of helplessness	14	4.4
	Feelings of low self-confidence	6	1.9
	Self-blame	3	0.9
New subthemes of barriers	Refusal to disclose or talk about abuse with any third-party	29	9.0
	Difficulties communicating what is happening to them (e.g., due to a stroke, stutter, or learning disabilities)	23	7.2
	Disability, feelings of exhaustion, distress, loneliness, or advanced age	22	6.9
	Serious mental health issues (e.g., depression, suicidal ideation)	17	5.3
	Feelings about the perpetrator (e.g., feeling sorry)	13	4.0
	Private personality, shyness, stubbornness, or independence	11	3.4
	Unclear wishes, or feelings of confusion, insecurity or being "stuck"	11	3.4

		Cases	
		n	%
	Hiding the abuse, "putting up with abuse", passiveness about situation or wanting to keep it a secret or keep peace	7	2.2
	Problems talking about the abuse (e.g., getting tearful, angry, needing a lot of time to disclose)	7	2.2
	Lack of readiness for "harsh" measures	4	1.2

Note. Barriers were not exclusive, so the sum of percentages exceeds 100.
The percentages are calculated with respect to the cases where there were barriers reported (*n* = 321).

Formal Services. In only a few of the cases barriers relating to formal services fit exactly within the pre-identified subthemes. These can be found in Table 4.10. New subthemes can be found in Table 4.11 with examples.

Table 4.10

Victims' Barriers Related to Formal Services by Subtheme

		Cases	
		n	%
Subthemes of barriers identified in systematic review	Services' inadequacy for the victim	19	6.2
	Victim lacks trust in professionals	6	2.0
	Services are difficult to access	5	1.6
	Victim doubts about services' capacity to help	2	0.7
	Victim ignores where to seek help	1	0.3
New subthemes of barriers (presented in Table 11)		285	93.4

Note. Barriers were not exclusive, so the sum of percentages exceeds 100.
The percentages are calculated with respect to the cases where there were barriers reported (*n* = 305).

Table 4.11

Victims' New Formal Service Barriers by Subtheme

Barrier Subtheme	*n*	%	*Subcategories (n)* or Example
Barriers due to services' responses or involvement.	147	48.2	• *Lack of response or appropriate response from services or the response obtained was unsuccessful (i.e., did not stop the abuse*) (117). *For example, the victim has been interviewed by social services with the perpetrator in the room.* • *Problems specific to legal help (e.g., because it is too expensive or due to lack of proper representation)* (10). • *Problems finding the right support or perceiving that the advice or support is inadequate or difficult to follow* (9).

Barrier Subtheme	*n*	%	*Subcategories (n)* or Example
			• *Inconsistent or inadequate involvement from services, such as social workers or carers* (6). • *Services are blocking, ignoring, or acting against the victim's wishes* (5).
Barriers relating to the victim and victim's opinions or experiences with services.	146	47.9	• *The victim refuses to disclose to services (e.g., police, adult safeguarding) or did not disclose anything or engage when services visited or asked* (63). • *The victim does not want or is not ready for specific formal help or measures* (20), *such as discussing a Power of Attorney or an injunction.* • *A third party believes that the victim will refuse help from services or the victim has already refused such help* (17). • *The victim does not always engage with services more generally* (12). *They may have negative opinions about services (e.g., GP), not specific to seeking help for the abuse.* • *The victim fears a formal intervention generally or a specific formal service's intervention (e.g., by police)* (5). • *The victim has other concerns regarding intervention or disclosure to services* (4), *such as not having the strength to make a police statement due to ill health.* • *The victim took action but has now backtracked or regretted it* (2). • *The victim lacks general knowledge about how to about seeking formal help generally or from a specific service* (2).
Barriers relating to the perpetrator.	30	9.8	The perpetrator is impeding contact with services or making it harder for the victim to contact services or for services to assist. The perpetrator may not be happy with any outside influence or may not let carers work. They may be convincing services that everything is fine or influencing their decision-making.

Note. *n* = 305.

Fear. Barrier subthemes, including new subthemes, can be found in Table 4.12.

Table 4.12

Victims' Barriers Related to Fear by Subtheme

	Cases	
	n	%
Fear for themselves	149	71.3

Subthemes of barriers identified in systematic review	Of isolation	14	6.7
	Due to perpetrator threats	11	5.3
	Of institutionalisation	9	4.3
	Of retaliation	9	4.3
	Of not being believed	3	1.4
	Of others knowing	3	1.4
	Of "making a fuss"	3	1.4
	Of abandonment	2	1.0
	Of authorities	1	0.5
	Fear for the perpetrator or a desire to protect the perpetrator	61	29.2
	Desire to help or protect the perpetrator	40	19.1
	Fear of consequences for the perpetrator	34	16.3
	Fear of harm to the perpetrator	28	13.4
	Fear of worsening relationship with perpetrator	8	3.8
New subthemes of barriers	Fear for themselves	127	60.7
	Afraid, scared, or intimidated by the perpetrator	57	27.3
	Other fears (not being able to see grandchildren, not getting the care they need)	25	12.0
	Afraid or scared of doing anything (without specifying reasons)	22	10.5
	Frightened to "speak up" or tell the perpetrator to leave (without specifying reasons)	19	9.1
	Fears related to the victim's living situation (e.g., homelessness, eviction from care home)	4	2.0
	Fear for the perpetrator (e.g., the perpetrator being placed in a care home)	4	2.0

Note. Barriers were not exclusive, so the sum of percentages exceeds 100.
The percentages are calculated with respect to the cases where there were barriers reported (n = 209).

Perception of Abuse. The pre-identified subthemes' frequencies and percentages can be found in Table 4.13, together with the new subthemes identified in the current study.

Table 4.13

Victims' Barriers Related to the Perception of Abuse by Subtheme

		Cases	
		n	%
Subthemes of barriers identified in systematic review	Lack of awareness that abuse is occurring or they do not perceive the situation as abusive	54	32.5
	Difficulties labelling the behaviour as abusive	21	12.7
	Thoughts that the behaviour is not serious enough	1	0.6
New subthemes of barriers	Memory-related problems, in some cases linked to dementia (e.g., not remembering details about abuse—financial transactions, paperwork signed, conversations)	41	24.7

	Not acknowledging concerns or “turning a blind eye”	14	8.4
	Having given away money willingly or as a good deed	14	8.4
	Confusion	11	6.6
	Denial about the perpetrator as an abuser or justification of their behaviour	10	6.0
	Problems specifically comprehending financial affairs or their financial status	9	5.4
	Mental health problems or learning disabilities that influence the perception of the situation	4	2.4
	Changing perceptions about the abusive situation	3	1.8
	Described as “brainwashed” by the perpetrator	2	1.2

Note. Barriers were not exclusive, so the sum of percentages exceeds 100.
The percentages are calculated with respect to the cases where there were barriers reported (n = 166).

External Circumstances. In several cases, the victim’s experience of bereavement around the time of the abuse seemed to make it harder to seek help (n = 83, 65%) and sometimes the victim’s socioeconomic dependency on others was understood as a barrier (n = 45, 35%). Finally, there were five cases with new barriers reported within this theme (4%): a general lack of money or resources (n = 2), a dependency on the perpetrator for other things, such as bringing alcohol (n = 2), and a precarious legal status in the country (immigration-related, n = 1).

Family Barriers. Barrier subthemes (pre-identified and new) related to family can be found in Table 4.14.

Table 4.14

Victims’ Barriers Related to Family by Subtheme

		Cases	
		n	%
Subthemes of barriers identified in systematic review	Importance of relationship with the perpetrator or other family members	18	29.5
	Relative perpetrator’s dependency on the victim	16	26.3
	Parental duty	9	14.8
New subthemes of barriers	Victim’s relationship with their adult children or grandchildren	13	21.3
	Responsibility for the perpetrator (e.g., because they are the legal guardian)	4	6.6

	The importance of family's wellbeing or the grandchildren's wellbeing	3	4.9
	A trusted family member sides with the perpetrator	1	1.6

Note. Barriers were not exclusive, so the sum of percentages exceeds 100.
The percentages are calculated with respect to the cases where there were barriers reported (*n* = 61).

Cultural, Generational, or Religious barriers. The content of these barriers was analysed and subthemes can be found in Table 4.15. The most frequent subtheme was language barriers.

Table 4.15

Victims' Cultural, Generational, or Religious Barriers by Subtheme

Barrier Subtheme	*n*	%	Example
Language and language barriers.	22	56.4	Needing an interpreter who was not available or having the wrong interpreter arranged for them in interactions with services. In one case, the perpetrator had lied and stated that the victim did not speak English when services arrived; thus, said services did not interact with the victim.
Generational or traditional beliefs.	11	28.2	Believing that the abuse is a private matter or placing specific importance in staying in their own house at the cost of harm.
Culture.	6	15.4	Cultural sensitivities or beliefs (e.g., not bringing shame to the family, cultural pride) or barriers due to services not being culturally aware.
Religion.	2	5.1	Beliefs about the good deed of helping perpetrators or beliefs about divorce, both because of their religious faith.
Immigration status.	1	2.6	Barriers related to the immigration status of the victim.

Note. Barriers were not exclusive, so the sum of percentages exceeds 100.
The percentages are calculated with respect to the cases where there were barriers reported (*n* = 39).

4.5.3.2. Victims' Facilitators

Research Question 1b. What are the facilitators (e.g., social support) that enable help-seeking and/or the circumstances (e.g., escalation) that prompt a decision to seek help? In 213 cases (13%) one or more facilitators to help-seeking and/or circumstances that prompted a

decision to seek help were identified. Of these, 77 were additional to those identified in the systematic review (Study 1). These themes can be found in Table 4.16. The new themes identified are explained in Table 4.17. Amongst both pre-identified and new themes, the most common were circumstances leading to seeking help (e.g., abuse escalation prior to help-seeking), rather than facilitators.

Table 4.16

Frequencies of Pre-Identified Victims' Facilitators by Theme

		Cases	
		n	%
Facilitators from the systematic review (Study 1)	Abuse escalation [a]	70	32.9
	Victims' fear for safety [a]	42	19.7
	Good informal support	35	16.4
	Situation reached an unbearable threshold [a]	25	11.7
	Good formal support	13	6.1
	Feeling of betrayal by perpetrator [a]	4	1.9
	Lack of emotional attachment towards perpetrator	1	0.5
New facilitators		77	36.1

Note. Facilitators were not exclusive, so the sum of percentages exceeds 100.
Percentages are calculated with respect to the cases where a facilitator was reported (n = 213).
[a] These factors are considered circumstances leading to seeking help.

Table 4.17

Frequencies of Newly-Identified Victims' Facilitators by Theme

Facilitator Theme	*n*	%	Explanation
Unhappiness with situation or a desire for change in their circumstances [a]	15	7.0	The victim's unhappiness with their current situation and a desire for change (e.g., wanting justice or to recover their money).
Changing perceptions of the perpetrator or changes in their relationship with the perpetrator [a]	15	7.0	Changes in the perception they had about the perpetrator, such as feeling shocked about their behaviour or not wanting the perpetrator to be living with them anymore. There were also changes in the relationship they had, such as having a "falling out" or feeling that the perpetrator was no longer helping them or not doing what they promised.
Recent awareness of abuse [a]	12	5.6	For example, discovering that money was missing, being told by concerned persons that they were being

Facilitator Theme	*n*	%	Explanation
			abused, or finding out from the perpetrator (i.e., telling them that they had lost the victim's money).
Feelings of distress or other mental health difficulties [a]	10	4.7	Feelings of distress, vulnerability, depression, suicidality, anxiety or worry, or desperation.
Negative experiences with formal services or not being able to get the help they need [a]	6	2.8	Victims seeking help from the helpline/someone else because of their previous negative experiences with other services or lack of success in stopping the abuse or getting the help that they identified they needed.
Fear or worry about the abuse continuing or re-occurring or about specific potential impacts of the abuse [a]	5	2.3	
A sense of urgency or desperation about the situation [a]	4	1.9	
Worry about the current impact of abuse for themselves or others [a]	4	1.9	
Access to information that could make it easier to seek help	3	1.4	For example, proof or detail about the abuse, or access to information about EA.
The perpetrator's need for help [a]	2	0.9	
A specific distressing event making them feel vulnerable or lonely and prompted them to revisit their circumstances [a]	2	0.9	
Feelings of inability to cope or deal with the situation [a]	2	0.9	

Note. $n = 213$.
[a] These factors are considered circumstances leading to seeking help.

4.5.3.3. Victims' Previous Help-Seeking Attempts, Responses, and Outcomes

Research Question 1c. To whom do victims disclose the abuse? In 354 cases, the victim had previously disclosed the abuse to an informal and/or formal source (22%). In addition, in

112 (7%) there was some indication that the victim had disclosed the abuse, coded as "probably", because there was enough information to suggest that the enquirer or someone else had obtained the information about the abuse from the victim. Where source of help was known, most victims sought help from an informal source (*n* = 280, 63%), while others sought help from a formal source (*n* = 151, 34%) or both (*n* = 14, 3%). The full list of sources can be found in Appendix K (Table K1). The cases coded as "probably" are considered in this section but are excluded from the analysis where informal disclosure is an outcome (i.e., the logistic regression models reported on section 4.5.4).

Research Question 1b. What responses do victims obtain from disclosure recipients and what is their degree of success in improving the situation? Where the response type was known (*n* = 410), most victims obtained positive responses (*n* = 325, 79%) from the sources contacted, characterised by someone trying to help or support them. Some victims obtained negative (*n* = 41, 10%), neutral (*n* = 22, 5%) or mixed (positive and negative) responses (*n* = 22, 5%). As of the time of the enquiry to the helpline, most victims had been unsuccessful in stopping the abuse through help-seeking (*n* = 369, 90%). For some, the situation had improved but had not resolved (*n* = 40, 10%), and a small minority (*n* = 3, 1%) had been successful in stopping the abuse. In the latter, the reasons for enquiring were, for example, wanting to talk about their experience.

Research Question 1c(i). Do victims confront the perpetrator? Some victims (*n* = 52, 3%) had confronted the perpetrator, for example, by asking them to leave their house or stop their behaviour. In 31 of these cases (60%), the victim had also disclosed the abuse to someone else (71% yes, 29% probably). Perpetrators' responses to confrontation were gathered and analysed using qualitative content analysis. Of the 52, 10 (19%) responses were unknown or unclear. The type of responses in the remaining 42 cases can be found in Table 4.18, organised by whether the confrontation was successful or not.

Table 4.18

Perpetrators' Responses to Confrontation

Response Type	*n*	%	Examples of Perpetrator's Behaviour (*n*)
The confrontation was unsuccessful, but the abuse did not worsen	31	73.8	• Refusing to leave the victim's property (13). • Ignoring the confrontation and not providing an answer (7). • Refusing to return money (e.g., claiming it is their "early inheritance") or the deeds of the house (4). • Denying the accusation, making excuses, or lying about it (2). • Promising to pay the money they owe but then not following through (e.g., because the money was spent) (3). • Other (1, each): abuse continues, refusing to do what they were asked to do, being dismissive of the victim, blaming someone else, and saying they victim is confused.
The confrontation was not successful, and resulted in further abuse	5	11.9	• Becoming aggressive, angry, rude, shouting at the victim, intimidating or silencing the victim, or threatening escalation.
The confrontation was partly successful in stopping the abuse.	3	7.1	• Returning part of the money. • Leaving the house but still controlling it.
The confrontation was successful	2	4.8	• Agreeing to legal separation. • Relationship ending.
The confrontation was successful in stopping the abuse, but the victim is unhappy about the situation because the perpetrators has ended the relationship.	1	2.4	

Note. *n* = 42.

4.5.3.4. Differences in Victims' Help-Seeking Behaviours Depending on Case Characteristics

This section reports findings of any association between victim, abuse, and victim-perpetrator relationship (hereafter "case characteristics") and barrier themes outlined in Section 4.5.3.1. The analyses for facilitators are also presented; however, facilitators are analysed as a group (i.e., any facilitator present) and not by themes, because of the individual themes' low frequencies.

Research Question 2. Are help-seeking variables (barriers, facilitators) associated to other characteristics connected to the victim, abuse, and victim-perpetrator relationship?

Relationship Between Barriers and Case Characteristics. In this section, the presence of barriers by the pre-identified themes (i.e., previously identified in the systematic review) is explored in relationship to victim, abuse, and victim-perpetrator relationship characteristics. The statistical analyses that violated assumptions are not presented in the tables, but can be found in Appendix K.

Social Network Barriers. The presence of barriers related to social network were significantly more likely in cases where the victim had physical health problems (see Table 4.19), in cases of psychological abuse, neglect, poly-victimisation, where isolation techniques were employed, or where abuse was chronic. These barriers were significantly more likely in cases perpetrated by a partner, when there was co-habitation, or when the victim was dependent on the perpetrator; but less likely in cases perpetrated by a professional or other (non-family or friend).

Table 4.19

Chi-Square Findings for the Association Between Barriers Related to Social Network and Case Characteristics

			Barriers Related to Social Network				
			n	%	χ^2	df	φ/V[a]
Victim Characteristics	Gender	Male	153	28.9	.295	1	-.013
		Female	302	27.6			
	Age group	60-80	170	28.4	.799	1	.025
		81-102	201	30.7			
	Physical health problems	No	324	25.5	19.148***	1	.109[1]
		Yes	131	37.3			
	Physical disability	No	416	27.7	1.141	1	.027
		Yes	39	32.2			
	Mental health problems	No	426	28.1	.010	1	-.002
		Yes	29	27.6			
	Dementia	No	363	27.9	.101	1	.008
		Yes	92	28.8			
	Previous victimisation	No	439	27.7	3.343	1	.045
		Yes	16	41.0			
Abuse Type	Physical	No	398	27.9	.121	1	.009
		Yes	57	29.1			
	Psychological	No	153	18.7	72.216***	1	.211[1]
		Yes	302	37.6			
	Financial	No	176	28	.001	1	.001
		Yes	279	28.1			
	Neglect	No	334	26.6	5.356*	1	.057[1]
		Yes	121	32.8			
	Sexual	No	451	28.3	2.378	1	-.038
		Yes	4	14.8			
	Poly-victimisation	No	203	20.9	60.352***	1	.193[1]
		Yes	252	38.6			
Abuse Characteristics	Isolation	No	284	19.8	425.180***	1	.512[3]
		Yes	171	91.9			
	Threats	No	436	27.7	2.539	1	.040
		Yes	19	38.0			
	Chronic	No	320	25.6	15.043***	1	.097[1]
		Yes	131	36.0			
	Several perpetrators	No	356	28.3	.134	1	-.009
		Yes	99	27.3			
Victim-perpetrator Relationship	Partner		67	35.6[b]	24.322***	4	.122[1]
	Child		223	29.3			
	Other family member		74	30.2			
	Friend		41	29.9			
	Professional or other		50	17.1[b]			
	Co-habitation	No	140	20.8	57.364***	1	.221[1]
		Yes	208	41.2			

			Barriers Related to Social Network				
			n	%	χ^2	df	φ/V[a]
Other Relationship Characteristics	Victim's dependency	No	212	21.3	56.666***	1	.187[1]
		Yes	243	38.6			
	Perpetrator's dependency	No	439	28.5	3.546	1	-.047
		Yes	16	19			

[a] Phi (φ) results are presented, except for the victim-perpetrator relationship, where Cramer's V is presented.
[b] Adjusted standardised residuals show a significant result.
[1]Small effect: φ = .1/ V (df = 4) = .05. [2]Medium effect: φ = .3/ V (df = 4) = .15. [3]Large effect; φ = .5/ V (df = 4) = .25.
**p* < 0.05 ***p* < 0.01 ****p* < 0.001.

Barriers Related to Individual Feelings. These barriers were significantly more likely in those who were younger (60-80 years), who did not have dementia, who had physical or mental health problems, or a physical disability (see Table 4.20). They were also more likely in cases of physical or psychological abuse, poly-victimisation, or chronic abuse. They were more common in cases perpetrated by the victim's partner, with co-habitation, or when there was perpetrator dependency, but less likely in cases perpetrated by a professional or other (non-family or friend).

Table 4.20

Chi-Square Findings for the Association Between Barriers Related to Individual Feelings and Case Characteristics

			Barriers Related to Individual Feelings				
			n	%	χ^2	df	φ/V[a]
Victim Characteristics	Gender	Male	99	18.7	.080	1	.007
		Female	211	19.3			
	Age group	60-80	143	23.9	5.820*	1	-.068[1]
		81-102	120	18.3			
	Physical health problems	No	181	14.2	90.307***	1	.236[1]
		Yes	129	36.8			
	Physical disability	No	260	13.3	41.784***	1	.160[1]
		Yes	50	41.3			

			Barriers Related to Individual Feelings				
			n	%	χ^2	df	φ/V[a]
	Mental health problems	No	274	18.1	16.753***	1	.102[1]
		Yes	36	34.3			
	Dementia	No	271	20.8	12.327***	1	-.087[1]
		Yes	39	12.2			
	Previous victimisation	No	299	18.9	2.144	1	.036
		Yes	11	28.2			
Abuse Type	Physical	No	258	18.1	7.965**	1	.070[1]
		Yes	52	26.5			
	Psychological	No	119	14.5	22.580***	1	.118[1]
		Yes	191	23.8			
	Financial	No	127	20.2	.790	1	-.022
		Yes	183	18.4			
	Neglect	No	238	19.0	.052	1	.006
		Yes	72	19.5			
	Sexual	No	305	19.1	.006	1	-.002
		Yes	5	18.5			
	Poly-victimisation	No	151	15.6	19.480***	1	.110[1]
		Yes	159	24.3			
Abuse Characteristics	Isolation	No	274	19.1	.009	1	.002
		Yes	36	19.4			
	Threats	No	300	19.1	.027	1	.004
		Yes	10	20.0			
	Chronic	No	208	16.7	21.356***	1	.115[1]
		Yes	100	27.5			
	Several perpetrators	No	245	19.4	.431	1	-.016
		Yes	65	17.9			
Victim-perpetrator Relationship	Partner		48	25.5[b]	16.319**	4	.100[1]
	Child		160	21.1			
	Other family member		44	18.0			
	Friend		21	15.3			
	Professional or other		37	12.6[b]			
Other Relationship Characteristics	Co-habitation	No	110	16.4	16.848***	1	.120[1]
		Yes	132	26.1			
	Victim's dependency	No	190	19.1	.002	1	-.001
		Yes	120	18.0			
	Perpetrator's dependency	No	287	18.6	3.931*	1	.049[1]
		Yes	23	27.4			

[a] Phi (φ) results are presented, except for the victim-perpetrator relationship, where Cramer's V is presented.
[b] Adjusted standardised residuals show a significant result.
[1]Small effect; [2]Medium effect; [3]Large effect.
*$p < 0.05$ **$p < 0.01$ ***$p < 0.001$.

Barriers Related to Services. These barriers were significantly more likely in those who were female, younger (60-80 years), who did not have dementia, and who had physical or mental health problems (see Table 4.21). They were also more likely in cases of physical or

psychological abuse, poly-victimisation, or where threats were employed. Finally, these barriers were significantly more likely in cases of co-habitation.

Table 4.21

Chi-Square Findings for the Association Between Barriers Related to Services and Case Characteristics

			Barriers Related to Services				
			n	%	χ^2	df	φ/V[a]
Victim Characteristics	Gender	Male	84	15.9	3.890*	1	.049[1]
		Female	218	19.9			
	Age group	60-80	133	22.2	5.186*	1	-.064[1]
		81-102	112	17.1			
	Physical health problems	No	221	17.4	5.907*	1	.060[1]
		Yes	81	23.1			
	Physical disability	No	277	18.4	.364	1	.015
		Yes	25	20.7			
	Mental health problems	No	263	17.3	25.466***	1	.125[1]
		Yes	39	37.1			
	Dementia	No	261	20.0	8.838*	1	-.074[1]
		Yes	41	12.8			
	Previous victimisation	No	294	18.6	.096	1	.008
		Yes	8	20.5			
Abuse Type	Physical	No	244	17.1	17.759***	1	.105[1]
		Yes	58	29.6			
	Psychological	No	125	15.2	12.381***	1	.087[1]
		Yes	177	22.0			
	Financial	No	124	19.7	.830	1	-.023
		Yes	178	17.9			
	Neglect	No	232	18.5	.041	1	.005
		Yes	70	19.0			
	Sexual	No	297	18.6	.000	1	.000
		Yes	5	18.5			
	Poly-victimisation	No	155	16.0	10.995**	1	.082[1]
		Yes	147	22.5			
Abuse Characteristics	Isolation	No	269	18.7	.104	1	-.008
		Yes	33	17.7			
	Threats	No	283	18.0	12.810***	1	.089[1]
		Yes	19	38.0			
	Chronic	No	225	18.0	1.001	1	.025
		Yes	74	20.3			
	Several perpetrators	No	236	18.7	.056	1	-.006
		Yes	66	18.2			
Victim-perpetrator Relationship	Partner		44	23.4	5.297	4	.057
	Adult child		143	18.8			
	Other family member		40	16.3			

			Barriers Related to Services				
			n	%	χ^2	df	φ/V[a]
	Friend		28	20.4			
	Professional or other		47	16.0			
Other Relationship Characteristics	Co-habitation	No	108	16.1	8.905**	1	.087
		Yes	116	23.0			
	Victim's dependency	No	188	18.9	.178	1	-.010
		Yes	114	18.1			
	Perpetrator's dependency	No	285	18.5	.156	1	.010
		Yes	17	20.2			

[a] Phi (φ) results are presented, except for the victim-perpetrator relationship, where Cramer's V is presented.
[1]Small effect; [2]Medium effect; [3]Large effect.
$^{*}p < 0.05$ $^{**}p < 0.01$ $^{***}p < 0.001$.

Barriers Related to Fear. These barriers were significantly more likely in those who were younger (60-80 years) and who did not have dementia, as well as in cases of physical abuse, psychological abuse, poly-victimisation, chronic abuse, or where threats were employed (see Table 4.22). On the other hand, these barriers were less likely when neglect was perpetrated and in cases perpetrated by a friend or a professional or other (non-family); however, they were more common in cases perpetrated by an adult child, where there was co-habitation and when the perpetrator was dependent on the victim.

Table 4.22

Chi-Square Findings for the Association Between Fear-Related Barriers and Case Characteristics

			Fear-Related Barriers				
			n	%	χ^2	df	φ/V[a]
Victim Characteristics	Gender	Male	61	11.5	1.173	1	.027
		Female	147	13.4			
	Age group	60-80	104	17.4	11.085**	1	-.094[1]
		81-102	71	10.8			
	Physical health problems	No	154	12.1	2.645	1	.040
		Yes	54	15.4			
	Physical disability	No	192	12.8	.019	1	.003
		Yes	16	13.2			
	Mental health problems	No	199	13.1	1.810	1	-.033
		Yes	9	8.6			
	Dementia	No	189	14.5	16.877***	1	-.102[1]
		Yes	19	5.9			
Abuse Type	Physical	No	165	11.6	16.605***	1	.101[1]
		Yes	43	21.9			

			Fear-Related Barriers				
			n	%	χ^2	df	φ/V[a]
	Psychological	No	53	6.5	59.856^{***}	1	.192[1]
		Yes	155	19.3			
	Financial	No	84	13.4	.267	1	-.013
		Yes	124	12.5			
	Neglect	No	175	14.0	6.410^{*}	1	-.063[1]
		Yes	33	8.9			
	Poly-victimisation	No	90	9.3	27.000^{***}	1	.129[1]
		Yes	118	18.1			
Abuse Characteristics	Isolation	No	176	12.2	3.621	1	.047
		Yes	32	17.2			
	Threats	No	184	11.7	57.157^{***}	1	.188[1]
		Yes	24	48.0			
	Chronic	No	145	11.6	7.412^{**}	1	.068[1]
		Yes	62	17.0			
	Several perpetrators	No	163	12.9	.073	1	-.007
		Yes	45	12.4			
Victim-perpetrator Relationship	Partner		28	14.9	17.900^{**}	4	.105[1]
	Adult child		118	15.5[b]			
	Other family member		31	12.7			
	Friend		9	6.6[b]			
	Professional or other		22	7.5[b]			
Other Relationship Characteristics	Co-habitation	No	61	9.1	33.606^{***}	1	.169[1]
		Yes	106	21.0			
	Victim's dependency	No	133	13.4	.765	1	-.022
		Yes	75	11.9			
	Perpetrator's dependency	No	186	12.1	14.182^{***}	1	.093[1]
		Yes	22	26.2			

[a] Phi (φ) results are presented, except for the victim-perpetrator relationship, where Cramer's V is presented.
[b] Adjusted standardised residuals show a significant result.
[1]Small effect; [2]Medium effect; [3]Large effect.
$^{*}p < 0.05$ $^{**}p < 0.01$ $^{***}p < 0.001$.

Barriers Related to the Perception of Abuse. These barriers were significantly more likely in those who were male and older (81-102 years), and in financial abuse and chronic cases, and less likely in physical, psychological abuse or neglect cases (see Table 4.23). The presence of these barriers was more likely in cases perpetrated by a friend, but less likely in cases perpetrated by a partner, of co-habitation, or when the victim was dependent on the perpetrator.

Table 4.23

Chi-Square Findings for the Association Between Barriers Related to the Perception of Abuse and Case Characteristics

			Barriers Related to Perception of Abuse				
			n	%	χ^2	df	φ/V[a]
Victim Characteristics	Gender	Male	76	14.4	15.112***	1	-.097[1]
		Female	89	8.1			
	Age group	60-80	51	8.5	4.577*	1	.060[1]
		81-102	80	12.2			
	Physical health problems	No	135	10.6	1.286	1	-.028
		Yes	30	8.5			
	Physical disability	No	153	10.2	.009	1	-.002
		Yes	12	9.9			
	Mental health problems	No	149	9.8	3.162	1	.044
		Yes	16	15.2			
	Dementia	No	136	10.4	.532	1	-.018
		Yes	29	9.1			
Abuse Type	Physical	No	158	11.1	10.616**	1	-.081[1]
		Yes	7	3.6			
	Psychological	No	96	11.7	4.309*	1	-.052[1]
		Yes	69	8.6			
	Financial	No	19	3.0	57.420***	1	.188[1]
		Yes	146	14.7			
	Neglect	No	147	11.7	14.624***	1	-.095[1]
		Yes	18	4.9			
	Poly-victimisation	No	98	10.1	.011	1	.003
		Yes	67	10.3			
Abuse Characteristics	Isolation	No	148	10.3	.242	1	-.012
		Yes	17	9.1			
	Threats	No	162	10.3	.981	1	-.025
		Yes	3	6.0			
	Chronic	No	116	9.3	4.692*	1	.054[1]
		Yes	48	13.2			
	Several perpetrators	No	126	10.0	.171	1	.010
		Yes	39	10.7			
Victim-perpetrator Relationship	Partner		10	5.3[b]	67.197***	4	.203[2]
	Child		67	8.8			
	Other family member		25	10.2			
	Friend		41	29.9[b]			
	Professional or other		22	7.5			
Other Relationship Characteristics	Co-habitation	No	78	11.6	5.992*	1	-.071[1]
		Yes	37	7.3			
	Victim's dependency	No	115	11.6	5.606*	1	-.059[1]
		Yes	50	7.9			
	Perpetrator's dependency	No	157	10.2	.040	1	-.005
		Yes	8	9.5			

[a] Phi (φ) results are presented, except for the victim-perpetrator relationship, where Cramer's V is presented.
[b] Adjusted standardised residuals show a significant result.
[1]Small effect; [2]Medium effect; [3]Large effect.
$^{*}p < 0.05$ $^{**}p < 0.01$ $^{***}p < 0.001$.

Barriers Related to External Circumstances. These barriers were significantly less likely in those who had dementia and in cases of neglect (see Table 4.24), and were significantly more likely in cases of psychological, financial, or chronic abuse, poly-victimisation, where the victim was being isolated, and when the victim was dependent on the perpetrator.

Table 4.24

Chi-Square Findings for the Association Between Barriers Related to External Circumstances and Case Characteristics

			Barriers Related to External Circumstances				
			n	%	χ^2	df	φ/V[a]
Victim Characteristics	Gender	Male	40	7.6	.118	1	.009
		Female	88	8.1			
	Age group	60-80	51	8.5	.073	1	-.008
		81-102	53	8.1			
	Physical health problems	No	101	7.9	.023	1	-.004
		Yes	97	7.7			
	Physical disability	No	117	7.8	.261	1	.013
		Yes	11	9.1			
	Mental health problems	No	118	7.8	.414	1	.016
		Yes	10	9.5			
	Dementia	No	113	8.7	5.615*	1	-.059[1]
		Yes	15	4.7			
Abuse Type	Physical	No	115	8.1	.483	1	-.017
		Yes	13	6.6			
	Psychological	No	51	6.2	6.341*	1	.063[1]
		Yes	77	9.6			
	Financial	No	33	5.2	9.855**	1	.078[1]
		Yes	95	9.6			
	Neglect	No	111	8.9	7.071**	1	-.066[1]
		Yes	17	4.6			
	Poly-victimisation	No	61	6.3	8.474**	1	.072[1]
		Yes	67	10.3			
Abuse Characteristics	Isolation	No	104	7.2	7.277**	1	.067[1]
		Yes	34	12.9			
	Chronic	No	83	6.6	10.453**	1	.081[1]
		Yes	43	11.8			

			Barriers Related to External Circumstances				
			n	%	χ^2	df	φ/V[a]
	Several perpetrators	No	108	9.6	3.637	1	-.047
		Yes	20	5.5			
Victim-perpetrator Relationship	Partner		21	11.2	6.317	4	.062
	Child		53	7.0			
	Other family member		22	9.0			
	Friend		14	10.2			
	Professional or other		18	6.1			
Other Relationship Characteristics	Co-habitation	No	47	7.0	.944	1	.028
		Yes	43	8.5			
	Victim's dependency	No	51	5.1	26.644***	1	.128[1]
		Yes	77	12.2			
	Perpetrator's dependency	No	123	8.0	.456	1	-.017
		Yes	5	6.0			

[a] Phi (φ) results are presented, except for the victim-perpetrator relationship, where Cramer's V is presented.
[1]Small effect; [2]Medium effect; [3]Large effect.
$^{*}p < 0.05$ $^{**}p < 0.01$ $^{***}p < 0.001$.

Barriers Related to Family. These barriers were significantly more likely in female victims (see Table 4.25), cases of psychological abuse, and with multiple perpetrators. They were less likely in neglect cases or where isolation techniques were employed. These barriers were more likely in cases perpetrated by an adult child and with co-habitation, but less likely in cases perpetrated by a friend or a professional or other (non-family), or when the victim was dependent on the perpetrator.

Table 4.25

Chi-Square Findings for the Association Between Barriers Related to Family and Case Characteristics

			Barriers Related to Family				
			n	%	χ^2	df	φ/V[a]
Victim Characteristics	Gender	Male	7	1.3	12.440***	1	.088[1]
		Female	53	4.8			
	Age group	60-80	29	4.8	1.763	1	-.037
		81-102	22	3.4			
	Physical health problems	No	52	4.1	2.528	1	-.039
		Yes	8	2.3			
	Mental health problems	No	57	3.8	.222	1	-.012
		Yes	3	2.9			

	Dementia	No	54	4.1	3.716	1	-.048
		Yes	6	1.9			
Abuse Type	Physical	No	51	3.6	.502	1	.018
		Yes	9	4.6			
	Psychological	No	17	2.1	12.273***	1	.087[1]
		Yes	43	5.4			
	Financial	No	25	4.0	.222	1	-.012
		Yes	35	3.5			
	Neglect	No	56	4.5	9.158**	1	-.075[1]
		Yes	4	1.1			
	Poly-victimisation	No	33	3.4	.589	1	.019
		Yes	27	4.1			
Abuse Characteristics	Isolation	No	58	4.0	4.055*	1	-.050[1]
		Yes	2	1.1			
	Chronic	No	41	3.3	2.953	1	.043
		Yes	19	5.2			
	Several perpetrators	No	54	4.3	5.487*	1	.058[1]
		Yes	6	13.4			
Victim-perpetrator Relationship	Partner		3	1.6	31.118***	4	.138[1]
	Adult child		46	6.1[b]			
	Other family member		11	4.5			
	Friend		0	0[b]			
	Professional or other		0	0[b]			
Other Relationship Characteristics	Co-habitation	No	12	1.8	14.465***	1	.111[1]
		Yes	30	5.9			
	Victim's dependency	No	49	4.9	11.007**	1	-.082[1]
		Yes	11	1.7			

[a] Phi (φ) results are presented, except for the victim-perpetrator relationship, where Cramer's V is presented.
[b] Adjusted standardised residuals show a significant result.
[1]Small effect; [2]Medium effect; [3]Large effect.
*$p < 0.05$ **$p < 0.01$ ***$p < 0.001$.

Cultural, Generational or Religious Barriers. The presence of these barriers was significantly more likely in cases of younger victims (60-80 years; see Table 4.26) and in cases of psychological abuse and co-habitation, but less likely in cases of financial abuse.

Table 4.26

Chi-Square Findings for the Association Between Cultural, Generational, or Religious Barriers and Case Characteristics

			Cultural, Generational, or Religious Barriers				
			n	%	χ^2	df	φ/V[a]
Victim Characteristics	Gender	Male	9	1.7	1.654	1	.032
		Female	30	2.7			

	Age group	60-80	23	3.8	7.649*	1	-.078[1]
		81-102	9	1.4			
	Physical health problems	No	27	2.1	1.971	1	.035
		Yes	12	3.4			
	Dementia	No	36	2.8	3.650	1	-.047
		Yes	3	0.9			
Abuse Type	Psychological	No	13	1.6	4.724*	1	.054[1]
		Yes	26	3.2			
	Financial	No	24	3.8	8.739**	1	-.073[1]
		Yes	15	1.5			
	Neglect	No	27	2.2	1.468	1	.030
		Yes	12	3.3			
	Poly-victimisation	No	21	2.2	.582	1	.019
		Yes	18	2.8			
Abuse Characteristics	Chronic	No	25	2.0	3.020	1	.043
		Yes	13	3.6			
	Several perpetrators	No	30	2.4	.012	1	.012
		Yes	9	2.5			
Other Relationship Characteristics	Co-habitation	No	8	1.2	11.635**	1	.099[1]
		Yes	22	4.4			
	Victim's dependency	No	22	2.2	.383	1	.015
		Yes	17	2.7			

[a] Phi (φ) results are presented, except for the victim-perpetrator relationship, where Cramer's V is presented.
[1]Small effect; [2]Medium effect; [3]Large effect.
*$p < 0.05$ **$p < 0.01$ ***$p < 0.001$.

Relationship Between the Presence of Victim Facilitators and Case Characteristics. The presence of facilitators was significantly more likely in cases where the victim was female, younger (60-80 years), had a physical disability, mental health problems, or had been previously victimised (see Table 4.27). They were less likely in cases where the victim had dementia. Facilitators were also more likely to be present in cases of physical or psychological abuse, chronic abuse, poly-victimisation, or where threats were employed; however, their presence was less likely in neglect cases. Facilitators were more common in cases perpetrated by a partner of the victim, but less likely in cases perpetrated by a professional or other (non-family or friend). In addition, victim facilitators were more likely in cases of co-habitation and perpetrator dependency, but less likely when the victim was dependent on the perpetrator.

Table 4.27

Chi-Square Findings for the Association Between the Presence of Facilitators and Case Characteristics

			Facilitators				
			n	%	χ^2	df	φ/V[a]
Victim Characteristics	Gender	Male	43	8.1	17.228***	1	.103[1]
		Female	170	15.6			
	Age group	60-80	123	20.5	30.479***	1	-.156[1]
		81-102	62	9.5			
	Physical health problems	No	166	13.1	.028	1	.004
		Yes	47	13.4			
	Physical disability	No	185	12.3	11.506**	1	.084[1]
		Yes	28	23.1			
	Mental health problems	No	183	12.1	23.496***	1	.120[1]
		Yes	30	28.6			
	Dementia	No	198	15.2	24.881***	1	-.124[1]
		Yes	15	4.7			
	Previous victimisation	No	202	12.8	7.972**	1	.070[1]
		Yes	11	28.2			
Abuse Type	Physical	No	164	11.5	27.577***	1	.130[1]
		Yes	49	25.0			
	Psychological	No	46	5.6	82.074***	1	.225[1]
		Yes	167	20.8			
	Financial	No	92	14.6	2.034	1	-.035
		Yes	121	12.2			
	Neglect	No	193	15.4	24.860***	1	-.124[1]
		Yes	20	5.4			
	Poly-victimisation	No	94	9.7	24.923***	1	.124[1]
		Yes	119	18.2			
Abuse Characteristics	Isolation	No	185	12.9	.686	1	.021
		Yes	28	15.1			
	Threats	No	191	12.1	43.136***	1	.163[1]
		Yes	22	44.0			
	Chronic	No	138	11.0	21.267***	1	.115[1]
		Yes	74	20.3			
	Several perpetrators	No	172	13.7	1.372	1	-.029
		Yes	41	11.3			
Victim-perpetrator Relationship	Partner		27	19.7[b]	15.088**	4	.096[1]
	Child		108	14.2			
	Other family member		30	12.2			
	Friend		11	8.0			
	Professional or other		27	9.2[a]			
Other Relationship Characteristics	Co-habitation	No	82	12.2	10.973**	1	.097[1]
		Yes	97	19.2			
	Victim's dependency	No	152	15.3	10.695**	1	-.081[1]
		Yes	61	9.7			
		No	192	12.5	10.958**	1	.082[1]

		Facilitators		χ^2	df	φ/V[a]
		n	%			
Perpetrator's dependency	Yes	21	25.0			

[a] Phi (φ) results are presented, except for the victim-perpetrator relationship, where Cramer's V is presented.
[b] Adjusted standardised residuals show a significant result.
[1]Small effect; [2]Medium effect; [3]Large effect.
$^{*}p < 0.05$ $^{**}p < 0.01$ $^{***}p < 0.001$.

4.5.4. Characteristics Associated to Victims' Disclosure

4.5.4.1. Research Question 3a. Are there any case characteristics that predict a victim enquirer to the helpline? The following models include several characteristics (explained in Chapter 2) as predictors and the victim's disclosure to the helpline as outcome.

Model With Victim Variables. The first model included several victim variables as predictors and the variable of enquirer type (victim vs non-victim) as outcome. The victim variables were the victim's gender (female vs male), victim's age (60-80 vs 81-102 years), and several victim characteristics (the presence or absence of physical health problems, physical disability, intellectual disability, mental health problems, dementia, substance abuse problems, and previous victimisation independent of the present situation of EA). After obtaining large standard errors for intellectual disability and dementia, these two variables were eliminated from the model. A model with the remaining variables was statistically significant; $\chi^2(7, N = 1{,}254) = 106.218$, $p < .001$, and a good fit of the data, as indicated by a non-significant result in the Hosmer and Lemeshow test; $\chi^2(6, N = 1{,}254) = 4.510$, $p = .608$. The model parameters are reported in Table 4.28. The victim being the enquirer was explained by the victim being female (2.11 times more likely to be a victim enquirer), younger (5 times more likely to be a victim enquirer), and experiencing mental health problems (2.41 times more likely to be a victim enquirer). The model correctly classified 88% of cases (0% of the cases where the enquirer was the victim).

Table 4.28

Model With Victim Variables and Enquirer Identity

		95% CI for Odds Ratio		
	B (SE)	Lower	Odds Ratio	Upper
Intercept	-1.94 (.21)***			
Female Gender	.75 (.22)**	1.38	2.11	3.22
Age (81-102 years)	-1.62 (.21)***	.13	.20	.30
Physical Health Problems	-.41 (.24)	.42	.66	1.05
Physical Disability	.11 (.33)	.58	1.12	2.14
Mental Health Problems	.88 (.27)**	1.41	2.41	4.13
Substance Abuse	-.51 (1.07)	.07	.60	4.88
Previous Victimisation	.77 (.45)	.89	2.16	5.32

Note. Nagelkerke = .155.
$^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

Model With Abuse Variables. The second model included abuse-related variables as predictors and the enquirer type as outcome. The variables were the presence or absence of different abuse types (physical, psychological, financial, neglect, sexual), the existence of poly-victimisation, and several abuse characteristics (use of isolation techniques, use of threats, abuse chronicity, and several perpetrators involved). This model was statistically significant; $\chi^2(10, N = 1,613) = 190.816$, $p < .001$, and a good fit of the data, as indicated by a non-significant result in the Hosmer and Lemeshow test; $\chi^2(7, N = 1,613) = 4.942$, $p = .667$. The model parameters are reported in Table 4.29. The presence of psychological abuse and sexual abuse in the case increased the chances of the enquirer being the victim (OR = 7.33 and OR = 3.7, respectively). On the other hand, the presence of neglect or the use of isolation by the perpetrator decreased the chances of the victim being the enquirer (OR = 5.55, OR = 5.88, respectively). The model correctly classified 88% of cases (2% of the cases where the enquirer was the victim).

Table 4.29

Model With Abuse Variables and Enquirer Identity

		95% CI for Odds Ratio		
	B (SE)	Lower	Odds Ratio	Upper
Intercept	-2.79 (.39)***			
Physical Abuse	.66 (.35)	.97	1.93	3.85
Psychological Abuse	1.99 (.41)***	3.27	7.33	16.45
Financial Abuse	-.07 (.38)	.44	.93	1.96
Neglect	-1.75 (.48)***	.07	.18	.45
Sexual Abuse	1.31 (.59)*	1.17	3.70	11.72
Poly-victimisation	-84 (.43)	.19	.43	1.01
Isolation	-1.73 (.40)***	.08	.17	.39
Threats	.67 (.35)	.99	1.94	3.82
Chronic	.20 (.19)	.84	1.22	1.77
Several Perpetrators	.01 (.21)	.66	1.01	1.52

Note. Nagelkerke = .217.
$^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

Model With Relationship Variables. The third model included several variables related to the victim-perpetrator relationship as predictors or explanatory variables. Specifically, the victim-perpetrator relationship: partner (1), adult child (2), friend (3), professional and other (4), with a family member that is not a partner or child employed as the reference category. Other variables were the victim's dependency on the perpetrator, the perpetrator's dependency on the victim, and the victim-perpetrator's co-habitation. The model was statistically significant; $\chi^2(7, N = 1{,}177) = 46.357$, $p < .001$, and a good fit of the data, as indicated by a non-significant result in the Hosmer and Lemeshow test; $\chi^2(6, N = 1{,}177) = 3.392$, $p = .758$. The model parameters are reported in Table 4.30. Within the model, the victim-perpetrator relationship and the victim's dependency on the perpetrator were the only significant predictors. The victim being the enquirer was less likely in cases where the victim was being abused by a friend, as compared to the reference category, and less likely when the victim depended on the perpetrator (OR = 3.03; OR = 2.86). The model correctly classified 87% of cases (0% of the cases where the enquirer was the victim).

Table 4.30

Model With Victim-Perpetrator Relationship Variables and Enquirer Identity

		95% CI for Odds Ratio		
	B (SE)	Lower	Odds Ratio	Upper
Intercept	-1.40 (.23)***			
Victim-perpetrator Relationship (Family member)				
Partner	.46 (.32)	.86	1.59	2.96
Adult Child	-.26(.26)	.46	.77	1.29
Friend	-1.12 (.48)*	.13	.33	.83
Professional and Other	.18 (.30)	.66	1.20	2.16
Co-habitation	-.34 (.21)	.47	.71	1.08
Victim's Dependency	-1.05 (.22)***	.23	.35	.54
Perpetrator's Dependency	.59 (.33)	.96	1.81	3.42

Note. Nagelkerke = .072.
$^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

Model With Perpetrator Variables. The fourth model included several perpetrator variables as predictors and the variable of enquirer type as outcome. The perpetrator variables were similar to the victim variables, except for age, which was missing in most cases and was not considered relevant to the outcome variable. The variables were the perpetrator's gender (female vs male), and several perpetrator characteristics (the presence or absence of physical health problems, physical disability, intellectual disability, mental health problems, dementia, substance abuse problems, previous victimisation as a child, and antisocial attitudes). This model was not statistically significant; $\chi^2(9, N = 1{,}401) = 12.950$, $p = .165$, but it was a good fit of the data, as indicated by a significant result in the Hosmer and Lemeshow test; $\chi^2(5, N = 1{,}401) = 3.346$, $p = .647$. The model parameters are reported in Table 4.31. The model correctly classified 88% of cases (0% of the cases where the enquirer was the victim).

Table 4.31

Model With Perpetrator Variables and Enquirer Identity

		95% CI for Odds Ratio		
	B (SE)	Lower	Odds Ratio	Upper
Intercept	-1.85 (.13)***			
Female Gender	-.35 (.17)*	.51	.71	.99

Physical Health Problems	-.03 (.67)	.26	.97	3.59
Physical Disability	-.26 (1.21)	.07	.77	8.28
Mental Health Problems	.35 (.32)	.77	1.42	2.65
Substance Abuse	-.14 (.35)	.43	.87	1.74
Previous Victimisation	.78 (.87)	.40	2.19	11.93
Antisocial Attitudes	-15 (.20)	.58	.86	1.27

Note. Nagelkerke = .018.
$^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

Overall Model. The final model included several variables relating to the victim, abuse, and victim-perpetrator relationship as predictors and the enquirer type as outcome. The variables included were the ones that were significant within models that were significant overall and a good fit of the data. These variables were the victim's gender, age group, mental health problems, psychological abuse, neglect, sexual abuse, dependency on the perpetrator, the use of isolation, and the victim-perpetrator relationship. This model was statistically significant; $\chi^2(12, N = 1{,}253) = 227.166$, $p < .001$, and a good fit of the data, as indicated by a non-significant result in the Hosmer and Lemeshow test; $\chi^2(8, N = 1{,}253) = 6.961$, $p = .541$. The model parameters are reported in Table 4.32. The case was more likely to be reported by the victim when the victim was female (OR = 2.48), younger (60-80) (OR = 4.17), when they had mental health problems (OR = 2.33), and were suffering psychological abuse by the perpetrator (OR = 3.63). On the other hand, cases where the victim was experiencing neglect were more likely to be reported by someone else (OR = 7.69), as were those where the perpetrator was employing isolation techniques (OR = 5.88). Victims were also less likely to be the ones reporting when the perpetrator was an adult child (OR = 1.75) or friend (OR = 3.85). This model correctly predicted 89% of cases but was a poor predictor of victims' self-reporting to the helpline, predicting only 20% of cases correctly.

Table 4.32

Overall Model With Victim, Abuse, and Victim-Perpetrator Relationship Variables and Enquirer Identity

		95% CI for Odds Ratio		
	B (SE)	Lower	Odds Ratio	Upper
Intercept	-2.38 (.34)***			
Female Gender	.91 (.24)***	1.54	2.48	3.99
Age (81-102)	-1.43 (.23)***	.14	.24	.38
Mental Health Problems	.84 (.31)**	1.27	2.33	4.26
Psychological Abuse	1.29 (.23)***	2.29	3.63	5.76
Neglect	-2.04 (.49)***	.05	.13	.34
Sexual Abuse	.68 (.61)	.60	1.97	6.48
Isolation	-1.76 (.49)***	.07	.17	.45
Victim-perpetrator Relationship (Family member)				
Partner	.30 (.34)	.69	1.35	2.63
Adult Child	-.55 (.27)*	.34	.57	.97
Friend	-1.36 (.59)*	.08	.26	.82
Professional and Other	.45 (.34)	.81	1.56	3.01
Victim's Dependency	-.44 (.25)	.39	.64	1.06

Note. Nagelkerke = .316.
$^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

4.5.4.2. Research Question 3b. Are there any case characteristics that predict victims contacting formal vs informal sources? To understand if different predictors were associated to different disclosure types, a variable was created with two categories: informal disclosure and formal disclosure (to the helpline or to other formal sources). Variables were analysed by groups, following the procedure in 4.5.4.1.

Model With Victim Variables. The first model included several victim variables (see Section 4.5.4.1.) as predictors and the variable of victim disclosure type (formal vs informal) as outcome. Due to large standard errors, the victim's intellectual disability was removed from the model. A model with the remaining variables was statistically significant; $\chi^2(8, N = 417) = 45.015$, $p < .001$, and a good fit of the data, as indicated by a non-significant result in the Hosmer and Lemeshow test; $\chi^2(5, N = 417) = .787$, $p = .978$. The model parameters are reported in Table 4.33. Within the model, the victim's age and dementia were significant predictors of

disclosure type. The victim disclosing informally as opposed to formally was more common when the victim was older (81-102 years) (OR = 2.43) or when the victim had dementia (OR = 5.88). This model correctly classified 63% of cases.

Table 4.33

Model With Victim Variables and Disclosure Type (Formal vs Informal)

		95% CI for Odds Ratio		
	B (SE)	Lower	Odds Ratio	Upper
Intercept	-.09 (.24)		.92	
Female Gender	.45 (.24)	.98	1.57	2.51
Age (81-102)	-.90 (.22)***	.26	.41	.62
Physical Health Problems	-.03 (.27)	.57	.97	1.66
Physical Disability	.12 (.36)	.44	.89	1.80
Mental Health Problems	.59 (.38)	.87	1.81	3.79
Dementia	-1.75 (.63)**	.05	.17	.60
Substance Abuse	-1.43 (1.15)	.03	.24	2.29
Previous Victimisation	.53 (.60)	.53	1.70	5.46

Note. Nagelkerke = .137.
$^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

Model With Abuse Variables. The second model included several variables related to the abuse (see Section 4.5.4.1.) as predictors and victim disclosure type as the outcome. The model was statistically significant; $\chi^2(10, N = 503) = 66.185$, $p < .001$, and a good fit of the data, as indicated by a non-significant result in the Hosmer and Lemeshow test; $\chi^2(10, N = 503) = 4.210$, $p = .883$. The model parameters are reported in Table 4.34. Within the model, psychological abuse, isolation, and poly-victimisation were significant predictors of disclosure type. Specifically, suffering psychological abuse was positively associated with formal disclosure (OR = 3.49). On the other hand, poly-victimisation and the use of isolation were positively related to informal disclosure (OR = 3.12; OR = 4.16; respectively). The model correctly classified 64% of cases.

Table 4.34

Model With Abuse Variables and Disclosure Type (Formal vs Informal)

		95% CI for Odds Ratio		
	B (SE)	Lower	Odds Ratio	Upper
Intercept	-.31 (.41)			
Physical Abuse	.76 (.40)	.98	2.15	4.70
Psychological Abuse	1.25 (.45)**	1.49	3.49	8.40
Financial Abuse	-.11 (.41)	.50	1.11	2.48
Neglect	-1.79 (.42)	.20	.45	1.04
Sexual Abuse	.50 (.65)	.46	1.65	5.91
Poly-victimisation	-1.14 (.47)*	.13	.32	.80
Isolation	-1.44 (.39)***	.11	.24	.51
Threats	.03 (.39)	.48	1.03	2.24
Chronic	-.04 (.23)	.62	.97	1.51
Several Perpetrators	.38 (.24)	.43	.68	1.09

Note. Nagelkerke = .165.
$^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

Model With Relationship Variables. The third model included several variables related to the victim-perpetrator relationship (see Section 4.5.4.1.) as predictors or explanatory variables. It was statistically significant; $\chi^2(7, N = 398) = 20.913$, $p = .004$, and a good fit of the data, as indicated by a non-significant result in the Hosmer and Lemeshow test; $\chi^2(7, N = 398) = 4.764$, $p = .689$. The model parameters are reported in Table 4.35. The victim-perpetrator relationship and the victim's dependency on the perpetrator were the only significant predictors. The perpetrator being a professional or other was positively associated with formal disclosure (OR = 2.33) and a victim's dependency on the perpetrator was positively associated with informal disclosure (OR = 1.96). The model correctly classified 61% of cases.

Table 4.35

Model With Victim-Perpetrator Relationship Variables and Disclosure Type (Formal vs Informal)

		95% CI for Odds Ratio		
	B (SE)	Lower	Odds Ratio	Upper
Intercept	-.11 (.27)		.90	
Victim-perpetrator relationship (Family member)				
Partner	.68 (.38)	.94	1.98	4.15
Adult child	.04 (.31)	.57	1.04	1.88
Friend	-.31 (.51)	.27	.73	2.01
Professional and other	.84 (.37)*	1.13	2.33	4.80
Co-habitation	-.24 (.24)	.49	.79	1.26
Victim's dependency	-.67 (.24)**	.32	.51	.81
Perpetrator's dependency	.38 (.38)	.69	1.46	3.09

Note. Nagelkerke = .068.
$^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

Model With Perpetrator Variables. The fourth model included several perpetrator variables as predictors (see Section 4.5.4.1.) and disclosure type as outcome. This model was not statistically significant; $\chi^2(7, N = 462) = 7.896$, $p = .342$, but was a good fit of the data, as indicated by a non-significant result in the Hosmer and Lemeshow test; $\chi^2(5, N = 462) = .439$, $p = .994$. The model parameters are reported in Table 4.36. The model correctly classified 57% cases.

Table 4.36

Model With Perpetrator Variables and Disclosure Type (Formal vs Informal)

		95% CI for Odds Ratio		
	B (SE)	Lower	Odds Ratio	Upper
Intercept	.06 (.15)			
Female Gender	-.47 (.20)*	.43	.63	.92
Physical Health Problems	-.26 (.79)	.16	.77	3.64
Physical Disability	-.11 (1.05)	.11	.90	7.03
Mental Health Problems	.19 (.36)	.60	2.21	2.45
Dementia	.48 (.96)	.25	1.61	10.57
Substance Abuse	-.59 (.42)	.25	.55	1.25
Antisocial Attitudes	-.06 (.22)	.61	.94	1.45

Note. Nagelkerke = .023.
$^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

Overall Model. The final model included several variables relating to the victim, abuse, and victim-perpetrator relationship as predictors and disclosure type (formal vs informal) as outcome. The variables included were the ones that were significant within models that were significant overall and a good fit of the data: the victim's age group, the victim's dementia, psychological abuse, the use of isolation, poly-victimisation, the victim-perpetrator relationship, and the victim's dependency on the perpetrator. This model was statistically significant; $\chi^2(10, N = 417) = 68.024$, $p < .001$, and a good fit of the data, as indicated by a non-significant result in the Hosmer and Lemeshow test; $\chi^2(8, N = 417) = 4.429$, $p = .816$. The model parameters are reported in Table 4.37. Within the model, several variables were significant: the victim's age group and dementia, the presence of psychological abuse, the use of isolation techniques, and poly-victimisation. Specifically, cases of psychological abuse were more likely to be reported to formal sources (OR = 1.79). On the other hand, cases where the victim was older (81-102 years), suffering from dementia, being isolated, or suffering from multiple types of abuse were more likely to be disclosed to informal sources (OR = 2.13; OR = 5.26; OR = 3.23; OR = 2.04: respectively). This model correctly classified 66% of cases (63% of informal disclosure cases and 68% of formal disclosure).

Table 4.37

Overall Model With Victim, Abuse, and Victim-Perpetrator Relationship Variables and Disclosure Type (Formal vs Informal)

		95% CI for Odds Ratio		
	B (SE)	Lower	Odds Ratio	Upper
Intercept	.41 (.31)		1.51	
Victim Age (81-102)	-.75 (.23)**	.30	.47	.74
Victim Dementia	-1.66 (.64)*	.05	.19	.67
Psychological Abuse	.58 (.29)*	1.02	1.79	3.14
Isolation	-1.17 (.43)**	.14	.31	.72
Poly-victimisation	-.72 (.25)**	30	.49	.80
Victim-perpetrator Relationship (Family member)				
Partner	.23 (.38)	.59	1.26	2.68
Adult child	-.18 (.30)	.47	.84	1.51

		95% CI for Odds Ratio		
	B (SE)	Lower	Odds Ratio	Upper
Friend	-.62 (54)	.19	.54	1.54
Professional and Other	.48 (.39)	.74	1.62	3.47
Victim's Dependency	-.44 (.26)	.39	.65	1.08

Note. Nagelkerke = .201.
$^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

4.5.5. Goals When Contacting the Helpline

Research Question 4. What do victims want to achieve by seeking help (for example, from contacting a helpline)? The reason for contacting the helpline (i.e., what they wanted to achieve) in the cases that were self-reported (n = 82) was analysed using qualitative content analysis. The main goals can be found in Table 4.38. Primarily, victims wanted emotional support or to talk with someone, followed by wanting general or specific support (e.g., from Hourglass, legal or housing advice).

Table 4.38

Victims' Goals When Enquiring From the Helpline

	Frequency	
Things victims want	*n*	%
Emotional support or talking to someone (including face-to-face)	18	20.9
Specific support by Hourglass (e.g., writing a letter, referral to EARS or adult safeguarding)	15	17.4
General support or advice, or help in getting such support or advice	13	15.1
Support in finding legal advice (general or relating to POA, prosecution, or the perpetrator's eviction)	10	11.6
Housing advice (e.g., relocating to a new place or country, returning home)	9	10.5
Advice on accessing a specific service or help (e.g., mediation, counselling)	7	8.1
Help to stop the perpetrator, the abuse, or resolve situation	4	4.7
Publicise or record their experience	4	4.7
Support for the perpetrator or support for both themselves and the perpetrator	3	3.5
Information or knowledge about rights	3	3.5

Note. The total percentage exceeds 100 because several victims provided several goals for the enquiry. n = 86. EARS = Elder Abuse Recovery Service; POA = Power of Attorney.

4.5.6. Attitudes Towards Third-Party Intervention

Research Question 5. What are victims' attitudes towards third-party intervention? Another study aim was to gather more information about victims' attitudes towards third-party intervention. For example, what victims want to happen when others, particularly formal services, get involved, and what they want to avoid. This information was gathered in free texts, where available, for both the victim and non-victim enquirer. This section examines the victims' views, as reported by the victims themselves or by non-victim enquirers. Some of the categories relating to wishes towards intervention (particularly, specific wishes) may overlap with the goals for contacting the helpline. However, the latter represents what they wanted at the time of contacting the helpline and their reason for contacting the helpline, which is a narrower aspect than their general wishes towards third-party intervention—which also covered areas other than outcomes for themselves.

Qualitative content analysis was utilised, and the findings can be found in Table 4.39. It was found that both the wishes towards intervention and what victims wanted to avoid related to several main areas (e.g., specific support from services, living arrangements, the perpetrator). The most common categories within these areas are highlighted. A full list of categories coded can be found in Appendix K.

Table 4.39

Victims' Wishes Towards Third-Party Intervention

Things Victims Want (n = 195)					
Area of Focus	n	%	Most Common Categories	n	%
Specific support from services	76	39.0	• Talking to someone or getting emotional support	17	8.7
			• Legal advice, support, or assistance, or help in getting such advice	13	6.7
Housing or living arrangements	61	31.3	• The perpetrator to leave, or be evicted	25	12.8
			• Leaving house temporarily or permanently (for suitable housing)	13	6.7
			• Remaining at home "in peace"	10	5.1

Things Victims Want (n = 195)					
Area of Focus	*n*	%	Most Common Categories	*n*	%
Relationship with the perpetrator	17	8.7	• Continuing a similar relationship where abuse is still happening • Perpetrator to be away • Maintaining relationship but with the abuse stopping or changing, or an improvement in the relationship	5 4 4	2.6 2.1 2.1
Support from and relationship with CPs	15	7.7	• Support from CPs or staying close to them • CPs actively supporting them, being POAs or looking after finances • CPs being with them in accepting support, as their bridge to support	6 5 4	3.1 2.6 2.1
Disclosure of abuse	10	5.1	• Time to disclose or talk about what happened	3	1.5
The perpetrator	10	5.1	• Help, support, or protection for the perpetrator (e.g., medical, with an addiction)	7	3.6

Things victims do not want (n = 251)					
Area of focus	*n*	%	Most common categories	*n*	%
Specific support from services	100	39.8	• Social services' involvement • Police involvement • Taking "harsh" steps (e.g., prosecution, charges, injunction, court)	23 19 12	9.2 7.6 4.8
Housing or living arrangements	27	10.7	• The perpetrator to leave or asking them to do so • Being admitted to a care home, especially one that is inappropriate for them • Leaving their home or moving out	7 6 5	2.8 2.4 2.0
Relationship with the perpetrator	22	8.8	• Losing contact with the perpetrator, divorcing them, or not being visited by them • Perpetrator managing finances, being POA, or deputy	11 5	4.4 2.0
Support from and relationship with CPs	18	7.2	• CPs being involved, interfering with abuse, or confronting perpetrators • Listening to CPs' concerns or meeting to discuss those	8 5	3.2 2.0
Disclosure of abuse and outcomes from it	37	14.7	• Talking a lot about situation or discuss what is happening • Making situation worse by reporting • Speaking in front of the perpetrator (e.g., with social services) • Reactions of disbelief by services	7 7 4 4	2.8 2.8 1.6 1.6
The perpetrator	26	10.4	• Any negative consequences for the perpetrator (e.g., job loss, arrest, homelessness)	26	10.4

Note. CP = concerned person.

Some victim wishes were at odds with other victims' wishes. For example, some victims wanted a relationship with the perpetrator, while others wanted none; some wanted help from concerned persons, and others did not want them to interfere. However, some

commonalities can be found. There seemed to be a general wish for emotional and legal support, and a reluctance to involve social services or the police, or "harsh" steps—at least initially. Victims also wanted to live in their homes, but many wanted the perpetrator to leave. Some were willing to leave their home for suitable housing, but there was a reluctance to go into a care home, especially one that was not appropriate for their needs. Finally, regarding the perpetrator, there was a common wish to avoid negative consequences such as the perpetrator losing their job or becoming homeless, and some victims wanted help for them.

4.5.7. Advice Provided

Research Question 6. What are enquirers advised to do by an EA helpline? The advice provided by the helpline was gathered and classified, depending on the service that enquirers were signposted to. In 1,388 cases, some advice was recorded by the helpline (86%). The most common service advised was adult safeguarding or local social services (n = 704, 51%). Enquirers were also frequently advised to seek legal advice (e.g., contacting Solicitors for the Elderly or other legal services; n = 433, 31%). Contacting the police was advised in fewer cases (n = 203, 15%). Sometimes enquirers were advised to contact management staff (e.g., at a nursing home) (n = 63, 5%) or the Care Quality Commission, which monitors care quality in care homes and other care services (n = 33, 2%).

Many other enquiries involved advice to contact other services not previously reflected in the categories (n = 654, 47%). These included domestic violence organisations, contacting Hourglass again, the Health Ombudsman, an Independent Mental Capacity Advocate (IMCA), the Grandparents Association, Silverline helpline, a GP, Action Fraud UK, Men's Advice Helpline, Action against Medical Accidents (AvMA), Elderly Accommodation Council (EAC), or specific services for dementia, Alzheimer's, or Parkinson's.

Research Question 6a. Are there any differences in the advice provided when the enquirer is a victim vs a third party? There was a significant association between enquirer's identity (victim vs. non-victim) and the advice type provided. Specifically, victim enquirers were less likely to be advised to contact safeguarding, $\chi^2(1, N = 1{,}388) = 28.377$, $p < .001$, and legal services, $\chi^2(1, N = 1{,}388) = 5.211$, $p = .022$. However, victims were more likely to be signposted to other services outside of these categories (see examples in the section above) than non-victims, $\chi^2(1, N = 1{,}388) = 35.163$, $p < .001$. There was no significant association between enquirer's identity and the signposting to other services, i.e., the police ($p = .687$), management ($p = .542$) or the Care Quality Commission ($p = .110$).

Research Question 6b. Are there any differences in the advice provided based on the abuse type suffered by the victim? There was a significant association between the different types of advice provided and the abuse type experienced. For example, adult safeguarding was more likely to be advised for victims of neglect; $\chi^2(1, N = 1{,}388) = 48.286$, $p < .001$ and physical abuse; $\chi^2(1, N = 1{,}388) = 5.367$, $p = .021$, and less likely in financial abuse cases; $\chi^2(1, N = 1{,}388) = 20.622$, $p < .001$.

The helpline was more likely to advise contacting the police in cases of physical; $\chi^2(1, N = 1{,}388) = 6.053$, $p = .014$, psychological; $\chi^2(1, N = 1{,}388) = 5.252$, $p = .022$, and financial abuse; $\chi^2(1, N = 1{,}388) = 7.127$, $p = .008$ but less likely in neglect cases; $\chi^2(1, N = 1{,}388) = 17.749$, $p < .001$. They were more likely to suggest legal advice in cases of financial abuse; $\chi^2(1, N = 1{,}388) = 83.173$, $p < .001$, but less likely to suggest this type of advice in every other EA type: physical, $\chi^2(1, N = 1{,}388) = 16.231$, $p < .001$; psychological, $\chi^2(1, N = 1{,}388) = 20.687$, $p < .001$; neglect, $\chi^2(1, N = 1{,}388) = 10.359$, $p = .001$; and sexual, $\chi^2(1, N = 1{,}388) = 5.089$, $p = .024$.

They were more likely to advise contacting management (e.g., at a care home; see section above) in cases of physical abuse, $\chi^2(1, N = 1,388) = 7.786$, $p = .005$, or neglect, $\chi^2(1, N = 1,388) = 6.194$, $p = .013$, and less likely in financial abuse cases; $\chi^2(1, N = 1,388) = 9.718$, $p = .002$. Advice to contact the Care Quality Commission was more likely in cases of neglect, $\chi^2(1, N = 1,388) = 33.631$, $p < .001$ and less likely in psychological, $\chi^2(1, N = 1,388) = 5.094$, $p = .024$, and financial abuse cases; $\chi^2(1, N = 1,388) = 34.858$, $p < .001$. Finally, the helpline was more likely to advise other services to victims of psychological abuse, $\chi^2(1, N = 1,388) = 22.275$, $p < .001$.

4.6. Findings Study 3

The characteristics of the victims, the abuse, and the victim-perpetrator relationship can be found in Table 4.40. Victims ($N = 20$) were predominantly female, and all but one suffered more than one abuse type. Concerned persons were asked to indicate the victims' ages; some provided a range of ages (from the time they started supporting them until they stopped supporting them or until the moment of their participation in the study, if the situation was ongoing). The victims' ages when the concerned person started supporting them ranged from 50 to 93 years ($M = 76.15$, $SD = 10.82$), and the victims' ages at the moment of participating in the study or when they stopped supporting the victim ranged from 60 to 99 years ($M = 80.20$, $SD = 10.48$). One concerned person reported the experience of two victims.

Table 4.40

Victim, Abuse, and Victim-Perpetrator Relationship Characteristics

			Cases	
			n	%
Victim characteristics	Gender			
		Female	16	80.0
		Male	4	20.0
	Country of residence			
		UK	7	35.0
		United States	6	30.0
		Australia	4	20.0

			Cases	
			n	%
		Canada	3	15.0
	Relationship status			
		Widowed	10	50.0
		Divorced/separated	6	30.0
		Married	3	15.0
		Other	1	5.0
	Lacks capacity according to enquirer		7	35.0
	Assessed by professional as lacking capacity		7	35.0
Abuse type	Psychological		15	75.0
	Financial		14	70.0
	Neglect		10	50.0
	Physical		7	35.0
	Sexual		4	20.0
Abuse poly-victimisation	Any co-occurrence		19	95.0
Abuse location	Victim's home		14	70.0
	Care home/nursing home		10	50.0
	Hospital		3	15.0
	Sheltered accommodation		1	5.0
	Other		2	10.0
Abuse chronicity (>6 months of duration)			15	75.0
Victim-perpetrator relationship	Family member		13	65.0
	Adult child		6	30.0
	Adult child and child in-law		3	15.0
	Stepchild		1	5.0
	Great-grandchild		1	5.0
	Partner		1	5.0
	Partner and stepchildren		1	5.0
	Professional		5	25.0
	Neighbour		1	5.0
	Professional and care home resident		1	5.0
Victim-perpetrator co-habitation during abuse			7	35.0
Victim-perpetrator co-habitation currently			3	15.0
Victim's dependency on the perpetrator			14	70.0
Perpetrator's dependency on the victim			10	50.0

Note. Participants could indicate multiple answers for abuse type and location.

The following paragraphs include the results of the analysis of the survey and interview qualitative data referring to the victim. These are presented in line with the research questions.

Research Question 1a(i). Are there any barriers caused by the perpetrator's behaviour?

In seven cases (35%), concerned persons reported barriers to victims' help-seeking specific to the perpetrator behaviour (i.e., the perpetrator did something to prevent the victim from reporting). Specifically, they alienated the victim from the rest of the family or prevented the concerned person from visiting them (n = 2) or failed to acknowledge the issues raised (n = 1). In one case, the perpetrator reacted angrily if their behaviour was questioned. A perpetrator who was a carer was described as using "detailed notes" as a distraction. Finally, two respondents mentioned that the perpetrator(s) manipulated the victim or manipulated the information that they victim could access. For example,

> *"(...) carefully psychologically manipulate the information that my mother could access and restrict the vast amount of information (...)" (P1).*

One of those also thought that the perpetrator had threatened the victim but did not specify how.

Research Question 1d. What responses do victims obtain from disclosure recipients?

The concerned persons who participated in the study found out about abuse through the victim's disclosure in 10 cases (50%) and reported that in four of those cases (40%), there had been an escalation prior to the victim's disclosure. In one case (10%), the situation had just started. Eight participants indicated how they responded to the victim's disclosure (40%). Two concerned persons described how they felt (stunned, angry, helpless), but not exactly how they responded. Two respondents stated that they tried to obtain more information or clarification from the victim, in one case after a vague disclosure. One of those tried to direct the victim to advice. Three responded by validating the victim's feelings, hugging them, or telling them that they would try to stop the abuse. Finally, a respondent highlighted that they were unsure about how to react at the time, even though they provided the help that the victim was asking for:

> *"I didn't know what to do with that information. (...) I don't think I even knew what to say to her at the time" (P6).*

Research Question 5. What are victims' attitudes towards third-party intervention?

In terms of how concerned persons thought the victim would react to their trying to help, there were 18 responses referring to 19 victims. These were divided into whether participants thought the victim would support their actions or not, and whether they understood the situation. Some concerned persons' responses fit into two response types; thus, the frequencies exceed 19.

- Negatively or unsupportively (*n* = 9, 47%): worrying about themselves or the concerned person—as well as their relationship with the concerned person—or not agreeing that they needed help or that the concerned person should take action:

  "Her wishes would be that I'd kept my mouth shut and didn't stand up for her" (P1)

  "She worried about the abuser and was also afraid of his anger" (P5).

  "Mum was worried for me; she knew he was trying to stop me from visiting and she did not want that" (P11).

- Positively or supportively (*n* = 7, 37%): for example, the victim was "appreciative" or "glad", or "wanted to be believed".
- Would not understand the situation, its severity, or was unaware due to cognitive limitations (*n* = 5, 25%):

  "I don't think she would understand the severity and consequences and how harmful it is to have such a person working with vulnerable elders" (P3).

In terms of the help the victim received, five respondents indicated that there was no help (25%) and one said there was "very little" help (5%). One indicated that they only got help from the respondent (5%). Two were unsure or did not know (10%). For the other victims (*n* = 11, 55%), the help received was varied: medical, with housing, perpetrator's eviction, victim's advocacy, help by detectives, assisted living, from the family, staff support, access to care, gift cards, emotional support, or help with destroying credit cards. Regarding victims'

satisfaction with the help received, respondents were asked to indicate whether they thought the victim was satisfied, not satisfied, or satisfied with some help but not all, and give reasons for dissatisfaction:

- Victim was satisfied with the help received in only two cases (10%).
- The victim was not satisfied with the help received in 11 cases (55%). Eight respondents indicated reasons, such as not being believed, not recovering the money, the abuse continuing, or the help coming slowly. For example:

  > *"After a long hospital stay, she was moved to another nursing home. They too are treating my mother horribly. They knew what happened to her and they have done nothing to help her" (P9).*
  >
  > *"She was treated as having BPSD (Behavioural and Psychological Symptoms of Dementia). And she had made up all of her allegations" (P12).*

- The victim was satisfied with some help but not all (n = 1, 5%). In this case, the respondent indicated that the victim understood that the concerned person had *"pushed and pushed for her to get the help she has needed for so many years" (P6).*
- The respondent did not know whether the victim was satisfied in six cases (30%). As one respondent indicated, it was sometimes difficult to know due to lack of information about the victim:

  > *"That's impossible to answer, whether she's satisfied or not. Because, ehm, yeah, I've no idea what's going on in the house" (P1).*

Research Question 5a. What would victims like to happen to the perpetrator, and what is the relationship that victims would like with the perpetrator?

When asked about the victims' wishes for the perpetrator, six did not provide a (clear) answer, and three said that they did not know or that it was unclear. Among the other answers (n = 11), the following wishes were reported:

- Legal consequences (e.g., charges, prosecution, prison sentence, $n = 4$, 36%).
- Nothing (bad) to happen ($n = 2$, 18%).
- The perpetrator to be away from victim or prevented from visiting victim ($n = 2$, 18%).
- Firing or removal from a position of caring for victim (i.e., in a care home, $n = 2$, 18%).
- The perpetrator to change ($n = 1$, 9%).

In six cases (30%), the victim was still in contact with the perpetrator, and in 12 they were no longer in touch (60%).

- In terms of how they felt about being in touch, participants indicated that "they loved their children (perpetrator)" ($n = 2$, 33%), they were frightened or afraid ($n = 2$, 33%), or they had no choice or were forced to stay ($n = 2$, 33%).
- In terms of how they felt about not being in touch, respondents indicated that six victims were deceased (50%). Four participants provided no answer (33%) and two indicated that the victim did not care or wanted no contact (33%).

However, seven participants indicated that the victims wished for their relationship to be different (35%). Four participants indicated that the victim wanted a better relationship with the perpetrator, where there was less conflict and anger, and they were treated better. Three participants indicated that the victim wanted to be away from the perpetrator.

4.7. Discussion

The two studies reported in this chapter aimed to provide a better understanding of several aspects related to help-seeking behaviour by EA victims. Specifically, Study 2 aimed to fill the gaps of Study 1 (the systematic literature review) as well as test some of the findings from Study 1 to identify whether these applied to a UK-based sample. The analyses in this chapter identified that the barriers and facilitators from Study 1 were reported in the EA cases that comprised the Study 2 sample. Although most barriers and facilitators reported fit into the general themes and subthemes identified in Study 1, several present in the cases analysed did

not fit in those pre-identified subcategories; thus, Study 2 expanded on the understanding of the myriad barriers that victims experience, as well as the factors that facilitate help-seeking.

Victims were a minority of the helpline enquirers; however, many had disclosed the abuse to someone prior to their enquiry, and victims had sometimes confronted the perpetrator. Prior to enquiring, victims sought help primarily from informal services and obtained mostly positive responses. Nevertheless, they had generally not been successful in stopping the abuse and, in some cases, the abuse had worsened. Significant predictors of victims' self-report to the helpline were identified, as well as differences between victims who disclosed informally or formally, and these are discussed in this section. Finally, information arose about what victims' wishes are when they contact a helpline, both immediately and long-term, and the advice that they are given from the helpline in these cases.

In Study 3, the aim was to explore victims' help-seeking further through gathering primary data, including some areas not covered in Study 2, such as satisfaction with services and the help received. The findings provided further knowledge about the way in which victims disclose abuse, their attitudes towards the perpetrators of abuse, and the victims' views on intervention and satisfaction with help received.

4.7.1. Discussion Study 2

4.7.1.1. Summary of Findings in Relation to Previous Research

Barriers. The findings provided support for the barriers and facilitators identified through the systematic review (Study 1), as all of these were present to some degree in the cases reported. In addition, Study 2 highlighted the relative frequencies of barrier themes. Barriers related to the victim's social network and individual feelings regarding help-seeking were the most frequently reported. Many victims were isolated, and some experienced a variety of negative feelings regarding help-seeking, many of which did not fit into the pre-identified

subthemes (Acierno et al., 2020; Bows, 2018; Chokkanathan et al., 2014; Gil et al., 2017; Lafferty et al., 2013; Mowlam et al., 2007; Mysyuk et al., 2016; Ribot et al., 2015; Tamutiene et al., 2013; Vrantsidis et al., 2016; Yan, 2015). However, the context of the helpline may introduce some bias, making some barriers more likely to be mentioned than others. For example, barriers related to formal services, previously identified in research studies (Bows, 2018; Chokkanathan et al., 2014; Lafferty et al., 2013; Mowlam et al., 2007; Tamutiene et al., 2013; Wydall & Zerk, 2017) were the third most common. The commonality of this barrier type is not surprising as enquirers to the helpline are likely to be commenting on their experiences with formal services of help, if they have tried any, as well as their concerns regarding future engagement. Another limitation is that there is no information about the relative importance of barriers from the perspective of victims; thus, the relative frequencies do not translate in relative influence on victims' behaviours.

A commonality in several of these new categories was the influence of the perpetrator on the victims' ability to seek help, and the interconnectedness between the perpetrator's behaviour and the barriers described. Examples of these can be seen in the barrier subthemes related to services and social network. For example, perpetrators blocked services from reaching the victim, prevented the victim from speaking to anyone alone, and influenced the victims' perceptions of those trying to help (e.g., by alleging that concerned persons were the perpetrators). Instances of the perpetrators preventing the victim from using a telephone or communicating with others have been previously reported, and this behaviour could be more impactful during the social distancing measures to fight COVID-19, where communication via telephone may be essential in keeping older adults connected (Elman et al., 2020).

Some of these perpetrator behaviours reflect the concept of coercive control (Barlow et al., 2020), and these findings illustrate how they can impact victims' opportunities to seek help. In previous research with older female domestic abuse victims, perpetrator behaviour was

identified as one of the key barriers, involving perpetrators' tactics to prevent the victim from seeking help (Newman et al., 2013). Knowledge about perpetrators' behaviours can be helpful for practitioners, who may encounter them and need to recognise that they present a red flag. In a previous study (Storey & Perka, 2018), case workers frequently experienced challenges in visiting or communicating with the victim, commonly related to the perpetrator not allowing contact, or making this contact unsafe.

There was a significant association between the barriers reported in Study 2 and several case characteristics, relating to the victim, abuse, and victim-perpetrator relationship, consistent with previous research (Acierno et al., 2020). Although some barriers examined in the current study overlap with case characteristics (e.g., isolation was logically more common in those who were isolated by the perpetrator), many findings are useful for future research and practice. Specifically, by probing a client about certain factors related to themselves, the abuse, or their relationship with the alleged perpetrator, practitioners may be able to understand which barriers to help-seeking to expect moving forward. For instance, barriers related to the perception of the abuse were more common in cases of older male victims who were experiencing financial abuse, and who were being abused by a friend. These characteristics are consistent with previous literature (e.g., McClurg, 2013) indicating that financial abuse may not always be as apparent as other types of abuse and that victims may not always recognise it as abusive or exploitative. The finding related to the victim-perpetrator relationship also fits within a pattern of a perpetrator befriending an older person for financial gain. These findings are complemented by the qualitative analysis of barriers relating to the perception of abuse. In some cases, victims were described as thinking that giving money to the perpetrator was a good deed or that they would recover the money, when it was clear to others that they would not.

Barriers related to formal services were quite common, and they encompassed a variety of negative attitudes towards and negative experiences with formal services, as well as the

blocking of services by the perpetrator. Barriers related to formal services were addressed in the research studies reviewed in Study 1 (Bows, 2018; Chokkanathan et al., 2014; Lafferty et al., 2013; Mowlam et al., 2007; Tamutiene et al., 2013; Wydall & Zerk, 2017). In the current study, barriers related to formal services were more common in females in the younger age group (60-80), with physical or mental health problems, possibly suggesting that these vulnerabilities may have led to the previous interaction with services (Andersen, 1965), and, perhaps, to more negative experiences than other victims. These barriers related to formal services were also more likely in cases of physical or psychological abuse, poly-victimisation, and cases where the perpetrator employed threats. This association could be because, in some of these cases, victims were more likely to self-report, and thus, they may also have had more interaction with services. Barriers related to services seemed to occur on a continuum and some related to previous negative experiences with services, thus suggesting the effect of feedback on future help-seeking intention, as reflected in the Theory of Planned Behavior (TPB; Ajzen, 1985). In any case, the results show that victims' negative attitudes are likely to negatively impact both formal services and concerned persons' ability to support them, and the dynamics regarding the latter are explored further in Chapter 5.

Facilitators. Knowledge about facilitators was more limited in Study 2, and there were fewer pre-identified themes to explore. Consistent with the research reviewed in Study 1, the most commonly reported facilitators were circumstances leading to seeking help, particularly an escalation in abuse prior to the victim seeking help or the victim's fear for their safety (Jackson & Hafemeister, 2015; Mowlam et al., 2007; Mysyuk et al., 2016; Tamutiene et al., 2013; Vrantsidis et al., 2016; Yan, 2015). New facilitators from Study 2 follow a similar pattern of the victim's feelings of urgency or desperation, unhappiness with their situation, or need for change. These qualitative findings are consistent with some of the quantitative analyses in Study 2. For example, facilitators were significantly more likely in cases where there was

physical abuse, poly-victimisation, or threats, all of which suggest severity. Similarly, previous research by Burnes, Acierno, and Hernandez-Tejada (2019) has found higher help-seeking in cases of physical abuse and poly-victimisation. Facilitators were also more likely in cases which were chronic, suggesting that victims may endure abuse for some time, and seek help when the abuse increases in severity or when their perceptions of the situation change (Jackson & Hafemeister, 2015; Yan, 2015). Some victims sought help because they were concerned about the perpetrators' needs, consistent with research in Australia (Joosten et al., 2020).

The findings in Study 2 indicate that emotions such as fear acted both as barriers to help-seeking (e.g., fear of the perpetrator) and as factors that led victims to seek help (e.g., when they feared for their safety). Fear is a commonly experienced reaction, according to the results focusing on EA victims in Portugal (Santos et al., 2019). Similarly, victim's mental health problems were associated with seeking help; as well as one of the barriers (i.e., when victims felt anxious about going through the help-seeking process). Future research would benefit from a further exploration of when certain victims' feelings or circumstances relating to fear may act as barriers or facilitators. It may be related to reaching some sort of threshold (e.g., Mysyuk et al., 2016; Yan, 2015), which will be different depending on the victim.

Victim Disclosure and Predictors of Disclosure. The findings in Study 2 highlight victims' ability to disclose abuse, which has been discussed in previous research (Burgess & Phillips, 2006; Richmond et al., 2020). Although victims were a minority of helpline enquirers, 466 (29%) had disclosed the abuse previously to an informal source, such as the person contacting the helpline, or a formal source, including the helpline. Disclosure to an informal source was more frequent, which is common in other fields (e.g., child sexual abuse; Winters et al., 2020). Consistent with previous research on intimate partner violence and also on EA, the findings suggest that, by focusing only on formal reports by victims, there is an underestimation of older adults' ability to disclose abuse (Chabot et al., 2018; Jackson &

Hafemeister, 2015; Sylaska & Edwards, 2014). In fact, due to the lack of specific probing by the helpline staff in Study 2, it is possible that many more victims previously disclosed the abuse to someone else (Storey & Perka, 2018). There was evidence that some victims in the sample in Study 2 also acted by confronting the perpetrator, a behaviour that has rarely been studied in EA victims (Nahmiash, 1999). Understanding of the use of confrontation is important because, in some of the cases, there was an escalation of abuse following confrontation. Thus, confronting the perpetrator can be risky, and practitioners should make victims aware of the risks and explore alternative and safer ways of taking action.

In relation to victim's disclosure, Study 2 has provided additional information about the victims most likely to disclose abuse, and, conversely, those least likely to do so. The overall model found that female victims and those in a younger age group (60-80 years) were more likely to self-report to the helpline. These findings mean that male victims may be less likely to reach out to services and could be explained by research showing that there is more stigma associated to seeking help by older males (Band-Winterstein, 2012; Bates & Carthy, 2020; Kaye et al., 2007). Thus, it is important for practitioners to understand that their older male clients may face more barriers if they are experiencing abuse, and this knowledge should be incorporated into training. The findings also indicate that, as age increases, victims may encounter more barriers to seeking help, consistent with previous research (Tamutiene et al., 2013). Those experiencing mental health problems were more likely to self-report, perhaps prompted by other complex needs, and consistent with previous study findings and with the "need" component of the Behavioral Model of Health Services Use (Andersen, 1968; Naughton et al., 2013; Tamutiene et al., 2013).

In terms of victims least like to disclose, the findings indicated that victim's self-report was less likely in cases where the victim was experiencing neglect, isolation, or abuse by a friend or an adult child. The findings regarding neglect could be explained because victims

experiencing this type of abuse need more care and are more likely to be in a situation that does not allow them to report as easily, especially if they are institutionalised (Joosten et al., 2020). Findings concerning the adult-child relationship are consistent with previous research that identifies increased barriers when the perpetrator is an adult child (Vrantsidis et al., 2016). Lower likelihood of reporting abuse perpetrated by a friend could relate to findings regarding the association between barriers identifying the abusive situation as such and financial abuse perpetrated by friends. For example, when a victim is befriended by someone, it is usually those around the victim who see the abuse happening and not the victim (as described in some enquiries). In any case, information regarding predictors of self-reporting should inform awareness campaigns, so that those least likely to report can be targeted.

Predictors of Victims' Formal and Informal Disclosure. Study 2 also found that different case characteristics predicted informal as opposed to formal disclosure. Older victims, suffering from dementia, and who were being isolated, were more likely to disclose informally as opposed to reporting formally. Interestingly, despite the potential association with severity and formal help in previous research (Burnes, Acierno, & Hernandez-Tejada, 2019), poly-victimisation was also associated with informal disclosure. These findings suggest that, like in other fields of interpersonal violence, there are different factors associated to informal disclosure compared to formal reporting, which should be considered in future research (Sylaska & Edwards, 2014).

In the final models, characteristics of the victim, abuse, and victim-perpetrator relationship were significant in explaining victims' self-reporting and disclosure type. On the other hand, models which included perpetrator characteristics as predictors were not significant in explaining the outcome. This finding could be due to the relative low rates of perpetrator needs in the sample in Study 2, such as mental health or substance abuse problems. These perpetrator needs are frequently found in higher rates in other samples (Joosten et al., 2020;

Storey & Perka, 2018). Lower rates of complex needs are likely due to the lack of specific probing for these needs (Storey & Perka, 2018). Future research with more reliable data on perpetrators' needs should study their contributing role in victims' disclosure and help-seeking, particularly considering that qualitative data indicated that some victims in the sample in Study 2 sought help from services due to the perpetrators' increasing needs (Joosten et al., 2020).

Experiences of Victims Suffering Cognitive Limitations. One of the aims of Study 2 was to reflect the help-seeking experience of victims suffering from cognitive limitations, such as those associated with dementia. Specifically, there was an aim to understand whether cognitive limitations posed additional barriers to seeking help, as previously suggested (Bows, 2018; Nahmiash, 1999). This seemed to be the case when analysing barriers relating to the perception of abuse qualitatively. Some victims' memory problems meant that they had difficulty remembering abuse details, especially relating to financial abuse (e.g., if they had signed important paperwork, such as house deeds), which are likely to make it hard to report or prove the abuse. These findings add to the limited knowledge regarding the disclosure of EA and help-seeking by victims with cognitive limitations (e.g., Bows, 2018; Burgess & Phillips, 2006; Richmond et al., 2020) and should be considered in terms of their implications for interactions in the Criminal Justice System. A charity in Northern Ireland created an app to help domestic abuse victims record crucial facts about the abuse and keep a record of events, which they could use afterwards to prove and prosecute abuse (Scaffold, n.d.). An adaptation of this idea—considering ability limitations—could be explored in relation to older victims of abuse with cognitive limitations, who may benefit from help in recording and remembering events.

Responses to and Outcomes of Help-Seeking. The general experiences of victims with regard to services accessed were mostly negative, at least in reference to an improvement of their situation or a cessation of the abuse, which is a common way of measuring EA outcomes

(Burnes et al., 2021). Although, logically, those who have been unsuccessful are more likely to contact a helpline—thus skewing the data—this finding is still a worrying discovery. The experiences of those who were not successful, even if they were not representative of all EA cases, are important in terms of adequately servicing this population. These findings are helpful for understanding how to offer victim services that they will be likely to accept.

A recent scoping review highlighted the need to conduct qualitative research with victims focused on understanding "meaningful intervention outcomes from their perspectives" (Burnes et al., 2021, p. 7). The current study has contributed knowledge about victims' wishes in terms of intervention, as well as the things that they would like to avoid, such as involving specific services (e.g., social services or the police) or being placed in a care home. Although victims were not direct participants, this is a step forward towards including victims' perspectives and priorities in intervention outcomes (Burnes, Hsieh, et al., 2019; Burnes et al., 2021). Consistent with a recent study (Burnes, Hsieh, et al., 2019) which looked at outcomes of success, victims' wishes towards third-party intervention did not solely concern themselves or the specific formal help they could get. Victims had wishes regarding help for the perpetrator of abuse, the relationship and frequency of contact with them, their living arrangements, concerned persons' involvement in helping them, the ways in which they wanted to discuss the abuse (e.g., face to face), and the direct outcomes from disclosure. Another finding in Study 2 was that there were a variety of feelings towards intervention, and that what some victims wanted was the opposite of what other victims wanted. For example, some victims wanted "justice", and others wanted emotional support. Although there were some common themes, such as a wish for the perpetrator to leave and for the perpetrator to receive help, a blanket intervention approach is likely to fail in servicing all older adults who suffer abuse.

Hence, practitioners may benefit from a victim-centred (Spangler & Brandl, 2007) and broad approach in probing about wishes and planning intervention. An intervention plan may

respect victims' wishes in one area (e.g., perpetrator's eviction), but fail to meet other wishes (e.g., the perpetrator not being homeless) if there is not an appropriate remediation (e.g., housing assistance for the perpetrator). As expressed by Storey and Perka (2018), "failure to (…) meet the victims' needs may lead to victims recanting or refusing to cooperate with intervention" (p. 1065). It may also make them less likely to pursue help in the future, by negatively influencing their attitudes towards help-seeking (Ajzen, 1985). Thus, failure to consider victims' needs in different areas could leave the older adult in a position of harm (i.e., living with the perpetrator). Overall, since successful interventions with the victim will need to also consider the perpetrator, more research aimed at understanding perpetrators' perspectives and needs is necessary (DeLiema et al., 2018; Dong, 2015; Labrum & Solomon, 2018).

4.7.2. Limitations and Strengths of Study 2

Study 2 is not without limitations. Primarily, it represents a group of EA cases that is biased in several ways. One source of bias is that these are cases in which there is at least one person, either the victim or someone else, trying to seek a remedy for the abusive situation. This might therefore underrepresent cases with isolated victims, victims who cannot overcome other barriers, and where there has been no successful attempt to seek help. Cases where victims are managing abuse on their own may also be underrepresented. This sample is also skewed geographically, as it is more representative of England than any other UK nation, as the online database was being used more regularly in England.

The source of data (e.g., the organisation) may affect the data obtained. Hourglass has a specific agenda in terms of their own campaigning work and characteristics that may attract some enquiries but not others. Nevertheless, this helpline was chosen due to its strengths (i.e., representativeness, national recognition, and special focus on EA; Podnieks et al., 2010). The cases of abuse in this sample are not substantiated and are based on self-reporting by helpline enquirers. Thus, there could be false positives in the sample. However, the inclusion of false

positives is mitigated by the training of helpline staff and volunteers, and supervision by helpline coordinators. In addition, because the aim of Study 2 was to understand help-seeking in EA cases, the perception of enquirers as victims of EA or helpers of a person suffering abuse is of utmost importance.

Due to the use of secondary data, there may also be bias in the type of data gathered within the sample. For example, the available data is determined by the information that enquirers self-report and the details that helpline workers record in the database. The potential bias in the available data should be considered when interpreting results relating to variables that are more likely to be affected by the context of the helpline. Finally, due to the use of secondary data, the researcher did not have access to some variables of interest. For example, during piloting, it became clear that obtaining any reliable estimate of the frequency of abuse, or the source that victims contacted first (formal or informal), was not possible.

The sample used may also be more representative of certain EA types (i.e., financial and psychological), which were more common in the sample. However, this was consistent with their general prevalence (Yon et al., 2017). Sexual abuse cases were a minority; thus, future research should aim to explore this understudied type of EA (Joosten et al., 2020). It is unknown whether the sample in Study 2 is representative of the racial and ethnic diversity of the UK population. Even though, among the cases where race/ethnicity was recorded, the proportion of Black and Minority Ethnic groups was higher than is estimated in the older UK population (ONS, n.d.), the cases with race/ethnicity information were too few to determine whether it was in fact representative. In terms of representation, it is worth mentioning that other general characteristics of the victims and perpetrators in the sample matched previous literature. For example, the perpetrators were most commonly related to the victim, primarily adult children, and the abuse happened at the victim's home (Aas, 2018; Hamby et al., 2016). The abuse types perpetrated and poly-victimisation rates are also consistent with previous

research based on helpline data (Joosten et al., 2020; Weissberger et al., 2020). However, since the helpline workers do not enquire directly about all EA types, it is likely that the rates of poly-victimisation, as well as the rates of other variables, are higher than reported in Study 2 (Storey & Perka, 2018; Williams et al., 2020).

Finally, there are other limitations as they pertain to the logistic regression analyses with different forms of disclosure as outcomes. The set of analyses that used the victim's self-report to the helpline as an outcome may be biased due to the fact that the helpline is a specific source of formal reporting, and thus not representative of other sources of formal reporting (e.g., police, social services). However, this set of analyses is strong in terms of the temporal relationship between predictors and outcome, as all the case characteristics studied (e.g., a victim's mental health problems) were present prior to the victim contacting the helpline. On the other hand, the analyses using the outcome of previous or current formal disclosure and previous informal disclosure cannot establish temporality in the same way. For example, if a victim had sought help before, there is no information about when they sought help and whether some of the characteristics preceded help-seeking. On the other hand, using this outcome has the advantage of considering both formal and informal reporting, as well as different cases of formal reporting not exclusive to the helpline context.

Despite the limitations in Study 2, there are also clear strengths associated to the use of secondary data from a helpline, which contribute to available knowledge. For example, this is a national sample, representative of different types of abuse, victim characteristics, and abuse locations (e.g., victim's home, residential facilities). Some of these strengths have been recently reported in a study that employed a similar methodology by Weissberger et al. (2020). For example, the fact that the study uses data representative of the information available to frontline workers. Study 2 is also diverse in terms of the victims and abuse cases represented, as previous studies reviewed have been limited by their exclusion of cases where the victim has any

cognitive limitations and their lack of focus on cases of institutional abuse (Fraga Domínguez et al., 2021). Study 2 included cases of victims living with dementia, thus furthering knowledge of this understudied population, for example, by examining barriers and facilitators associated to cognitive limitations or memory problems. Chapter 5 expands more on issues related to victims who have dementia or are institutionalised, from the perspective of concerned persons.

Similarly, and thanks to the use of secondary data, the sample in Study 2 is three times larger than the biggest sample in the studies reviewed in Study 1. As a result, the researcher was able to perform quantitative analyses that may not have been possible in previous research samples due to their small sample size (e.g., those relating barriers and facilitators to specific case characteristics). It has also been possible to ascertain the relative frequency of different barriers and facilitators identified in Study 1. Further, Study 2 has considerably expanded on those barriers and facilitators, by discovering new themes and subthemes and describing them in detail. Finally, this is the first study to explore victims' attitudes towards intervention and wishes in such a large number of EA cases, an area that is in need of study (Burnes et al., 2021).

4.7.3. Discussion Study 3

The findings in Study 3 are consistent with findings in Study 2 and complement these by providing further qualitative data in areas that were not addressed in Study 2. The findings provide additional support for the idea that victims frequently disclose to informal supporters. Participants in Study 3, who were primarily family members, had found out about abuse from the victim in half of the cases. Hence, victims' informal disclosure should receive further attention in research and when reporting figures are provided, given the frequency in the sample and the fact that it has not been researched as frequently as formal disclosure. The way in which concerned persons responded was overall supportive; however, some felt anger, were unsure about how to react, or needed more information. The latter is not surprising, as disclosures can

be vague initially (Truong et al., 2019). Most participants were family members of the victim, in cases of abuse perpetrated by other family members, which may explain feelings of anger.

Findings related to barriers caused by the perpetrator are also consistent with Study 2. Perpetrators prevented victims from speaking out by isolating or manipulating them, as previously identified in research (Elman et al., 2020; Newman et al., 2013). In residential institutions, they used different techniques (such as failing to acknowledge issues or using "distraction" techniques). Further understanding of barriers caused by the perpetrator is needed, so that this knowledge can inform the general understanding of the reasons why victims do not disclose. In addition, information about these barriers should be incorporated into training for professionals and organisations working in these cases, who may encounter such behaviours.

Study 3 provided further findings on victims' attitudes towards external help, particularly when this help was offered by concerned persons in the study. Many victims did not want concerned persons involved, consistent with the findings in Study 2, and the reasons were varied. For example, to protect themselves or the concerned person, but also due to disagreement with the concerned person about the need for help. Finally, some victims were unaware of the situation due to cognitive limitations (e.g., caused by dementia). Victims' rejection of concerned persons' help is likely to be challenging for concerned persons and is further explored in Chapter 5. Similarly, a lack of awareness from the victim might place more weight on the response by concerned persons, who may feel sole responsibility for the victim's safety (Latané & Darley, 1970). This may also be true in cases where victims do not receive much help from formal services, which was indicated by participants in Study 3, who reported that victims' satisfaction with the help received was low. For example, some victims were not believed and there were disclosures that were attributed to dementia.

Finally, Study 3 has expanded on the victims' views towards their relationships with the perpetrators, as well as what they wished happened to the perpetrator of abuse. Victims' wishes for perpetrator outcomes were mixed, mirroring the findings in Study 2; however, some supported legal consequences (e.g., charges or prosecution) or wanted the perpetrator to be physically away from them. This indicates that, at least for some victims, there is some support for legal consequences, and it should not be assumed that victims will oppose these measures (Jackson & Hafemeister, 2011). On the other hand, several wanted the perpetrator to change, which was identified as a goal in previous research (Mowlam et al., 2007), or to receive no negative consequences. Victims' wishes in terms of their relationship with the perpetrator were equally diverse, and some wanted a better relationship with the perpetrator. Staying away from a blanket or one-size-fits-all approach is likely to be most beneficial in intervening with victims and addressing the perpetrator's relationship, consistent with a victim-centred approach (Fraga Domínguez et al., 2020; Spangler & Brandl, 2007).

4.7.4. Limitations and Strengths of Study 3

Study 3 is limited by a small sample size and there is also a probable bias in the participants towards those who have experienced more negative experiences with services, who may have felt more inclined to share these experiences. Regardless, as in Study 2, it is clear that at least some victims and concerned persons experience negative interactions with services, which are worth highlighting and have implications for practice. Another limitation is that the data was not obtained directly from victims; however, many findings are consistent with findings in Study 2, which included data self-reported by victims. Future studies should gather these data directly from victims, but the challenges of doing so are acknowledged.

The study also has important strengths. Firstly, the sample is diverse in terms of abuse types, the victim-perpetrator relationships, and countries involved. Particularly, it includes several cases of sexual abuse, as well as abuse occurring in residential facilities, thus expanding

research on help-seeking in these under-researched areas. Importantly, this is one of the first studies to date to obtain so much in-depth data about the involvement of concerned persons in helping victims, and their experiences are explored in Chapter 5.

4.7.5. Theoretical Implications

The following section summarises the theoretical implications of the studies reported in this chapter, including the original contributions that they make to existing knowledge of EA victims' help-seeking. The findings provide support for the conceptualisation of help-seeking as an ongoing process, rather than an isolated incident (Truong et al., 2019). The studies reported have provided further support for the theories and the model presented in Chapter 1. Specifically, the consideration of barriers and facilitators to help-seeking at different levels (individual, interpersonal, societal) is consistent with the Ecological Systems Theory (Bronfenbrenner, 1979). Victims appear to seek help prompted by an escalation in the abuse or their circumstances and a sense of urgency. This is consistent with the Behavioral Model of Health Services Use (Andersen, 1965), in which one of the key contributing factors to service utilisation is the "need" factor, which relates to the nature and magnitude of the abuse (Burnes, Acierno, & Hernandez-Tejada, 2019). Finally, victims' attitudes towards help-seeking (including wanting to avoid services, or negative attitudes as a result of previous interaction with services) were influential in the victim's decision to seek help, consistent with the TPB (Ajzen, 1985). Thus, it is possible that a combination of several theories and models, rather than an isolated model, is best suited to explain help-seeking in EA, perhaps due to the complexity of this phenomenon and the diversity of EA cases.

The main contributions to knowledge are the support that these studies provide for the idea that victims disclose in higher rates than usually attributed by a focus on formal reporting (Lachs & Berman, 2011; Richmond et al., 2020). The studies also provided further information about the variety of barriers to help-seeking that victims experience, as well as more

information about the facilitators to help-seeking or the circumstances that prompt victims to reach out to others about abuse. Importantly, this chapter has outlined the ways in which barriers and facilitators are associated with case characteristics, which can guide further research in the area. Finally, more knowledge about victims who are more and less likely to seek help, as well as the evidence of differences between informal and formal help-seeking, is important in furthering understanding of help-seeking. Studies 2 and 3 have also provided more information about EA victims' wishes when they seek help, which complements the knowledge about outcomes that victims want to avoid (Burnes et al., 2021).

4.7.6. Implications for Practice

The findings reported in the current chapter have several implications for practice. First, the constellation of barriers and facilitators can be used to train professionals, so that they are not only aware of detection signs of EA, but also of the reasons why victims stay quiet, or what circumstances may help victims to report abuse. Professionals can also expect to identify different barriers in victims depending on the victim characteristics, the abuse they are suffering, and their relationship with the perpetrator. This knowledge and expectations can help professionals to explore the barriers most relevant to the clients they are working with and may facilitate engagement. Second, the knowledge about the characteristics of the victims least likely to seek help should also be integrated into training for professionals likely to encounter EA (i.e., those who work with older adults) and should also be utilised in the design of awareness campaigns. Third, the understanding that victims seek help with diverse goals in mind, and with a variety of wishes in terms of intervention outcomes, as well as different things they want to avoid, should help to inform practitioners that a one-size-fits-all approach is unlikely to work, and may lead many victims to disengage with services.

Approaching each potential victim as an individual, and enquiring and respecting that victim's wishes, may lead to trust and further engagement. It is important not to make

assumptions (e.g., that victims will not want prosecution), but rather recognise each client as a person with their own particular set of circumstances, consistent with a victim-centred and personalised approach (Daniel & Bowes, 2011; Dong & Wang, 2016; Spangler & Brandl, 2007). However, knowledge about the barriers and facilitators most likely to be present in certain cases may help practitioners in approaching victims when they know who the perpetrator is or what type of abuse they are suffering. The influence of the perpetrator in trying to prevent victims from seeking help should be considered by professionals. Some of the behaviours described in this chapter, such as isolating techniques—i.e., preventing the victims from speaking with or seeing others, including services (Storey & Perka, 2018)—should be considered red flags.

4.7.7. Implications for Research

The findings reported in Study 2 and 3 have several implications for future research priorities, which have been highlighted in the discussion section of this chapter. First, further research should be conducted relating to specific barriers to help-seeking that may be more susceptible to change or recognition by professionals. One of them is victims' perception of different abuse types, including financial abuse, and how this influences help-seeking. Such knowledge could help to inform the design and content of awareness campaigns and also how to address victims' perceptions in their interaction with services. Another important area is investigating barriers related to the perpetrators' influence. A further understanding of perpetrators' behaviours could then inform professionals' interactions so that they are able to recognise these and identify them as red flags. Finally, it is important to explore the circumstances in which certain feelings (e.g., fear) may act as barriers or facilitators.

Second, further research that considers informal disclosure as well as formal disclosure will be important in understanding how often victims disclose informally, as opposed to research which considers only formal reports. In connection to this, research should focus on

understanding the different dynamics (and barriers and facilitators) related to formal and informal disclosure, so that targeted information can be used to train professionals and to inform the general population via awareness campaigns, respectively.

Third, more research on the help-seeking experience of victims of understudied EA types, such as sexual abuse, is needed to understand whether different barriers apply to these cases. Knowledge about barriers specific to this type of abuse could help in training professionals in services likely to interact with older victims of sexual abuse. Fourth, more studies focused on perpetrators and involving perpetrators as participants are needed in order to advance EA help-seeking research, given that the perpetrators' needs and behaviours influence victims' help-seeking. This research should focus on two particular areas: 1) perpetrator characteristics and their relationship with victims' self-report, and 2) perpetrators' attitudes towards external help. Knowledge in these two areas can help to further understand victims' help-seeking predictors and their willingness to get involved with formal services.

4.8. Conclusions

The current chapter aimed to provide a further understanding of EA victims' help-seeking, reporting the data of two studies: a secondary analysis of helpline data, and an analysis of primary data gathered through surveys and interviews. The findings indicate that victims face many barriers to help-seeking at different levels, and that these barriers are different depending on their own characteristics and circumstances, the abuse they are suffering, and their relationship with the perpetrator. Despite these barriers, victims disclose abuse, informally and formally, potentially at larger rates than are usually attributed to this population. However, it seems that several victims seek help following an escalation in the abuse or its impact, their unhappiness with the situation, and a situation of urgency. A considerable number of victims hold negative views towards specific services, and victims hold a variety of views towards external help and intervention. These findings should be integrated into learning for

professionals as they may need to explore these negative experiences in their interaction with older adults. The best method for researchers and practitioners is a victim-centred approach that listens to victims’ voices and aims to respect their wishes.

CHAPTER 5- CONCERNED PERSONS' HELP-SEEKING

5.1. Introduction

The focus of this chapter is on concerned persons (Breckman et al., 2017), who are family members, friends, neighbours, or acquaintances who seek help on behalf of victims of elder abuse (hereafter "EA"). The general review of the literature on concerned persons' help-seeking experiences presented in Chapter 1 identified limited research. As a result, the two studies discussed in this chapter aimed to gather data about the experiences of help-seeking by concerned persons. The two studies explored the profile of concerned persons, their experience of seeking help (including barriers, facilitators, sources, and responses), as well as the impact of seeking help on behalf of a victim. A second aim was to explore concerned persons' attitudes towards external intervention, including formal and informal help, and their wishes in terms of outcomes for the perpetrators of abuse.

5.2. Literature Review

There is little known about the experience of those who try to support victims of EA but are not professionals guided by training on detection and reporting (Fraga Domínguez et al., 2020). Although concerned persons have sometimes been included in studies with victims, the primary objective of their involvement in research has usually been to "inform" about the victim's experience, rather than to investigate their own experience of accessing help (e.g., Jackson & Hafemeister, 2015; Schiamberg et al., 2012). More frequently, family members participate in studies on EA as caregivers of the victim (e.g., Lin, 2018; Orfila et al., 2018) and may be approached or included by researchers as potential EA perpetrators. Further research on people who help victims has focused mostly on understanding what may move a bystander, in a professional or informal context, to get involved, as well as on issues related to the process of EA recognition (e.g., Gilhooly et al., 2016). Thus, there is little research on the help-seeking experiences of non-abusing family members of EA victims.

Nonetheless, a number of researchers have published studies that provide insight about the role and experience of concerned persons. Recent survey research conducted in the United States provided more information about family members, friends, and neighbours who know an EA victim (Breckman et al., 2017). For example, they found that knowing about a situation of EA is associated with experiencing distress, and supporting a victim of EA is associated with higher distress (Breckman et al., 2017). However, due to the study being based on part of a larger survey, it was not possible to enquire and report about the reasons for distress, as well as the kind of things that supporters were asked to do by victims or services. Thus, there is still little understanding about the barriers that concerned persons face when trying to support an EA victim, as well as the effect that this experience might have on their wellbeing. In the UK, a case study by Mackay (2017) provided some insight on the challenges and burden of a family member who supported an older couple at risk of harm. More recently, Kilaberia and Stum (2020) have further reported on the impact of supporting a family member, based on their interviews with concerned family members in the United States in cases of financial EA. The impact reported was wide-ranging and severe; however, the findings may be more applicable to family supporters and cases of financial abuse (Kilaberia & Stum, 2020). Research by Burnes, Breckman, et al. (2019) in the United States identified that concerned persons' involvement in EA cases predicted victims' formal service utilisation, thus stressing their important role in connecting EA victims with help.

Overall, there is limited understanding of ways to support concerned persons in helping their loved ones. Given the key role of informal support in EA victims' service utilisation, and potentially in informal disclosure and formal reporting, a better understanding of concerned persons' experience is needed (Burnes, Breckman, et al., 2019). In cases where the victims' cognitive abilities may prevent them from making decisions about their risk, the role of informal concerned persons may be essential in connecting the older person to the necessary

formal services. Therefore, a better understanding could help in identifying the kind of support that concerned persons may need in supporting older victims of abuse. Geographically, research is generally limited to the United States, so it is unknown whether the situation is similar in the UK and other countries.

5.3. Research Questions

Based on the research gaps identified, research in this chapter aimed to improve the understanding of the perspective of help-seeking by concerned persons in a UK context and in several other English-speaking countries, as well as in Spain (although there were no Spanish participants). These were countries with which the researcher was familiar through research and which had some commonalities in the way they addressed EA. Specifically, these studies focused on the characteristics of concerned persons, barriers, facilitators, sources of help sought, responses received when seeking help, and concerned persons' attitudes towards intervention. Another focus of these studies was the impact of seeking help or knowing about EA on concerned persons.

The following research questions and sub-questions were the focus of this chapter:

1. What are the characteristics of concerned persons and their help-seeking experience?
    a. What is the profile of concerned persons (demographic characteristics, relationship with victim and perpetrator)?
    b. What are the barriers concerned persons face when seeking help?
        i. Are there any barriers caused by the perpetrator's behaviour?
    c. What are the facilitators (e.g., social support) that enable help-seeking and/or the circumstances (e.g., escalation) that prompt a decision to seek help?
    d. To whom do concerned persons disclose the abuse?
        i. Do concerned persons confront the perpetrator?

e. What responses do concerned persons obtain from sources of help, and what is concerned persons' degree of success in improving the victims' situation?

2. What is the impact of knowing about the abuse and/or getting involved in helping the victim?
3. What do concerned persons want to achieve by seeking help (for example, contacting a helpline)?
4. What are concerned persons' attitudes towards third-party intervention?
    a. Are there any specific expectations or wishes relating to informal or formal intervention?
    b. What would concerned persons like to happen to the perpetrator?
5. What are the most common sources signposted by an EA helpline in their advice to enquirers?

Research questions 1 and 2 link with thesis aim b) in Chapter 2 (p. 81). Questions 2-5 are related to thesis aim c).

5.4. Methodology

This chapter focuses on data relating to concerned persons. To answer the research questions, two studies were conducted gathering two types of data: secondary data (Study 2) and primary (Study 3). Thus, two different studies are discussed in this chapter. First, Study 2 was based on the analyses of secondary data from a helpline; the full methodology is described in Chapter 4. Second, Study 3 was based on primary data obtained using a survey and a semi-structured interview. Both the semi-structured interviews and survey had the same objectives and nature. However, the semi-structured interviews allowed for a more in-depth discussion of issues and participants' perceptions.

5.4.1. Methodology Study 2

The full methodology is described in Chapter 4 of this thesis (see pp. 159-170). The sample of the original study, after inclusion criteria (*N* = 1,623) consisted of EA cases, affecting a primary victim aged on average 80.9 years and a perpetrator aged on average 51.9 years. The data were obtained from a charity and cases which met inclusion and exclusion criteria were fully coded by the researcher. This chapter focuses only on cases reported by concerned persons; thus, other cases were excluded. Specifically, within the 1,623 cases in the original sample, 189 cases (12%) were reported by victims, and 67 cases (4%) were reported by professionals. There were also several cases where the person contacting the helpline was the perpetrator (*n* = 3, 0.2%) and where the relationship with the victim was unknown (*n* = 12, 0.7%). This left a final sample for this chapter of 1,352 cases. The analyses reported in the current chapter are descriptive statistics and the results of qualitative content analysis of secondary data from Study 2 for those 1,352 cases.

5.4.2. Methodology Study 3

The methodology for Study 3 is described in Chapter 2 of this thesis (pp. 103-114); please see Chapter 4 for the details of participants and the corresponding victims (pp. 221-222). The analyses that were conducted for the current chapter were descriptive statistics and qualitative content analysis. In addition, focusing on the two interviews, which were more in-depth than the survey responses and contained more data, thematic analysis was used in order to further engage with these data and reflect the participants' experience. The objective was to identify common themes in these participants' experiences of seeking help on behalf of an EA victim. The analysis followed the orientation of reflexive thematic analysis (Braun & Clarke, 2020), characterised by the researcher's reflective engagement with, and interpretation of, the data. The researcher familiarised herself with the data and took notes during transcription and while reading the transcriptions. Afterwards, she coded the transcriptions focusing on the help-

seeking experience, and then generated initial themes from these codes. Themes were developed, reviewed, and refined as necessary, and are reported in Section 5.6.3.

5.5. Findings Study 2

5.5.1. Concerned Persons' Profile

Research Question 1a. What is the profile of concerned persons (demographic characteristics, relationship with victim and perpetrator)?

As shown in Table 5.1, concerned persons were primarily female, and family members of the victim and among those, most were the victim's adult children. They were also commonly related to the perpetrator, primarily the perpetrator's sibling. The full list of relationships with the victim and the perpetrator can be found in Table 5.1.

Table 5.1

Relationship of the Concerned Person With the Victim and the Perpetrator

		Cases	
		n	%
Relationship with the victim [a]			
	Family member	1077	79.7
	Adult child	632	46.7
	Grandchild	119	8.8
	Child in-law	98	7.2
	Niece/nephew	77	5.7
	Sibling	34	2.5
	Partner	14	1.0
	Parent	1	0.1
	Other family member	93	6.9
	Family member unspecified	9	0.7
	Friend	93	6.9
	Neighbour	81	6.0
	Acquaintance	78	5.8
	Other	23	1.7
Relationship with the perpetrator [b]	Family member	791	58.7
	Sibling	351	26.0
	Niece/nephew	76	5.6
	Sibling in-law	72	5.3
	Adult child	48	3.6
	Stepchild	39	2.9
	Aunt/uncle	37	2.7
	Cousin	36	2.7

	Cases	
	n	%
Adult child in-law	17	1.3
Grandchild	4	0.3
Parent	4	0.3
Partner	2	0.2
Other family member	88	6.5
Family member unspecified	17	1.3
Acquaintance	283	21.0
Professional	143	10.6
Stranger	74	5.5
Neighbour	47	3.5
Friend	5	0.4
Other	5	0.4

[a] $n = 1{,}352$
[b] $n = 1{,}348$

5.5.2. Concerned Persons' Help-Seeking

Research Question 1b. What are the barriers concerned persons face when seeking help?

In 595 cases (44%) a barrier was identified in EA reporting by concerned persons. There were no pre-identified (through the systematic review in Study 1) categories of facilitators or barriers in the case of non-victim enquirers, given lack of prior research. However, the general barrier themes that existed for victims (e.g., fear) were also coded for concerned persons when the barriers fit into these themes. The most common theme was barriers in relation to services, followed by fears, and 193 cases related to new themes (see Table 5.2).

Table 5.2

Concerned Persons' Barriers by Theme

	Cases	
	n	%
Formal services	399	67.1
Fears	42	7.1
Social network	27	4.5
Individual feelings	12	2.0
Family	6	1.0
Perception of abuse	4	0.6
New themes	193	32.4

Note. Barriers were not exclusive, so the sum of percentages exceeds 100.
The percentages are calculated with respect to the cases where there were barriers reported ($n = 595$).

Victim's subthemes were not coded for concerned persons, thus, the data from the free texts belonging to each theme were analysed inductively using qualitative content analysis. The following tables report the barrier subthemes resulting from the analyses.

Formal Services. Barriers related to services was the most commonly reported theme. The most common problems related to services were that the concerned persons perceived an inadequate or negative response from them, based on examples in Table 5.3. This finding applied both to services in general and most of the relevant services that would be engaged by an EA reporter (e.g., care, financial, justice). However, specific services had other barriers commonly mentioned. For example, in the case of legal services, there were commonly problems related to affordability (e.g., solicitors being too expensive and concerned persons not having enough money). Similarly, in the case of care and nursing homes, there were barriers related to actual retaliation following concerned persons' help-seeking, including the inability to visit the victims at the residential facility. In some cases, the concerned person recognised that services could not help (e.g., due to the victim having mental capacity and not wanting an investigation). However, it is possible that in some other cases where concerned persons identified and reported a negative response, said negative response was due to an inability to help, but this was not identified or known by concerned persons. For example, it could be that a concerned person reported a negative response in a case where a service could not intervene because they did not have the victim's consent, because the concerned person did not agree with this way of proceeding.

Table 5.3

Concerned Persons' Barriers Related to Formal Services by Subtheme

		Cases	
		n	%
Services		123	30.8
(general,	Inadequate response	98	24.6
unspecified)	Retaliation or threats from services	9	2.3
	CP does not want to involve services or is unsure	7	1.8

		Cases	
		n	%
	Services cannot help (e.g., due to victim's mental capacity)	7	1.8
Specific services			
	Social services	118	29.6
	Inadequate response	84	21.1
	Service cannot help (e.g., due to victim's mental capacity)	21	5.3
	CP does not want to involve service (e.g., has a negative attitude towards this service)	13	3.3
	Police	75	18.8
	Inadequate response	56	14.0
	Service cannot help (e.g., due to victim's mental capacity)	16	4.0
	CP does not want to involve service (e.g., has a negative attitude towards this service)	3	0.7
	Legal services	26	6.5
	Problems related to accessibility (e.g., affordability)	14	3.5
	Inadequate response	7	1.8
	Service cannot help	4	1.0
	CP does not want to involve service	1	0.3
	Care or nursing home	22	5.5
	Inadequate response	18	4.5
	Retaliation or negative repercussions of reporting	4	1.0
	Bank	19	4.8
	Inadequate response	16	4.0
	Service cannot help	3	0.7
	OPG (Office of the Public Guardian)	19	4.8
	Inadequate response	13	3.3
	Service cannot help	4	1.0
	Problems of accessibility (e.g., completing forms)	2	0.5
	Social worker	14	3.5
	Inadequate response	13	3.3
	Professional cannot help	1	0.3
	GP	9	2.3
	Inadequate response	8	2.0
	Professional cannot help	1	0.3
	Council: inadequate response	6	1.5
	Care Quality Commission: inadequate response or issues with accessibility	5	1.3
	Patient Advice and Liaison Service: inadequate response	4	1.0
	Care company or agency: inadequate response	4	1.0
	Hourglass: inadequate response	3	0.7
	Carers: inadequate response	3	0.7
	Ombudsman: inadequate response	2	0.5
	CoP (Court of Protection): inadequate response	2	0.5
	Housing Association: inadequate response	2	0.5
	Other services or professionals: Age UK, deputy, loan company, memory clinic, Member of Parliament, psychiatrist, Women's Aid.	8	2.0
Victims' attitudes or blocking		14	3.5
	Victim would not support CP contacting services and will not engage	12	3.0
	CP worried about the impact for the victim or the victim-CP relationship if they seek help	2	0.5

	Cases	
	n	%
CP's lack of knowledge about where to seek help	12	3.0
Perpetrator's blocking or interference	9	2.3
CP's problems accessing services or going through the process	8	2.0

Note. Barriers were not exclusive, so the sum of percentages exceeds 100.
The percentages are calculated with respect to the cases where there were barriers reported (*n* = 399).
CP = concerned person.

Fear. Barriers related to fear (see Table 5.4) were the second most common. Concerned persons were fearful for themselves, primarily due to perpetrator influence; however, they were also fearful of consequences for the victim, for family members or the perpetrator. Some concerned persons feared negative consequences related to the relationship with the victim.

Table 5.4

Concerned Persons' Barriers Related to Fear by Subtheme

	Cases	
	n	%
Fear for themselves	28	66.7
Fear of perpetrator, due to perpetrator threats, of or repercussion from the perpetrator	13	30.9
Fear of repercussions from someone other than the perpetrator	6	14.3
CP's identity being revealed	3	7.1
Fear of not being believed	2	4.8
Other fears (e.g., having uncovered something serious)	4	9.5
Fear for the victim	11	26.2
Victim being distraught, upset, or isolating themselves	5	11.9
Victim getting in danger or victim's wellbeing affected	2	4.8
Victim getting in trouble (e.g., because of immigration status)	2	4.8
Victim having to leave their house and move to a care home	2	4.8
Fear of consequences for the CP's relationship with the victim (e.g., not being able to visit victim, a breakdown of relationship)	4	9.5
Fear for the family (e.g., causing family problems)	3	7.1

	Cases	
	n	%
Fear for the perpetrator (e.g., being fired, losing their home, being wrongfully accused)	3	7.1

Note. Barriers were not exclusive, so the sum of percentages exceeds 100.
The percentages are calculated with respect to the cases where there were barriers reported (*n* = 42).

Social Network. In some cases, barriers related to the social network were reported, primarily relating to the lack of a social network with individuals willing to help, but also to a social network that would actively block the concerned person's attempt to help (see Table 5.5).

Table 5.5

Concerned Persons' Barriers Related to Their Social Network by Subtheme

	Cases	
	n	%
Other family members are unsupportive or they cannot help	7	25.9
The CP is estranged from other family or people who could help, or they are not kept informed about developments	6	22.2
Other family members or friends are blocking services, refusing to report, or not allowing the CP to see victim	5	18.5
Other family members or friends are not addressing or acknowledging problems; they may side with the abuser or benefit from the abuse	5	18.5
The CP is having trouble connecting with the victim's family	3	11.1
The CP is anxious about discussing the situation with their friends	1	3.7

Note. Barriers were not exclusive, so the sum of percentages exceeds 100.
The percentages are calculated with respect to the cases where there were barriers reported (*n* = 27).
CP = concerned person.

Of the remaining barriers (see Table 5.6), the most common were individual feelings or circumstances that made it harder to seek help, such as anxiety, worry, or distress. Several concerned persons reported barriers related to their family and to their perception of abuse.

Table 5.6

Concerned Persons' Barriers Related to Individual Feelings or Circumstances, Family, and the Perception of Abuse by Subtheme

	Cases	
	n	%
Individual feelings or circumstances [a]		
Anxiety	2	16.7
Worry about upsetting victim or conflicted because of victim's anger	2	16.7
CP's mental health has been severely impacted	2	16.7
CP is very distressed	2	16.7
CP does not want to upset the victim	2	16.7
CP does not want to be a 'nosy neighbour'	1	8.3
Ambivalence	1	8.3
Helplessness	1	8.3
Hopelessness	1	8.3
Difficulty expressing themselves during enquiry	1	8.3
Family [b]		
Not wanting a family "fall out" or problems with family	3	50.0
The family is stressed whenever CP tries to do anything	1	16.7
Not wanting to upset the relationship between the victim and a relative perpetrator	1	16.7
Reluctance to discuss family matters	1	16.7
Perception of abuse [c]		
Lacking information about abuse	2	50.0
Feeling abuse is not serious enough to report	1	25.0
Being unsure about the facts of the abuse	1	25.0

Note. Barriers were not exclusive, so the sum of percentages can exceed 100.
The percentages are calculated with respect to the cases where there were barriers reported.
CP = concerned person.
[a] $n = 12$.
[b] $n = 6$.
[c] $n = 4$.

Other Barriers. Finally, in many cases, there were some barriers reported that did not fit within the victims' barrier themes derived from the systematic review in Study 1. The analysis of these new barriers yielded several themes, which can be found in Table 5.7. The most common of these barriers arose from the perpetrator's interference, behaviour, or influence on the victim. However, other barriers identified related to the victim's behaviour. For example, in some cases, the victim had mental capacity and did not want any third-party intervention, which made it harder for the concerned person to act. In some cases, lacking proof

of abuse was a barrier, and some concerned persons struggled to get any help because the victim was deceased.

Table 5.7

Concerned Persons' New Barriers by Theme

	Cases	
	n	%
The perpetrator's behaviour, interference, or influence on the victim	45	23.3
Being obstructive to the CP's help-seeking efforts	8	4.1
Lying, denying liability, or covering up their behaviour	8	4.1
Abusing CP or making allegations	7	3.6
Blocking access to documents or information	6	3.1
Refusing to stop abuse or continuing with abuse despite measures	6	3.1
Denying the need for support	4	2.1
Not talking to or engaging with the CP	3	1.6
Behaving aggressively	2	1.0
Influencing the victim	1	0.5
The victim's behaviour (e.g., unwilling to talk about situation, in denial, pretending everything is okay)	28	14.5
The victim has mental capacity and does not want third-party involvement	23	11.9
Lack of proof or evidence	23	11.9
The victim is deceased	20	10.4
The case or the process of help-seeking is complex	10	5.2
The CP lacks authority to intervene or has difficulties representing the victim	10	5.2
The CP wants to remain anonymous	4	2.1
The CP's attitudes	4	2.1
There are conflicting ideas or knowledge about the victim's mental capacity	2	1.0
The action taken has not worked	2	1.0
The perpetrator is deceased	1	0.5

Note. Barriers were not exclusive, so the sum of percentages exceeds 100.
The percentages are calculated with respect to the cases where there were barriers reported (n = 193).
CP = concerned person.

Research Question 1c. What are the facilitators to help-seeking?

In 542 cases, there were facilitators and/or circumstances that prompted a decision to seek help from the perspective of the concerned person (40%); these facilitators are presented in Table 5.8. Most commonly, these were circumstances leading to seeking help (e.g., recent abuse awareness), rather than facilitators. Most commonly, concerned persons were seeking help due to recently becoming aware of, or learning new information about, abuse; a concern for the victim's wellbeing or safety; or an escalation of abuse.

Table 5.8

Concerned Persons' Facilitators by Theme

Facilitator Theme (*n*, %)	*n*	%	Explanation
Recent awareness of abuse or new information about abuse [a]	216	39.9	The CP became aware of abuse recently, including through the victim's or perpetrator's disclosure, or the concerns of others. They may have witnessed the abuse or become aware of the situation upon the victim's death (e.g., while reviewing the victim's records).
Concern for the victim's wellbeing or safety [a]	75	13.8	The CP is concerned for the victim's wellbeing or safety, or the impact that the abuse is having on the victim.
Escalation [a]	72	13.3	There has been an escalation in the abuse, indicated by increased intensity (e.g., taking more money from victim, increased isolating behaviours), frequency, or new forms of abuse (e.g., an incident of physical violence which had not happened before).
Victim's wish for change, unhappiness with the situation, or readiness to seek help [a]	36	6.6	The victim has expressed to the CP that they want a change in their situation (e.g., the perpetrator to leave their accommodation) or that they are ready to seek help or receive help through the CP.
Escalation in the victim's situation [a]	33	6.1	There has been an escalation in the victim's situation, indicated by their health worsening or them displaying concerning behaviour.
Lack of success seeking help from other sources or confronting the perpetrator [a]	33	6.1	The CP has already sought help but has been unsuccessful in stopping the abuse or has received an inadequate response, so they are seeking help from other sources (i.e., the helpline).
Impact to themselves or worry about the impact [a]	32	5.9	The CP is seeking help because of the impact of the situation (e.g., distress, stress, not being able to see victim, retaliation, abuse from perpetrator).

Facilitator Theme (*n,* %)	*n*	%	Explanation
Proof of abuse	27	5.0	The CP has recently obtained proof of abuse (e.g., audio recordings, photographs, video footage, bank statements).
Worry about abuse re-occurring, continuing, or escalating [a]	27	5.0	The CP is worried because they think a change in the victim's circumstances (e.g., more vulnerability) may lead to more or different abuse.
Urgency [a]	18	3.3	The CP is seeking help in an urgent situation. For example, the victim may be about to run out of money, or they may be currently in hospital but about to be discharged into the perpetrator's care.
A feeling of obligation to do something or that something needs to be done [a]	18	3.3	The CP feels an obligation to report, try to stop the abuse, or seek justice.
Others have expressed concerns or have reported the abuse [a]	17	3.1	The CP is seeking help because others (e.g., professionals, informal network) have expressed concerns or have reported the abuse.
Recent knowledge	10	1.8	They have recently increased their knowledge about EA or about where to seek help for the situation. In eight of these cases, this knowledge had come from an article or interview in the media (i.e., newspapers or TV).
Lack of attachment towards perpetrator	5	0.9	In these cases, the lack of attachment towards the perpetrator made it easier to seek help.
Abuse reaches threshold [a]	5	0.9	In these cases, the abuse had reached a threshold that became unbearable.
Worry about abuse happening to someone else [a]	5	0.9	The CP was worried about abuse happening to someone else (e.g., other residents at a care home).
Opportunity [a]	4	0.7	Some CPs were seeking help during a period of opportunity (e.g., the victim was staying at their house, the perpetrator was temporarily away).

Facilitator Theme (*n*, %)	*n*	%	Explanation
Deterioration of relationship with perpetrator [a]	3	0.5	
Worried about impact on others (e.g., family) [a]	3	0.5	
Professional support	2	0.4	
Feeling unsure about next steps or not knowing where else to turn [a]	2	0.4	
Feeling prepared to contact services again	1	0.2	
Wanting to tell story and make a difference [a]	1	0.2	
Seeing reporting as the only solution [a]	1	0.2	

Note. Barriers were not exclusive, so the sum of percentages exceeds 100. *n* = 542. CP = concerned person.
[a] These factors are considered circumstances leading to seeking help. The difference between circumstances and facilitators is explained in "2.5.2.1. Aspects of help-seeking".

Research Question 1d. To whom do concerned persons disclose the abuse?

Out of the 1,352 concerned persons, 460 reported seeking help previously (34%), most of whom (*n* = 435, 95%) had contacted a formal source of help. Some had contacted an informal source (*n* = 13, 3%), and some had contacted both (*n* = 10, 2%) (2 cases unknown). The full list of sources contacted can be found in Appendix K.

Research Question 1d(i). Do concerned persons confront the perpetrator?

In 80 cases, the concerned person had confronted the perpetrator (6%). Perpetrators' responses to confrontation were gathered and analysed using qualitative content analysis. Of the 80, six (8%) responses were unknown or unclear; the type of responses in the remaining 74 cases can be found in Table 5.9, organised by whether the confrontation was successful. In several cases, there were multiple types of responses indicated (e.g., an improvement, followed by a worsening in the situation) so the number of responses exceeds 74. The most common

outcome was that the confrontation was unsuccessful, and in 24% of cases, there were also negative consequences for the concerned person.

Table 5.9

Perpetrators' Responses to Confrontation

Response Type	*n*	%	Examples of Perpetrator's Behaviour (*n*)
The confrontation was unsuccessful, but the abuse did not worsen	51	68.9	• Not responding or refusing talk or meet with the CP (17). • Lying about abuse, denying abuse, dismissing concerns, or providing false information or documents (11). • Refusing to do what they have been asked to do (e.g., leave the property, return money) (9). • Responding brusquely, crying to get sympathy, talking about mental health issues, or unloading their responsibility on others (6). • Refusing to provide information, documentation, or access to information (5). • Justifying abuse or talking about abuse positively (3).
The confrontation was not successful, and resulted in abuse or other negative consequences	18	24.3	• Making allegations against CP or CP's relatives (to services or to the victim) (7). • Becoming abusive towards CP verbally or physically (6). • No longer talking to CP; there has been a relationship breakdown (5).
The confrontation was partly successful and there has been a change in the situation, but it has not resolved yet	9	12.0	• For example, the perpetrator has acknowledged their wrong and may be trying to seek help or pay the money back.
The confrontation was successful	1	1.4	

Note. n = 74. CP = concerned person.

Research Question 1e. What responses do concerned persons obtain from sources of help and what is their degree of success in improving the victims' situation?

Where the type of response was known (*n* = 371, 81%; 89 cases unknown), the responses obtained were predominantly negative (*n* = 170, 46%), followed by neutral (*n* = 96, 26%), positive (*n* = 57, 15%), and mixed (both positive and negative; *n* = 48, 13%). At the time of the enquiry, where outcome was known (*n* = 370, 80%; 90 cases unknown) most concerned persons had been unsuccessful in stopping or improving the abusive situation (*n* = 314, 85%). In some cases, the situation had improved (*n* = 42, 11%), while in a few cases it had worsened following seeking help (*n* = 8, 2%). In a minority of cases, the enquirers had been successful in resolving the abusive situation (*n* = 6, 2%).

Research Question 2. What is the impact of knowing about the abuse and/or getting involved in helping the victim?

Within the sample of concerned persons, data about impact related to the abusive situation was recorded in over a third of the cases (*n* = 586, 43%). All the data gathered were analysed using qualitative content analysis, and frequencies are provided. Some a priori categories existed: for example, the impact was categorised as physical health, mental health or psychological impact, financial impact, and/or other. Data for each case were classified in one of four categories depending on the source of impact: resulting from the abusive situation itself (e.g., not being able to see the victim due to perpetrator influence), from getting involved in helping (e.g., retaliation from the perpetrator for reporting them to the police), from both, or undefined (when the source of the impact could not be discerned). Finally, the object of the impact was recorded, specifying whether it affected the enquirer only, the enquirer and someone else, or someone else only. If it affected someone else, the identity of this person is reported.

Type of Impact. The impact of the abuse or seeking help on behalf of the victim can be found in Table 5.10. The most common type of impact was psychological or an impact on the person's mental health, followed by an impact on the relationship with the victim.

Table 5.10

Impact Suffered by Concerned Persons by Type

Impact Type	*n*	%	Subcategories (*n*) or Examples
Psychological impact or an impact on the CP's mental health	498	85.0	• Concern (287). • Anxiety or stress (88). • Mood-related symptoms (51), such as depression or depressive symptoms. For example, being upset, distressed, sad, distraught, feeling emotional, having trouble sleeping, being unhappy, heartbroken, being on antidepressants, feeling tearful, crying a lot, being devastated, or feeling displeasure. • Feeling fearful, alert, or intimidated (11). • Frustration (9). • Anger (8). • Feeling baffled or shocked (7). • Psychological impact or impact on the mental health unspecified (6). • Feeling desperate (e.g., "at wits end") (5). • Feeling disturbed, horrified, or appalled (5). • Self-blame or guilt (4). • Experiencing a dilemma (3). • Difficulty coping or inability to cope (3). • Helplessness or hopelessness (3). • Pity, agony, or feelings of unfairness (3). • Difficulty witnessing abuse (2). • Trauma or trauma-related symptoms, such as reliving the abuse (2).
Relationship with the victim	82	14.0	• Not allowed to see the victim or talk to the victim (56) • Difficulties seeing the victim, talking to them, or doing so privately (15). • The victim had "shut them out", was angry at them, or there was a breakdown in the relationship (9). • Prevented from caring for the victim (1). • Worried about offending the victim (1).

Impact Type	*n*	%	Subcategories (*n*) or Examples
Burden of seeking help	47	8.0	• This included seeking help for a long time, sometimes many years, many contacts with services, and many different actions to try to seek remedy for the situation, as well as dealing with negative experiences with and inadequate responses from services.
Subject to abuse or threats, primarily by the perpetrator	30	5.2	• This involved being the receiving end of threats, aggressive, and rude behaviour, shouting or screaming, hostility, and being asked for money. In one extreme case, the CP was threatened with homicide by the perpetrator.
Subject to false allegations	20	3.4	• CPs had been subject to false allegations, such as safeguarding alerts, harassment allegations, or been accused of being the ones abusing the victim. In some cases, this had led to "trouble" with the police or to an investigation by safeguarding.
Financial impact	19	3.2	• Spending money to support the victim, such as being asked by the victim for money, to provide things for the victim, helping to buy food or clothes, or paying the victim's care home fees (7). • Money spent in solicitors and legal advice, ranging from 1,000 to 80,000 pounds (6). • Other financial impact, such as not receiving benefits anymore, a change of will which negatively affected the CP, or being removed from a family business (3).
Feeling ignored, not listened to, or helped by services [a]	16	2.7	
Lacking information about the victim	11	1.9	• For example, information about the victim's whereabouts, or not having been informed of the victim's death.
Impact on the CP's family or family relationships	11	1.9	• For example, family tension or problems in the marriage.
Physical health impact	8	1.4	• Attacked or assaulted by the perpetrator (5) • Attacked by the victim (1) • Physical deterioration (1) • Undetermined impact on their physical health (1)

Impact Type	n	%	Subcategories (n) or Examples
Feelings or hesitance or inability to act [a]	8	1.4	
Fear of retaliation [a]	8	1.4	
Impact on the relationship with the perpetrator [a]	8	1.4	
Feelings of responsibility about the situation	6	1.0	• For example, feeling like they are the ones responsible for preventing more people from being victimised.
Different types of impact arising from the perpetrator's behaviour [a]	2	0.3	• For example, feeling frightened or intimidated by the perpetrator.
Experience of retaliation for seeking [a] help	2	0.3	
Unspecified [a]	4	0.6	

Note. n = 586. CP = concerned person.
[a] These impact types do not have examples.

Reason for the Impact Reported. In most cases, the reason for the reported impact was knowing about the abuse or the abusive situation itself (n = 445, 76%). However, in a number of cases, from the recorded data, it was a result of helping with the abusive situation or trying to help (n = 77, 13%). In some cases, there was impact related to the abusive situation itself and trying to help (n = 56, 10%) and in several cases the reason for the impact was unclear (n = 8, 1%).

Target of the Impact. While in most cases, the enquirer was the only person impacted (n = 546, 93%), there were 21 cases where one other person was impacted. This was most commonly the enquirer's partner/spouse (n = 8) or the enquirer's sibling (n = 7), followed by their child (n = 3), mother (n = 2), or friend (n = 1). In a similar number of cases (n = 16), there were two or more persons impacted in addition to the enquirer; usually the "family" (n = 13), but also identified as siblings (n = 2), and a husband and daughter (n = 1). There were two cases in which the impact reported was only relating to someone other than the enquirer; in both cases it was the enquirer's spouse.

5.5.3. Goals When Contacting the Helpline

Research Question 3. What do concerned persons want to achieve by seeking help (for example, contacting a helpline)?

Information about the concerned person's goals when contacting the helpline (e.g., what they wanted to achieve) was available in 334 cases (25%) and was analysed using qualitative content analysis. The main goals of enquirers when contacting the helpline can be found in Table 5.11. Primarily, concerned persons wanted general advice or advice regarding a specific service/measure that they had in mind. In addition, they frequently wanted more information about laws, or the legal obligations of services or individuals, older adults' rights, and the nature of EA itself.

Table 5.11

Concerned Persons' Goals When Enquiring from the Helpline

Things Concerned Persons Want	Frequency		Examples
	n	%	
General advice	128	38.3	• For example, about how to help or support the victim, investigate abuse, or about taking "the right direction".
Advice about a specific service or measure	87	26.0	• Particularly, regarding legal advice and intervention, or involving police or adult safeguarding.
General or specific information	38	11.4	• Particularly, about laws, services' obligations, older people's rights, and information about EA.
Report or inform about abuse	25	7.5	• For example, they wanted to report the abuse, inform the charity about abuse, their enquiry to be recorded, or to be part of a case study. They also wanted assistance in reporting (e.g., how to report and to whom).
Advice on next steps	21	6.3	• For example, they wanted to know how to proceed following lack of success from the services contacted or steps taken to date.
Hourglass to intervene	17	5.1	• They wanted the charity to intervene, investigate, or to contact other services on their behalf (e.g., raise a safeguarding alert).
Talk about the situation with someone or discuss concerns	13	3.9	• For example, they wanted to talk to someone outside of their informal support network.
Reassurance about next steps	11	3.5	• CPs wanted advice about whether the service or measure they were considered was the right choice.
Advice on dealing with services and professionals	10	3.0	• For example, how to proceed during an upcoming meeting or how to talk to professionals.
Reassurance and confirmation	4	1.2	• CPs wanted to know whether their concerns were justified and whether they were acting correctly.

Note. n = 334. The total percentage exceeds 100 because a number of CPs provided several goals for the enquiry. CP = concerned person.

5.5.4. Attitudes Towards Third-Party Intervention

Research Question 4. What are concerned persons' attitudes towards third-party intervention?

Another study aim was to gather more information about concerned persons' attitudes towards third-party intervention: for example, what concerned persons want to happen when others, particularly formal services, get involved, and what they want to avoid. This information was gathered from the free texts and recorded in writing, where available, for the non-victim enquirer. This section examines the views of concerned persons. Qualitative content analysis was utilised, and the findings can be found in Table 5.12. Similar to findings for victims in Chapter 4, both the concerned persons' wishes towards intervention and the outcomes that they wanted to avoid related to several main areas (e.g., specific support from services, housing or living arrangements, the disclosure of abuse). The most common categories within these areas are highlighted. A full list of categories coded can be found in Appendix K.

Table 5.12

Concerned Persons' Wishes Towards Third-Party Intervention

Things CPs Want (*n* = 168)					
Area of Focus	*n*	%	Most Common Categories	*n*	%
Specific support	122	72.6	• Legal advice or measures	23	13.7
			• Social services' or adult safeguarding's involvement	16	9.5
			• Police involvement	12	7.1
			• Investigation into the matter	12	7.1
			• Complaining to services or getting services to acknowledge errors and act on abuse	8	4.8
			• Informal help (e.g., collaborating with other CPs)	7	4.2
Victims' housing or living arrangements	22	13.1	• Victim being placed in residential care	7	4.2
			• The perpetrator to move out	5	3.0
			• The victim to remain at home or return home	5	3.0
			• The victim to move out of the place where abuse is occurring	2	1.2

Things CPs Want (n = 168)					
Area of Focus	n	%	Most Common Categories	n	%
Disclosure and outcomes of disclosure	17	10.1	• Remaining anonymous or confidential	4	2.4
			• Talking to the media about their story, publicising experience, or being part of a case study	4	2.4
			• Obtaining others' reassurance	2	1.2
The perpetrator	10	6.0	• Legal consequences or prosecution	3	1.8
			• To "pay" or be "named and shamed"	3	1.8
			• Help or treatment	2	1.2
Relationship or interaction with the perpetrator	6	3.6	• Talking to the perpetrator, confronting them, or trying to solve situation together		
The victim	3	1.8	• The victim to be looked after and safe		
Relationship with the victim	2	1.2	• Being able to see the victim		

Things CPs do not Want (n = 70)					
Area of focus	n	%	Most Common Categories	n	%
Specific support from services	34	48.6	• Social services' involvement	7	10.0
			• Police involvement	6	8.6
			• Services not investigating the allegations, not keeping CPs informed, or "sweeping things under the carpet"	5	7.1
Disclosure and outcomes of disclosure	25	35.7	• Negative consequences of reporting such as making matters worse, causing the victim distress, or having services alert the perpetrators.		
Victims' housing or living arrangements	6	8.6	• The victim being placed in residential care	2	2.9
			• The victim going home to abusive situation	2	2.9
			• The victim leaving their home	1	1.4
			• The victim being separated from another victim	1	1.4
The victim	5	7.1	• Upsetting or stressing the victim		
The perpetrator	3	4.3	• Getting the perpetrator in trouble	2	2.9
			• The perpetrator "getting away" with abuse	1	1.4
Relationship with the victim	3	4.3	• Worsening their relationship with the victim or not being able to see the victim		

Note. CP = concerned person. The total percentage exceeds 100 because categories were not exclusive.

The wishes for resolution of some concerned persons were in opposition to others. For example, some concerned persons wished to involve services such as the police and social services, while others wanted to avoid such intervention. In terms of specific services, legal advice was the most popular service; however, this could be because other services (e.g., police, social services) had already been pursued at the time of the enquiry (see Table K12 in Appendix K). There was a common wish for services that got involved to fully investigate concerns, and

for these services to acknowledge abuse. Concerned persons also wanted to support victims while maintaining a positive relationship with them. Most of those who indicated wishes regarding perpetrator outcomes, supported some sort of consequences for the perpetrator, such as legal consequences or for the perpetrator to be removed from the victim's home.

5.5.5. Advice Provided

Research Question 5a. What are concerned persons advised to do by an EA helpline?

Among the 1,352 cases that were reported by concerned persons, the helpline recorded recommendations in 1,152 (85%). The most common recommendation was to contact adult safeguarding (similar to Adult Protective Services; *n* = 613, 53%), followed by legal services (*n* = 384, 33%). Other concerned persons were signposted to contact the police (*n* = 167, 15%), services' management (e.g., at a care home; *n* = 50, 4%), or the Care Quality Commission, which monitors care quality in care homes and other care services (*n* = 28, 2%). Finally, many were signposted to "other" services (*n* = 508, 44%). The meaning of all of these categories, as well as the differences in recommendations between victims and non-victim enquirers, can be found in Chapter 4 (pp. 219-221).

5.6. Findings Study 3

Study 3 involved the participation of concerned persons, who reported their experiences supporting EA victims. Participants in the study (*N* = 19) reported on their experience supporting 20 victims, predominantly female, and all but one suffering multiple abuse types. The following sections include Study 3's findings organised by its research questions. The characteristics of the victims, abuse, and victim-perpetrator relationship in these cases can be found in Table 4.40 in Chapter 4 (pp. 221-222). Findings relating to the victims' experience can also be found in Chapter 4. Thus, the current section focuses only on concerned persons.

5.6.1. Concerned Persons' Profile

Research Question 1a. What is the profile of concerned persons?

The characteristics of the concerned persons, whose ages ranged from 21 to 71 years (M = 53.89, SD = 13.73) can be found in Table 5.13. Participants were predominantly female and married or living with a partner, and the most common countries of residence were the United States and the UK. Concerned persons reported on their experience helping a family member, usually a parent, and were also commonly related to the perpetrator, who was frequently a sibling.

Table 5.13

Concerned Persons' Characteristics and Details About Their Relationship With the Victim and Perpetrator

			Cases	
			n	%
Characteristics	Gender			
		Female	17	89.5
		Male	2	10.5
	Country of residence			
		United States	6	31.6
		UK	5	26.3
		Australia	4	21.1
		Canada	3	15.8
		New Zealand	1	5.3
	Relationship status			
		Married	8	42.1
		Living with a partner	5	26.3
		Divorced/separated	5	26.3
		Single	1	5.3
Relationship with the Victim	Family member		17	89.5
	Adult child		12	63.2
	Adult child-in-law		2	10.5
	Grandchild		2	10.5
	Stepchild		1	5.3
	Acquaintance		1	5.3
	Friend		1	5.3
Relationship with the Perpetrator	Family member		10	52.6
	Sibling		6	31.6
	Stepchild		1	5.3
	Ex-spouse		1	5.3
	Sibling-in-law		1	5.3
	Professional		4	21.1
	Neighbour		1	5.3
	Acquaintance		1	5.3
	Child of their partner		1	5.3

	Cases	
	n	%
Unspecified	1	5.3
Professional or care home resident	1	5.3

Note. $N = 19$.

Concerned Persons' Understanding and Identification of the Abusive Situation

Most of the participants (n = 13, 68%) identified the experience of the victim they supported as EA at the time of the abuse, and all except one (n = 18, 95%) identified it as EA at the time of participating in the study. The other participant stated that they identified the situation as chronic domestic abuse extending into the victim's older age and as a case of coercive control. In terms of how participants found out about the abuse, five found out through the victim's disclosure only (26%), nine became aware in a way other than the victim's disclosure (47%) (e.g., detected signs of abuse), and in five cases (26%) the victim had disclosed but the participant also became aware of abuse in other ways. Of those who became aware of the abuse in a way other than the victim's disclosure or in addition to the victim's disclosure (n = 14, 74%), they became aware in the following ways:

- Observing the abuse (n = 3, 21%).
- Seeing the victim behaving worryingly or hearing fear in their voice (n = 3, 21%).
- Seeing the victim's wishes suddenly changing or reversing (n = 2, 14%), sometimes in a very short period of time, as identified by the following participant:
  "I could start to see things were going wrong when, one by one, all of these decisions were being overturned, sometimes in the space of 24 hours or less" (P1).
- Becoming aware of large amounts of missing money, for example, as evidenced in bank transactions (n = 2, 14%) or a letter from the bank denying a loan due to debt (n = 1, 7%).
- Observing the effects of abuse, including unexplained symptoms (n = 2, 14%).
- Witnessing the perpetrator's control (n = 1, 7%).

- Obtaining information and building a timeline of events after the victim's death (n = 1, 7%).
- Knowing the perpetrator's character (i.e., expecting them to engage in abuse, n = 1, 7%).
- A perpetrator's call communicating something worrying (n = 1, 7%).

5.6.2. Concerned Persons' Help-Seeking

Research Question 1. What is concerned persons' help-seeking experience?

Worries About Seeking Informal and Formal Help. Almost half of the participants were worried about seeking help on behalf of the victim (n = 9, 47%). Of those, seven indicated worries related to formal help (78%), three related to informal help (33%), and three indicated other worries (33%).

In terms of formal services, participants worried about a variety of things, such as not being believed or that services would not do anything to stop abuse and may cover up the abuse. In a case of sexual abuse, a participant worried about further frightening the victim by making them go through medical forensic testing. Another participant was worried about getting the victim in trouble because of claims of income support; another was worried about themselves, specifically that they would not be protected from the perpetrator's recrimination. One participant indicated the specific services they worried about, which were the police, management, and the regulator (without further specification). Finally, one participant worried that services would not get involved because the victim was competent and giving the money to the perpetrator voluntarily.

Additionally, one of the interview participants indicated that, even though they were not worried about contacting services at first, they worried about it after contacting a specific service, as illustrated in the following quote:

"I didn't worry about contacting, but if you asked me about it now? The answer would be very different, and I'd say, yeah, I would say I really was worried about contacting [them]. Oh, yeah, terrible. I don't feel like I trust any of them, ever again, not one, (...) if I ever need to contact [them], I would avoid them as much as possible" (P1).

Participants who indicated worries related to informal help were worried that the abuse would escalate, about the perpetrator's recrimination or anger, and about the victim becoming distressed. The three participants who indicated worries that they did not label as formal or informal mentioned their fear of repercussions towards the victim or themselves (i.e., retaliation and threats from the abuser).

Barriers Related to the Perpetrator's Behaviour. In more than half of the cases (n = 11, 58%), the perpetrator had done something to prevent the concerned person from speaking out or seeking help about the abuse.

- The most common was lying about the concerned person, bullying or threatening them, manipulating agencies to see the concerned person as the problem, or making false allegations about the concerned person's behaviour or intentions (n = 5, 46%).
- Perpetrators also prevented the concerned person from visiting the victim or alienated the victim from family (n = 2, 18%).
- Other perpetrator behaviours mentioned once each (9%) were: silencing the concerned person (i.e., preventing them from talking about the incident), not acknowledging the problem, behaving angrily if questioned, and distracting others from the abuse (e.g., a carer writing details notes about the victim).
- Finally, one concerned person (9%) responded that the perpetrator tried "many ways" to stop them but did not specify how.

Research Question 4a. Are there any specific expectations or wishes relating to informal or formal intervention?

Participants had some expectations about reactions from others if they sought help and provided information about the specific expectations they had for informal and formal sources when they told them about the abuse. Most participants (*n* = 14, 74%) reported on their expectations from informal sources. These participants usually had a positive expectation (*n* = 10, 71%), including support from those sources in taking action and protecting the victim, that they would understand the victim's vulnerability, and that they would feel outrage or anger about the situation. Three had negative expectations (21%), such as the source not believing the concerned person, siding with the perpetrator, or blaming the victim. Finally, one participant (7%) was unsure about whether others would believe the victim.

In terms of the expectations from formal help, 17 participants provided a response (90%). Most (*n* = 15, 88%) expected a positive response from services, primarily that these would take action to protect the victim and follow the appropriate procedures. However, this help did not seem to materialise, as indicated in some of the concerned persons' study responses. One (6%) expected a negative response (i.e., covering up of abuse), and one expected that they would not be able to help because the victim had mental capacity and did not want intervention.

Seeking Help and Facilitators to Seeking Help. All participants except one (*n* = 18, 95%) told someone about the abuse. Participants indicated that they told someone immediately after becoming aware in eight of those cases (44%). Three sought help within an hour, the next day, or "soon after" (17%), three sought help after a few weeks or a month (17%), and one after a few months (6%). Finally, two participants waited a year (11%). One participant (6%) did not specify as they identified they were "still trying to help", and another (6%) reported it was difficult to answer because there were many incidents of seeking help.

One of the facilitators of help-seeking for victims of EA is escalation of abuse (Mowlam et al., 2007); thus, participants were asked about escalation prior to seeking help. In five cases, participants had just become aware of the abuse, so the question did not apply (26%). Of the remaining 13, the majority identified that the situation had worsened before they sought help (n = 9, 69%). Participants were also asked about what had made them decide to talk about the situation or seek formal help, and 15 gave a response; the most common responses can be found in Table 5.14. Primarily, participants wanted to help the victim and protect them from danger, but they were also moved by their belief that the situation was wrong or that they had a duty to protect their loved one.

Table 5.14

Participants' Reasons for Seeking Help

	Frequency	
Reason or Facilitator	*n*	%
To help the victim or get the victim to safety	3	20.0
Because they saw the danger the victim was in or the severity of the situation	2	13.3
Because they thought it was wrong for a helpless person to be treated that way	2	13.3
Because they had a "duty" to protect a loved one	2	13.3
To remove the perpetrator from a position of influence over the victim	1	6.7
Because the perpetrator crossed a line, or the abuse reached a threshold	1	6.7
Because of their realisation of what the perpetrator could do	1	6.7
Because they saw the situation for what it was (i.e., wrong)	1	6.7
Because they thought it would be the services' role to protect the victim	1	6.7
Because they did not want anyone else to be abused	1	6.7
Because the perpetrator held a position of trust	1	6.7

Note. n = 15. The total percentage exceeds 100 because one participant indicated two reasons.

Participants were also asked to indicate whether there was anything that could have helped them seek support sooner or anything they wished they had known at the time. More than half of participants (n = 14, 74%) indicated something that could have helped. Of those, the majority (n = 9, 64%) believed that more awareness about EA in society, services and among professionals would have been beneficial, particularly prevalence, laws, reporting obligations, and who can help. Two respondents (14%) indicated that a better response from formal services and formal services' collaboration and communication with older adults and

their relatives could have helped them seek support sooner. Other responses, mentioned once each (7%), were: the existence of better plans and records about the victims' wishes, more knowledge about what to expect when interacting with staff at residential facilities, more rigorous evaluation of these facilities, general vigilance regarding the care of vulnerable people, and for EA to be a priority.

Sources of Help for Concerned Persons and Responses Obtained From These Sources. Almost half of the participants knew where to seek help for the abuse (n = 9, 47%) and 18 told someone about the abuse (95%). A majority of those who told someone indicated that they first told a formal service (n = 13, 72%): the police, solicitors, the management, staff, or director of a residential facility, EA hotline or advocacy services, the hospital, a GP, or social services. Those who disclosed to an informal source first (n = 5, 28%) told their friends, their relatives, or a relative of the victim. The responses to their disclosures were mixed; some formal services took action, but others responded with disbelief (e.g., saying that the perpetrator "would not do that" or that the victim was hallucinating and it was part of their illness). Some informal sources did not know how to help, and some also responded with disbelief. Several participants stated that some of their first sources of disclosure, working in residential facilities, were not surprised because incidents like that "were commonplace".

When asked about how talking about the situation with the persons they disclosed to made them feel, the majority reported negative feelings (n = 17, 94%), such as stress, frustration, trauma, fear, or shame. On the other hand, five (28%) reported positive feelings such as empowerment, validation, and positivity from knowing that there were others working to prevent abuse from happening. Among participants who had told someone about the abuse, a majority (n = 11, 61%) reported that their first disclosure had an impact on further disclosures. Consistent with the responses obtained, this impact was mostly negative (n = 6, 55%), with participants feeling less likely to pursue other avenues, or that their distress had deepened.

Sometimes impact was mixed (n = 3, 27%), as some services helped but others did not. Finally, two (18%) identified a positive impact, motivating the participant to bring perpetrators to justice.

Many participants did not stop at a single disclosure: 16 (89%) indicated that they had sought help from further sources after disclosure. Even though some participants only indicated contacting one or two additional informal or formal sources, this was a minority, and many participants indicated multiple sources were contacted. One participant said that there were "too many to count" and another estimated that they had been in touch with 40-50 agencies in total. Similar to the responses obtained after their first disclosure, many participants obtained negative or mixed responses from subsequent disclosure receivers, particularly from formal services, with only a few agencies or professionals able to help in stopping the abuse.

Also consistent with the responses described above, more than half of participants (n = 12, 63%) reported that they had struggled in the process of helping the victim or had been unable to help (e.g., because of victim's mental capacity). In terms of how this made them feel, participants described feelings of sadness, depression, helplessness, hopelessness, and despondency, but also fear, anger, and exhaustion. Some participants experienced guilt and blamed themselves for the abuse, not being able to help, or felt like they were failing the victim. This is illustrated in one of the survey responses, where the participant felt *"[l]ike [they were] failing [their] loved one, who had done everything for [them] her entire life" (P16).*

Research Question 2. What is the impact of knowing about the abuse and/or getting involved?

Participants were asked about the impact of knowing about the abusive situation and about the impact of the activities that they engaged in to support the victim. Though these were sometimes intertwined, the most common separate answers are indicated in Table 5.15.

Table 5.15

Participants' Reported Impact of Knowing About the Situation and Helping

Impact of Situation (*n* = 19)				Impact of Helping (*n* = 17)			
Area of focus	*n*	%	Examples	Area of focus	*n*	%	Examples
Psychological or mental health impact	17	89.5	• A variety of impact, including feeling angry, helpless, "heartbroken", devastated, problems sleeping, depression and anxiety symptoms, suicidal ideation, self-blame, guilt or trauma.	Psychological or mental health impact	14	82.4	• A variety of impact including depression, helplessness, feeling "burnt out", devastated, or "consumed" by the situation and the thoughts on how to deal with it; feelings that were affecting daily routine or were a constant feature in the participant's mind.
Relationship with the victim	3	15.8	• Not being able to see the victim because of the perpetrator's control.	Burden of seeking help	7	41.2	• Experiencing the burden of seeking help for a long time, particularly due to lack of success. • Feeling that they were doing the work that professionals should be doing.
Impact on the participant's family or the participant's family relationships	2	10.5	• Causing "friction" in the family, due to the participant's preoccupation, or affecting the participant's family (e.g., their relationship with their older adult relative).	Impact on the participant's family or the participant's family relationships	3	17.6	• Perpetrator's attacks on the participant's family, including a minor. • Breakdown of relationship with family members due to seeking help. • "Family hardship".
Financial impact	2	10.5	• Having to support the victim with	Financial impact	3	17.6	• Loss of income and savings (e.g., court fees).

Impact of Situation (n = 19)				Impact of Helping (n = 17)			
Area of focus	n	%	Examples	Area of focus	n	%	Examples
			expenses or pay to make changes in their POA.				
Distrust of others	2	10.5	• Feeling that they cannot trust anyone or any healthcare professional because of their experience.	Physical health	3	17.6	• Health deterioration, health problems, or exhaustion.
Physical health	1	5.3	• A physical health deterioration.	Positive impact	3	17.6	• Enjoyed the opportunity of caring for the victim and seeing the victim happy. • Learning experience: ensured that they investigated other facilities. • A change in the participant's life: now advocating for EA.
Subject to perpetrator's false allegations	1	5.3	• That the participant was trying to interfere with the victim's care.	Subject to the perpetrator's false allegations	2	11.8	• Accusations of harassment of the perpetrator. • Accusations of abusing other family members.
				Subject to abuse by the perpetrator	2	11.8	• Threatened by the perpetrator, subject to abuse, or intimidated.
				Relationship with the victim	1	5.9	• Time lost without the victim while the situation had been going on, for many years.
				Relationship with the perpetrator	1	5.9	• No longer talking to the perpetrator of abuse, who was a relative.

Note. POA = Power of Attorney.

The most common impact, both resulting from the abusive situation and as a result of helping, was psychological. A participant described living in a "constant state of nervousness

and threat". Participants felt the burden of seeking help on behalf of the victim for a long time, particularly due to negative responses from services. Two participants felt that they were doing the work that professionals should be doing, as illustrated by the quote below:

> *"I've tried more than anything to take action rather than them asking me. It's been sort of the other way around. I've kind of been doing their job for them, which has been having to notify lots of third-party people like other care homes and GPs" (P1).*

Another type of impact related to the participant's relationships with others, such as their family, the victim, or the perpetrator. In relation to the victim, a participant's quote illustrates the time lost while the abuse had been going on:

> *"That's the saddest thing, that's the thing I can't think of too much because we're talking five years. The last five years I have not been able to freely spend time with her, I haven't been able to go to her hospital appointments, I haven't been able to have lunch with her, I can't get a supper with her, because the abuser has held such control over her" (P6).*

Help Provided, Help Received, and Satisfaction With Outcomes. Participants were asked about the help they were asked to provide, the help they provided, the help the victim received, and whether they were satisfied with the outcomes. Some participants were asked to do several things by services (e.g., contact other services, make referrals, support the victim financially; n = 7, 37%). However, others were asked to ignore the issue and move forward (n = 2, 11%). Two participants (11%) reported that the victim had not asked them to do anything. The types of support provided by the concerned person can be found in Table 5.16; the most common was emotional support.

Table 5.16

Types of Support Provided by Participants

Type of support	Frequency *n*	%
Emotional support: listening to or talking to the victim, visiting them as often as possible, making them feel safe, valued, respected, and ensuring that their needs were met	9	52.9
Reporting or notifying multiple services (e.g., police, care homes, healthcare professionals, banks, credit card companies)	5	29.4
Practical support (e.g., applying for benefits, providing financial help, removing victim from unsafe residential facilities)	4	23.5
Taking the case to court	2	11.8

Note. n = 17. The total percentage exceeds 100 because some participants indicated more than one type of support.

The majority of participants were not satisfied with the help the victim received (n = 14, 74%), and three were satisfied with some of the help but not with all (16%). Only one participant (5%) was fully satisfied with the help the victim received. Some of the participants (n = 10, 71%) provided information about why they were not satisfied with the help received; primarily, this was because there was no help provided, the abuse continued, they were ignored, or the concerns were not taken seriously by services. Those who were satisfied with some but not all of the help recognised that some services had been helpful, or reported that some services and professionals had a high workload by way of explanation for the inadequate response received.

Research Question 4b. What would concerned persons like to happen to the perpetrator?

Before being asked about what concerned persons would like to happen to perpetrators, they were asked about what had happened (if anything). In most cases, concerned persons identified that there had been no consequences for the perpetrator's behaviour (n = 11, 58%). In only five (26%) cases, there had been some consequences, such as psychological suffering, being estranged from siblings, being given notice of intent to sue, or legal consequences (i.e., conviction). Finally, three participants (16%) were unsure or did not know what had happened

to the perpetrator. Participants also indicated what they wished happened to the perpetrator, which is reported in Table 5.17; the most common desired outcome was legal consequences.

Table 5.17

Desired Perpetrator Outcomes

	Frequency	
Outcome	*n*	%
Legal consequences (e.g., charges, prosecution, conviction, incarceration, being held accountable by a court of law)	8	42.1
Losing their job and/or being prevented from working with vulnerable populations (e.g., being added to an offender registry)	7	36.8
Accept responsibility, be held accountable, and stop abuse	2	10.5
Responsible residential facility to change or shut down	2	10.5
Be investigated by the police	1	5.3
The victim to stand up to him	1	5.3
Prevented from seeing victim unless supervised	1	5.3

Note. $n = 19$. The total percentage exceeds 100 because several participants indicated more than one outcome.

5.6.3. Themes From Interviewees' Experiences of Seeking Help

The findings in the previous sections are drawn from the survey and interview data. Thematic analysis was used to further engage with the interview data only, which was more in-depth than the survey data. The objective was to identify common themes in the two interview participants' experiences. Data from the two interviews were analysed to identify themes related to the participants' experience of seeking help. The interviews concerned two participants in the UK who had supported their parents with dementia in cases where more than one perpetrator was involved. Several common themes were identified.

Theme 1: "Fighting Against Many Walls". The interviewees' feeling of fighting—particularly professionals and formal services—was a common feature in their descriptions of seeking help. For example, referring to "fighting against a tide of disbelief" or contacting multiple professionals without receiving satisfactory help, as follows: "[…] I did keep a list, 45 professionals I've spoken to who haven't helped". From services, they identified instances of failure to act, ignoring evidence or the interviewees' concerns, and not following the right

procedure to protect the victim. Interviewees held the impression that a lot of the harm and hurt in these cases (both to themselves and to the victim) could have been avoided if services had followed procedure. Additionally, they identified a lack of understanding about EA or domestic abuse by many professionals or a failure to recognise risk, as illustrated in the following quotes:

> *"I have seen absolutely no skill, no awareness, no training, no ability to recognise the red flags, the coercion and control, and domestic abuse." (Interviewee 1/P6)*
>
> *"[...] they didn't understand EA or didn't care to understand EA. When you challenged them about it, then they built a wall and they refused to listen, and then they would build a bigger wall to shut you out, and then build a bigger wall to even try and discredit you." (Interviewee 2/P1)*

Another challenge in interacting with services was that interviewees identified that services worked in isolation and that there was not enough communication between different professionals about incidents, which made it harder to identify patterns of abuse. Interviewees also described services referring the incident to one another and unloading responsibility onto other agencies. Relatedly, the fact that a service did not intervene was perceived as influencing other agencies' willingness to take action:

> *"When the police are seen by other agencies (health, social care, etc.) as doing nothing, it gets quoted 'well, the police haven't done anything', which is to say, 'well, there's nothing to see'." (Interviewee 2/P1)*

Although the main source they seemed to be fighting were services, they were also fighting the perpetrator(s), who held control over the victim, prevented visits between the interviewees and the victims, had subjected the interviewees to abuse, and created false allegations so that services and the victim would see the interviewees as the problem, as illustrated in the quotes below:

> *"He's taken every opportunity to, hmm, portray me as a problem and that he is a victim of harassment by me and he's actually told the court in the witness statement that the police have advised him to take action against me for harassment." (Interviewee 1/P6)*

"And soon after that, all contact stopped, when [the victim] moved into [the perpetrators'] house, and I couldn't visit. [One of the perpetrators] has made various threats against me, hmm, since that time. And also, since this year, that threat to destroy my life." (Interviewee 2/P1)

And, on fewer occasions, they also expressed that obstacles were coming from the victim, who would sometimes be appreciative of their help and confide in them, but at other times would be unsupportive of their help-seeking efforts, as exemplified in the following quote:

"[The services] asked 'would you like us to continue investigating?' And she said 'no'. So, she kind of stopped them being able to carry on an investigation." (Interviewee 2/P1)

Theme 2: Challenges due to age and Age-Related Vulnerabilities. Some of the help-seeking challenges above had a connection with age-related vulnerabilities, particularly dementia. These made knowing the victim's wishes more difficult, but also made interaction with services more challenging. Interviewees also identified age discrimination within services, which made these services treat cases concerning older adults differently or minimise abuse, as in the following quote:

"And that's when I started to see this age discrimination, which is, 'ah, she is an old lady, and you know, all old ladies have falls, you know, she just had a fall' [...] You know, there was always minimising going on." (Interviewee 1/P6)

Vulnerabilities associated with increasing age, such as dementia and other cognitive limitations, resulted in more challenges coming from services, such as not believing the victim, or attributing signs of neglect to dementia symptoms, as illustrated below:

"[They said that] her weight loss was totally expected 'cause she's got dementia." (Interviewee 1/P6)

"[They said:] 'She's got Alzheimer's, people with Alzheimer's say things like that'." (Interviewee 1/P6)

Mental capacity, also a concern with increasing age, was another source of challenges for the interviewees. Contradictions amongst professionals and perpetrators were sometimes perceived as something that was being used to the perpetrator's benefit, and the reason why perpetrators sometimes blocked capacity assessments:

> *"[...] it's in other people's best interests to say she has mental capacity. Then, legal decisions can be made, supposedly from her, which may not really reflect the true state of things." (Interviewee 2/P1)*

Theme 3: Expectation vs. Reality. This theme is related to Theme 1 and refers mostly to interviewees' expectations of services and professionals and their contrast with reality. Although in the literature review in this thesis (Chapter 1), it was identified that victims may not seek help because of negative expectations from services, it seems that these interviewees had positive expectations and sought help under the impression that this would be the hardest step, as illustrated in the quote below:

> *"I've taken a big step to reach out and ask for help, you know, something very private, and it takes lots of courage and so you speak out and you think 'Thank god, I've had the courage, now I'm going to be helped'." (Interviewee 1/P6)*

After this hard step, they were expecting professionals to take over and take the necessary steps to protect the victim. However, they found that the professionals' interventions were unsatisfactory. In addition, interviewees were asked to take action themselves:

> *"I kind of expected that the professionals [...] would kind of do their job. And that was the biggest let down ever. Just that none of them really provided any type of satisfactory outcome, and, ehm, nobody looked at the evidence that we collected, nobody interviewed my mother without the abuser's presence." (Interviewee 2/P1)*

> *"[The professional said:] 'You need to report it', and I said, 'Well, I think, with all due respect, you need report it'. And he said "no, no [...] you can report it'. So, I was left with this awful situation of having to report this illegal behaviour by [the perpetrator] that I'm also frightened of." (Interviewee 1/P6)*

In one of the cases, these interactions made the interviewee wary of further contact, and said that they would now not seek help from the same professionals, illustrating that the responses from sources of help can impact further help-seeking, as below:

> *"I don't feel like I trust any of them, ever again, not one, not even for [other] things [...] in the future [...], if I ever need to contact [them], I would avoid them as much as possible." (Interviewee 2/P1)*

One interviewee, while acknowledging that there were many challenges in the professionals' work, and that the manipulation from perpetrator(s) was difficult to deal with, also thought that it was important to follow appropriate procedures:

> *"Maybe they're under pressure, maybe they don't care. I don't know, but they're dealing with people's lives, they need to get it right. There's no excuse for that." (Interviewee 2/P1)*

5.7. Discussion

This chapter, through two studies and a variety of methods (i.e., secondary data analysis, surveys, and interviews), aimed to explore the profile of concerned persons, their experience seeking help for the victim, and the impact of the abusive situation and the help-seeking process. Concerned persons were primarily family members, often helping a parent in a variety of abuse situations, and sometimes advocating for a family member and challenging the perpetrator, who was another family member, very frequently a sibling of the concerned person. Although concerned persons' expectations before seeking help were positive overall, their experiences with formal help were rather negative, and there were many challenges reported. The response from services was at odds with concerned persons' expectations of help. They also experienced challenges when the victim was not aware of the abuse or did not agree with seeking action. Finally, the impact on concerned persons was varied and wide-ranging in severity, affecting their mental and physical health, financial status, and relationship with the EA victim and with the concerned persons' family members.

5.7.1. Discussion Study 2

Concerned Persons' Profile. In terms of the profile of concerned persons in Study 2, who were third-party enquirers to a UK helpline, reporters were primarily family members and female. The most common situation was that of an adult child of the victim seeking help for abuse perpetrated by the concerned person's sibling. The familial relationship between concerned persons and alleged perpetrators is likely to create many challenges in seeking help, but also for professionals interacting with family members when there is suspected abuse. This finding is also important for research purposes and adds to the literature on EA dynamics; even though family members are the most common perpetrators of EA (Aas, 2017; Hayman, 2011), they are also the most common advocates for the victim.

Barriers and Facilitators to Help-Seeking. Study 2 has expanded knowledge on barriers and facilitators for concerned persons' help-seeking. In terms of barriers, the most common related to formal services, perhaps due to the context of the helpline. Given that the helpline is primarily a source of advice and signposting, helpline staff are likely to explore enquirers' previous attempts to seek help, in order to know where to signpost enquirers. Barriers related to fear (e.g., of repercussions) were also common, consistent with previous research where third parties involved in EA cases were afraid of retaliation for reporting the abuse (Storey & Perka, 2018). These worries do not seem to be unwarranted, as some concerned persons in Study 2 had experienced retaliation from services (e.g., residential facilities) or individual perpetrators. Barriers related to the social network were also common: sometimes concerned persons were the only people trying to help and did not have the support of other family members of the victim or friends. This dynamic is likely to add to the feelings of responsibility and to the burden they experienced.

Barriers related to services not only highlight the perspective of concerned persons, but, at the same time, offer an insight into the struggles of services to respond to EA and deal with

third-party concerns. Safeguarding requires the victim's consent when the victim has mental capacity, and this is required prior to assessment and intervention (Department of Health and Social Care, 2020; Mackay, 2017). However, the victim's view may differ with the views of family members, and this might mean that professionals are unable to assess the allegations. More information about legislation such as the Mental Capacity Act 2005 and the Care Act 2014 (Age UK, 2015; Crome et al., 2014) may be helpful in creating awareness and managing expectations amongst older adults' family members and friends. However, professionals need to be mindful that concerned persons will still struggle with seeing a loved one being hurt, even if their loved one rejects help, does not perceive the situation as harmful, and chooses to live with harm (Mackay, 2017). Professionals should also listen to the concerned persons' concerns and maintain regular contact, as they might be the first ones to become aware of critical situations (e.g., imminent risk of harm) that require an intervention in order to preserve the victim's safety.

Common themes in terms of barriers related to services included receiving limited information from services, as well as problems about the affordability of legal services. Overall, concerned persons had tried many services and were severely affected by the lack of a centralised service specialising in responding to EA. Depending on the abuse type that victims were dealing with, concerned persons seemed to be successful contacting different services. For example, previous research has identified that legal services may be the best or most logical choice if there is financial abuse involved (Brownell & Wolden, 2003). Unfortunately, when navigating services unsuccessfully, concerned persons experienced confusion and distress, which added to the toll of seeking help (e.g., time, expense). In addition, making victims or concerned persons consult various services for different EA types may not be an effective way of responding, as many cases of EA involve poly-victimisation (Heisler, 2017). Multidisciplinary approaches and a centralised response to EA concerns may be the best

approach to respond to poly-victimisation and should be further explored in countries where this does not already exist, considering the positive outcomes of initiatives such as the multidisciplinary EA Forensic Center in California (Navarro et al., 2013; Penhale, 2008; Yonashiro-Cho et al., 2019).

The findings from Study 2 provide information about facilitators to help-seeking from the perspective of concerned persons, which complements that of victims. Similar to victims, concerned persons sought help out of concern for the victim's safety and also following an escalation of abuse (Yan, 2015). Many concerned persons sought help as soon as they became aware of abuse or following a victim's disclosure, but also when the perpetrator disclosed something concerning. However, it is possible that concerned persons will wait to report if they do not have the victims' support in engaging services. This delay is consistent with the help-seeking of family members in a previous U.S. study (Jackson & Hafemeister, 2015). In this study, some concerned persons were aware of a situation of longstanding abuse, but only sought help once the abuse escalated or reached a threshold of dangerousness. Unfortunately, some concerned persons in Study 2 only became aware of abuse, particularly financial abuse and neglect, after the victim was deceased. As with victims, it is important to understand ways of supporting concerned persons to make earlier disclosures, and to avoid further harm (see Section 5.7.7).

Responses to Help-Seeking. In terms of concerned persons' help-seeking patterns, they primarily sought help from formal services, generally receiving negative responses and achieving little success in stopping the abuse. There could be an overestimation of negative experiences with services by concerned persons, given that those enquirers with less success are probably more likely to contact the helpline (see Section 5.7.2 "Limitations and Strengths of Study 2"). However, as discussed in Chapter 4, the experiences reported within Study 2 are still important in shaping practice and understanding how services can provide a better

response. The number of enquirers in Study 2 is relatively high (n = 1,352) and only covers one year of data from the helpline, suggesting there are many family members, friends, neighbours, and acquaintances who may be struggling to support EA victims and interact with services. Like victims, concerned persons also confronted the perpetrator, and almost one quarter were met with negative consequences for themselves or the victim, such as increased abuse. The findings suggest that confrontation is rarely successful and may put concerned persons and victims at risk of further harm. Thus, it is not an advisable or safe way of resolving abuse. However, confronting the perpetrator may be something that concerned persons prefer if they want to privately address a family matter, or where the victim does not support formal intervention (Mackay, 2017). For this reason, in order to reduce risk, confrontation needs to be explored and discussed actively by professionals when they interact with concerned persons. Professionals need to make concerned persons aware of the risks for victims and concerned persons.

Impact of the Abuse on Concerned Persons. An analysis of the impact of the abuse on concerned persons brought some clarity in connection with the findings of Breckman et al. (2017). The impact ranged widely in severity, but it was clear that, for some concerned persons, it was not mere concern that they were experiencing, but more severe impact to their mental health, as well as victimisation by the perpetrator. Abuse by the perpetrator was sometimes severe, including a threat of homicide, physical assault, and false allegations. In addition to what the concerned persons described to the helpline, their involvement in supporting the victim probably did not stop there. Many concerned persons were advised by the helpline on how to proceed further or on new routes to explore, such as contacting adult safeguarding or legal services.

A major impact of the abuse for the concerned person was the loss of their ability to see the victim, due to the perpetrator's control or restrictions placed by the perpetrator. This impact

seemed to cause particular anguish in concerned persons, who were frequently family members supporting a parent and blocked by a sibling from seeing the victim. Amidst COVID-19 restrictions, in which many care homes and nursing homes went into lockdown and banned visitors, the impact of not being able to see a loved one in a residential facility has been brought to light (Stall et al., 2020). The implementation of these measures has highlighted the distressing nature of what concerned persons seem to have experienced even before the pandemic started, and that may have been complicated during the pandemic.

Previous research found that helping an EA victim was associated with more distress than knowing about the abuse (Breckman et al., 2017). In the current study, in most cases it was not possible to determine that the impact was a result of seeking help on behalf of the victim rather than the result of knowing the abuse itself and the perpetrator's abusive behaviours. However, given that many concerned persons reported seeking help before, it is likely that some of the described impact was associated with seeking help. Therefore, there might have been an underestimation of the impact that was caused by seeking help and not simply by the abuse or knowledge about the abuse in Study 2. However, these two types of impact, from knowledge about the abuse itself and seeking help, may sometimes be intertwined. For example, a perpetrator who may be isolating the victim from a family member may increase their isolation once they notice that the family member is aware of abuse and trying to seek help. In this example, the concerned person would be affected both by the abuse itself and by the consequences of trying to support the older adult.

Findings regarding impact are consistent with previous research in the United States (Breckman et al., 2017; Kilaberia & Stum, 2020), and expand previous research by identifying some of the reasons concerned persons are impacted. Notably, in some cases, the concerned person making the enquiry was not the only one impacted, and another third party (usually another family member) was also suffering from a similar impact as a result of the abuse and/or

supporting the victim. This highlights the reach of the impact of EA and emphasises the need to support concerned persons. Nonetheless, there are ways of supporting this group of people, some of which are already being implemented. For example, the New York City Elder Abuse Center (NYC EAC) launched a helpline specifically targeted at concerned persons (Elman et al., 2020; NYC EAC, 2018) as a way of supporting concerned persons and continuing to gather information about their experience. It is also necessary to involve concerned persons in intervention and to explore how they are perceived by services. Some concerned persons were victimised by the perpetrator, which could be evaluated in light of recent suggestions that concerned persons may need to be considered as secondary victims (Kilaberia & Stum, 2020).

Concerned Persons' Attitudes Towards Intervention. Another study aim was to explore concerned persons' attitudes towards intervention, including wishes for the victim, themselves, and the perpetrator. Findings indicated that most concerned persons enquiring from the helpline wanted general advice about how to proceed, as well as information about EA and any relevant legislation. Some wanted more specific advice in their interaction with services. They expressed wishes in several areas (specific help, the victim, the perpetrator, and their relationship with the victim). Although the wishes were varied, there was a common desire for their concerns to be heard and fully investigated by services, as well as a desire not to negatively impact their relationship with the victim. Concerned persons had different wishes in terms of outcomes for the perpetrator; however, many supported some sort of consequence, ranging from legal consequences (e.g., police charges) to the perpetrator having to move out of the victim's property. As with victims, considering the different areas and the diversity of wishes is important in the planning of interventions. Although victims' best interests should always be the priority, concerned persons' wishes should be listened to in cases where the victim may no longer be able to communicate their preferences.

5.7.2. Limitations and Strengths of Study 2

For a full discussion of the limitations in Study 2, please see Chapter 4 (Section 4.7.2). From the perspective of concerned persons, there is likely a bias towards those experiencing more negative interactions with services because those may be more likely to continue seeking redress and more willing to enquire from a helpline. However, as highlighted earlier in the discussion, even without knowing the representativeness of these experiences with respect to concerned persons in the general population, the experiences presented in Study 2 should not be ignored. Other limitations refer to the cases in the sample, in which financial and psychological abuse are most common, and sexual abuse cases are under-represented; thus, there is less knowledge about the help-seeking experience and barriers that concerned persons may encounter in these cases. Nonetheless, the general frequencies are similar to previously reported prevalence rates (Yon et al., 2017). Despite these limitations, Study 2 has many strengths, which have been reported in Chapter 4 (Section 4.7.2). Specifically, the sample is national and representative of different EA types, victim characteristics, victim-perpetrator relationships, and abuse locations, encompassing both domestic and residential abuse.

5.7.3. Discussion Study 3

The findings in Study 3 expand on those in Study 2 by providing more in-depth data about the experiences of concerned persons supporting an older adult who is suffering abuse. In addition, these were gathered directly from those concerned persons, from different countries. It was also possible due to the design to enquire about several help-seeking aspects that were unaddressed in Study 2, such as how long concerned persons waited before seeking help for the abuse. The profile of participants was consistent with findings in Study 2: concerned persons were primarily family members supporting a parent. Although the perpetrator was also commonly a family member of the concerned person, there was representation of cases occurring in residential facilities and perpetrated by professionals (e.g.,

carers). Hence, the study offers some insight about the experiences of concerned persons in institutional abuse cases.

Most participants in the study sought help for the abuse, primarily from formal sources, and obtained generally negative responses. Participants sought help quite soon after becoming aware of the abuse, several doing so immediately; however, escalation was identified as preceding help-seeking by several participants. In seeking help, participants were also moved by the aim of getting the victim to safety or because they identified that the victim was in danger. These findings indicate that concerned persons may decide to seek help when the situation becomes more critical, a dynamic also common among victims (Yan, 2015). Participants identified that more knowledge and awareness about EA, both in society and among professionals, could have helped them seek support sooner. Hence, this finding stresses the need for continued professional training in different services, as well as societal awareness campaigns, also highlighted through the systematic review of Study 1 (Krug et al., 2002; Naughton et al., 2013). Testing of the effectiveness of these awareness campaigns and EA training in increasing professionals' knowledge of EA is also necessary.

Although there were some barriers to help-seeking (e.g., fear of retaliation, not being believed, causing further harm to the victim), study participants were not generally concerned about the response of services before contacting them. In fact, most had a positive expectation before reaching out; however, they associated their first disclosure with negative feelings. They were generally dissatisfied with the help and responses received, and this negatively affected their desire to engage in further help-seeking. These findings support the understanding that the responses that individuals receive when they disclose abuse are important and impactful (Fraga Domínguez et al., 2020; Sylaska & Edwards, 2014; Truong et al., 2019; Winters et al., 2020). Hence, it is essential for professionals to be mindful of their reactions to allegations, not only from victims, but also other concerned individuals, who may not be perceived as

vulnerable as they are not the direct victims. It is also important that appropriate and transparent reporting procedures are available in residential facilities, particularly given the findings indicating that concerned persons experienced retaliation for reporting abuse.

Most participants subsequently contacted additional sources of support, and more than half identified struggling to help the victim. Not surprisingly, many concerned persons described wide-ranging negative impacts, both from knowing about the abuse and from trying to help the victim. These experiences took a great toll on the concerned person's mental health, financial status, and relationship with the victim and other family members. Consistent with Study 2, participants were subject to abuse by the perpetrator and also to false allegations, which led to being investigated by services, such as safeguarding or the police. This dynamic of false allegations and manipulation of services, highlighted in both studies, and the negative impact on participants in Study 3, requires further investigation. This investigation should focus on concerned persons, but also on professionals, for example, enquiring from the latter how often they encounter reciprocal allegations in family members in cases of EA. If this is a common occurrence, it would not be surprising if services or professionals struggled to know who is at fault and how best to protect the victim. Given that, most commonly, perpetrators and concerned persons are both family members, this may create confusion for services (Killick & Taylor, 2009). Regardless, it stresses the importance of conducting careful investigations, considering the value of home visits in these investigations, and of always interviewing the victim in a safe and private environment where the alleged perpetrator and the concerned person are not present (Elman et al., 2020; Lachs & Pillemer, 2015).

Through thematic analysis, several themes were identified in the interviews conducted in Study 3, which were consistent with the general findings for the survey responses in the study. One of the themes referred to the challenges of supporting an older victim due to age discrimination from services, as well as age-related vulnerabilities, such as dementia and loss

of mental capacity, both of which affected the concerned persons' interaction with the victim and services. Concerned persons encountered challenges supporting victims with dementia who disclosed but were sometimes not believed by services, their disclosures dismissed, and EA signs identified by the concerned person attributed to dementia. This highlights the barriers that may exist in cases where the victim has cognitive difficulties, and supports previous research emphasising the need to investigate the experiences of people living with dementia with reference to their help-seeking experiences and experiences of abuse (Bows, 2018; Fraga Domínguez et al., 2020, 2021; Walsh et al., 2010). Age discrimination towards the victim was also identified by these participants, making services more likely to dismiss concerned persons' concerns for the victim or to treat these concerns differently. This stresses the role of ageism and considering societal factors not only when studying EA as a whole, but also help-seeking (Lachs & Pillemer, 2015; Walsh et al., 2010).

5.7.4. Limitations and Strengths of Study 3

Study 3 has several limitations, some of which have already been reported in Chapter 4 (Section 4.7.4). One limitation is that the researcher did not establish any limit as to when the case of abuse occurred; in fact, in several cases, participants were reporting on their experience where the victim was already deceased. Thus, it could be that some of the experiences reported were affected by memory recall, or that the issues that participants raised were no longer as relevant (e.g., the overall services' response could have improved due to increased awareness). However, in some cases (n = 6, 32%), including the two interviews, the participants described the situation as ongoing.

Another limitation is that, due to the approach to recruitment, there could be some overlap between the five UK participants in Study 3 and the concerned persons contacting the helpline (based in the UK) in Study 2. Nevertheless, these two studies complement one another in this chapter and the results are not necessarily redundant. As another limitation to sampling,

it is worth mentioning that one participant did not label the behaviours as EA; however, they still identified themselves as part of the population who could take part in the study. In addition, they sought redress through several EA routes and services, thus highlighting the appropriateness of their participation in the study.

The sample is quite likely biased in that participants are probably those who are really involved in helping older adults in situations of abuse. This bias means that the negative impact experienced may not be such in those that did not participate. It could also be biased towards those who had negative experience with services because those who had a positive experience may not feel compelled to share this in a study. Importantly, Study 3 shows that there are some people who experience major barriers trying to help EA victims. It also demonstrates the substantial negative impact of seeking help on behalf of the victim. For these reasons, these findings should not be ignored.

On the other hand, the study has several strengths in terms of sampling, namely the diversity in terms of types of abuse suffered, the victim-perpetrator relationship, and the victim-concerned person relationship. The sample included several cases of sexual abuse, as well as abuse perpetrated in residential facilities, which were under-represented in Study 2. Finally, it included the views of participants from several countries, thus highlighting that some of the experiences are common across countries.

5.7.5. Theoretical Implications

The findings reported in this chapter provide further support for the Theory of Planned Behaviour (Ajzen, 1985) as an appropriate framework for understanding help-seeking in EA. Particularly, the findings exemplified the effect of feedback on concerned persons' decision to seek help in the future. When they obtained negative responses from services, particularly if these did not match their positive expectations, they became reluctant to again contact services.

The findings also provide support for the Ecological Systems Theory (Bronfenbrenner, 1979) as a framework for understanding barriers to help-seeking in EA, as these occurred at different levels: individual (e.g., anxiety), relational (e.g., perpetrator's threats and allegations), and societal (e.g., ageism). The findings are also consistent with the Bystander Intervention Model (Latané & Darley, 1975). Some concerned persons sought help because they felt a responsibility to do so and they were the only ones who could help the victim or prevent abuse from happening to others in the future (Moschella et al., 2018). This suggests that a combination of theories may be helpful in explaining help-seeking in EA. The importance of a multi-theoretical approach is expanded on in Chapter 6.

Importantly, the chapter, through two studies, provides further insight into the experience and importance of concerned persons in EA cases. Concerned persons are essential in supporting victims, but this support comes at a cost, and should be considered in future research. They may need to help victims through many weeks, months, or years, and may not be able to intervene or improve the victim's situation until the victim chooses to take action themselves (Mackay, 2017). Thus, not surprisingly, the relationship with the victim is sometimes affected. Further research is necessary to understand how services perceive concerned persons and how they can effectively support them in supporting victims, as they can be an asset for services in engaging victims and ensuring their safety.

5.7.6. Implications for Practice

Practitioners should be mindful when interacting with family members of the victim and other concerned persons. Concerns by family members—the majority of concerned persons—should be taken seriously; however, given that the perpetrator is likely to be a family member as well, this can be confusing for practitioners, who may have difficulties establishing who is trying to help and who is harming the victim. Thus, interviewing the victim alone will be paramount, and so will be seeking corroborating evidence from multiple sources and

services. Such a protocol will ensure that victims and concerned persons are protected from the perpetrator.

A central source of help for concerned persons and victims of EA would be useful in timely assessment and intervention. Given that concerned persons in the studies had to seek help from many sources, this made the process confusing and made them unsure about what to do next. A centralised service is likely to be more effective in helping victims and concerned persons, and more cost-effective in the long-term for services (Yonashiro-Cho et al., 2019). There are few EA cases that involve only one type of abuse (Heisler, 2017), so it is counterproductive for concerned persons to have to seek help from different services depending on the type of abuse and characteristics of the case. This centralised service should work with existing services that are helpful to concerned persons, and should integrate the elements that concerned persons find beneficial in available organisations.

Concerned persons need support as well as victims, and the negative responses they receive from services can make them feel despondent and hopeless. Specific helplines for them, or other sources of support, are necessary (Elman et al., 2020). Professionals should not ignore these concerned persons and should remain in touch and listen carefully to their concerns. If concerned persons are supported in remaining close to victims, they might be able to tell when the situation escalates or when there is an emergency and services must intervene. They may also be the first ones to know when victims reach a threshold and decide that they support intervention, as happened in some of the cases reported in Study 2. The New York City Elder Abuse Center's (NYC EAC) helpline for concerned persons (Elman et al., 2020; NYC EAC, 2018) can be used as an example of supporting this population, and future research on service efficacy should be considered when modelling initiatives. Finally, further education for concerned persons may be helpful, so that they are able to understand how to best manage these

cases. For example, focusing on the risks of confrontations, and also emphasising the need to respect victims' wishes and the legislation around mental capacity and intervention by services.

5.7.7. Implications for Research

The findings reported in Study 2 and 3 have several implications for future research priorities, which have been highlighted in the discussion of this chapter, and are briefly summarised in the current section. First, further research should be conducted from the perspective of concerned persons, focusing on their experiences of seeking help, particularly any potential struggles in their interaction with services, and any barriers caused by the perpetrator's behaviour. A particular area of interest should be situations where the perpetrator is targeting the concerned persons by making false allegations. This situation should also be explored from the perspective of professionals, to understand how frequently they encounter these situations, and what their protocol is for addressing these. Further research involving formal services should explore their general perceptions of family members and other concerned persons who get involved in EA cases, and investigate the understanding of services of how best to support and engage these concerned individuals. Finally, it is important to involve concerned persons in future research to further explore their reasons for delaying help-seeking and what could have helped in seeking support sooner.

5.8. Conclusions

The current chapter presented findings of two studies exploring the profile of family members, friends, neighbours, and acquaintances of EA victims ("concerned persons"), their help-seeking experience, and the impact of knowing about abuse or seeking help on behalf of the victim. Concerned persons were primarily female family members of the victim, who experienced many barriers at different levels, but particularly in relation to formal services. Their negative experience with formal services made them reluctant to seek help in the future and impacted them psychologically and financially. Seeking help on behalf of the victim came

at a great cost. The two studies reported provide support for the need to continue paying attention to and investigating the experience of concerned persons. Additionally, they suggest that practitioners may need to provide support to these concerned persons, given that they are in an ideal position to assist victims, and connect victims with more formal assistance if needed.

CHAPTER 6- DISCUSSION AND CONCLUSIONS

6.1. Introduction

The studies in this thesis aimed to improve the understanding of elder abuse (hereafter "EA") and help-seeking, by focusing on two groups that had previously received limited attention in the EA literature: victims and their informal supporters (family, friends, neighbours or acquaintances; hereafter "concerned persons"). The thesis addressed these two groups' help-seeking behaviour, encompassing barriers and facilitators to informal (e.g., to friends) and formal (e.g., to services) disclosure, preferred sources of help, and attitudes towards and responses from third parties. Due to the lack of research focused on concerned persons, most research questions for this group were exploratory. Meanwhile, the research questions for victims were more targeted and built on previous research findings. In particular, Studies 2 and 3 were designed based on the findings of Study 1, a systematic review on victims' help-seeking which identified research gaps in this area. Two of the studies in this thesis were international in nature: both Study 1 and Study 3 gathered and utilised data from multiple countries. Study 2 was based on data from the UK, primarily from England. Study 1 focused only on victims and Studies 2 and 3 focused on both victims and concerned persons.

6.2. General Discussion of Findings for Victims

A research aim of this thesis was "*to explore the characteristics of help-seeking behaviour from the perspective of victims of EA, as well as their experience of accessing help*". The main findings were that victims experience myriad barriers to help-seeking (e.g., social network, perception of abuse; Jackson & Hafemeister, 2015; Tamutiene et al., 2013) at different levels (individual, relational, and societal). Several barriers were associated with characteristics of the abuse, victim, and victim-perpetrator relationship, consistent with previous research (Acierno et al., 2020). Facilitators were less varied, and there were more findings relating to the circumstances that lead victims to seek help (e.g., escalation; Yan,

2015). Facilitators and/or those circumstances conducive to help-seeking were also more commonly reported in certain scenarios for victims. For example, they were more common when the victim was suffering specific abuse types (e.g., physical) and for victim-perpetrator relationships (e.g., partner).

This thesis contributed more understanding to predictors of victim's disclosure of abuse. Certain case characteristics predicted formal disclosure to the helpline (e.g., younger age or suffering psychological abuse), and other case characteristics predicted informal disclosure versus formal disclosure (e.g., older age, suffering from dementia), consistent with differences between these two types of disclosure in other types of victimisation (Sylaska & Edwards, 2014; Winters et al., 2020). When victims sought help, they were mostly unsuccessful in stopping the abuse. They received overall positive responses from informal sources of help but had more negative experiences with formal services. Perpetrators were often a barrier to receiving help and blocked services and informal third parties from having contact with the victim, consistent with previous research (e.g., Elman et al., 2020; Storey & Perka, 2018).

Another aim was "*To understand victims' [...] attitudes towards intervention for EA, and the way in which they influence help-seeking behaviours*". Overall, some victims rejected the help offered by third parties or were not favourable to help from specific sources (e.g., social services, police). This reluctance was often linked to negative attitudes towards third-party intervention, which made victims less likely to pursue or accept the help offered. It was found that victims had a variety of wishes in terms of the outcomes of intervention, that concerned not only the specific help and source of help, but also their housing conditions and the perpetrator of abuse, consistent with previous research (Burnes, Hsieh, et al., 2019). Consideration of the variety of outcomes that victims anticipate through seeking help, and the

things that they want to avoid, is likely to be the most successful approach in intervening with victims and developing policy.

6.3. General Discussion of Findings for Concerned Persons

Another research aim was "*to explore the characteristics of help-seeking behaviour from non-professional concerned persons who support the victim of EA, as well as their experience of accessing help*". This thesis provided information about the profile and experience of concerned persons, and the impact they experience as a result of the abusive situation and trying to help. Despite their essential role in supporting victims, knowledge about concerned persons was generally lacking in the literature, with limited exceptions (Breckman et al., 2017; Burnes, Breckman, et al., 2019; Kilaberia & Stum, 2020). The data in this thesis demonstrated that concerned persons experienced their own barriers to receiving help, barriers that fit in a variety of themes, and that, for some, trying to support the victims came with a variety of costs to themselves. For example, concerned persons suffered an impact on their mental or physical health, as well as a financial cost and an impact on their relationship with the older adult they sought to support, consistent with previous research (Kilaberia & Stum, 2020). They were also sometimes subject to allegations by perpetrators—which led to investigations by police and adult protective services—and faced barriers related to the victims' rejection of help or formal service intervention.

Another aim was "*To understand concerned persons' [...] attitudes towards intervention for EA, and the way in which they influence help-seeking behaviours*". Overall, and contrary to victims, concerned persons seemed more favourable towards involvement by formal services; however, concerned persons had generally negative or mixed experiences with these services after involvement, which negatively impacted their intention to seek help in future. Similar to victims, what they actually expected as outcomes from formal services' involvement and the reality of the outcomes of help-seeking were varied. Some wanted

"harsher" outcomes for the perpetrator, such as involvement by the Criminal Justice System (e.g., prosecution, custodial sentences), and others focused on the victims' safety and living situations.

6.4. Theoretical Implications

The primary theory which served as a framework for this thesis was the Theory of Planned Behaviour (TPB; Ajzen, 1985), which posits that performing a behaviour is the result of the intention to perform said behaviour. The general thesis findings fit within this theoretical explanation of engaging in a behaviour. Several victims seemed to have decided whether to seek help or not based on their attitudes towards help-seeking behaviours, including what they expected the outcome to be after they sought help, the perceived attitudes towards help-seeking from society and those around them, and also the resources (e.g., financial) they had for seeking help. In addition, many victims did not seek help out of fear of what could happen if they did (e.g., retaliation from the perpetrator, losing the ability to remain in their own house; Gil et al., 2017; Tamutiene et al., 2013).

Victims' attitudes towards third-party intervention and help-seeking featured strongly in several of the barriers identified in the systematic review, and in the secondary data in Study 2. Similarly, the decision about whether to seek help depended on the perceived ability to carry out the task at hand, as per the Perceived Behavioural Control component of the theory (Ajzen, 1985). Where victims lacked resources (e.g., financial resources for seeking legal advice) or felt like they were too frail physically, or too mentally distressed, to go through the process of seeking help, they were less likely to seek help. Finally, in cases where the perpetrator was isolating the victim, non-victims were more likely to be reporting to the helpline, suggesting that this situation is likely to negatively impact the victims' ability to seek help.

The TPB also seems to fit with some of what has been learned about help-seeking from the perspective of concerned persons; particularly in regard to the expectations of the outcomes of seeking help from formal sources, but also the perceived behavioural control component (Ajzen, 1985). For example, some concerned persons' barriers to help-seeking were related to the perpetrator's blocking of services, the lack of financial resources, the lack of proof of abuse, and the concerned persons' lack of authority in advocating for the victim.

The findings regarding concerned persons' help-seeking also seem to fit with the Bystander Intervention Model (Latané & Darley, 1975) and with some of the findings regarding factors that may affect the likelihood of intervening (Moschella et al., 2018). For example, the presence of other bystanders is one of the factors likely to determine intervention by impacting feelings of responsibility (Moschella et al., 2018). In the studies presented, some concerned persons sought help because they felt that they were the only ones who could do so or because other family members did not want to intervene. Similarly, some concerned persons decided to seek help when they were worried that somebody else (other potential victims, in addition to the older adult) could be abused, highlighting that it was the feeling of responsibility that moved them to act. In addition, another factor that has been found to relate to the likelihood and time of intervention is the relationship between the bystander and both the victim and the perpetrator (Bennett et al., 2017; Jackson & Hafemeister, 2015). However, findings have been mixed in previous research on sexual violence, and a closer relationship with the victim may or may not facilitate intervention (Bennett et al., 2017; Moschella et al., 2018). In the current studies, some concerned persons were worried about intervening because of the negative effect that this could have in their relationship with the victim and perpetrator. Relatedly, previous research has suggested that a close relationship with the victim and perpetrator may delay help-seeking (Jackson & Hafemeister, 2015).

Originality and Contribution to Knowledge

This thesis has provided several important contributions to knowledge about help-seeking and EA, firstly, by expanding on the understanding about EA victim's help-seeking, particularly the process of disclosure. In the studies reported in this thesis, victims sought help more frequently than has been attributed to them in previous research. In Studies 2 and 3, a substantial percentage of victims (ranging from 22% to 50%) had disclosed previously to someone else. As anticipated based on previous research findings, by focusing only on formal disclosures to specific authorities, there may be a general lack of acknowledgement of victims' ability to disclose (Jackson & Hafemeister, 2015). Victims of intimate partner violence and child sexual abuse also prefer informal sources of help over formal sources, and sometimes seek help from informal sources before seeking help from formal sources (Dichter et al., 2015; Voth Schrag et al., 2020; Winters et al., 2020). Thus, the findings reinforce the need to study and consider both informal and formal disclosure, and initially approach all victims as capable of disclosing unless proven otherwise, including those who have a cognitive impairment (Burgess & Phillips, 2006; Richmond et al., 2020).

Secondly, this thesis has highlighted the role of concerned persons, a group infrequently represented in the EA literature, with exceptions (e.g., Breckman et al., 2017; Burnes, Breckman, et al., 2019, Kilaberia & Stum, 2020). Concerned persons were 83% of the reporters to the UK helpline in Study 2 and many were able to report on the victim's wishes. In both Studies 2 and 3, concerned persons had contacted a multitude of services and supported the victims in many ways. This support was sometimes provided over an extended period—in Study 3, for four years on average. They had also been severely affected by the situation in some cases and had sometimes been victimised by the perpetrators. These overall findings, which stress the important role of concerned persons as reporters of abuse and the many

challenges they experience, reinforce the need to study the role and experience of concerned persons, so that further findings can inform practice and policy.

According to the findings of the studies, barriers and facilitators follow some similar patterns for victims and concerned persons. For example, problems with formal services, fear of consequences, and problems related to the social network were common in both groups. Despite the differences between victims and concerned persons, the problems that they are facing are similar, which likely explains the commonality of challenges found. Both victims and concerned persons were impacted by the perpetrator's interference, in a way that demonstrates power dynamics and behaviours consistent with coercive control (Barlow et al., 2020). The most common relationship dynamic, in which the perpetrator is related to both the victim and the concerned person, means that these are people the perpetrator knows and, as a result, is also likely to have knowledge about their weaknesses and how to harm them. Thus, the studies reported in this thesis have contributed to existing understanding about barriers to help-seeking experienced by those involved in EA cases—victims and concerned persons alike—and improved understanding of barriers placed by the perpetrator.

Relationship of Victims' Barriers and Facilitators to Help-seeking With Case Characteristics: A Summary. A final important contribution of this thesis has been in studying victims' barriers and facilitators or circumstances leading to help-seeking (hereafter "facilitators") in relation to case characteristics. Table 6.1 summarises the ways in which different barriers and facilitators may be present depending on the case characteristics. The "+" symbol indicates that the barrier/facilitator is statistically more likely to be present in those cases, and the "-" symbol that the barrier/facilitator is statistically less likely to be present. For example, in cases of abuse perpetrated by a friend, barriers related to the perception of abuse are more likely to be present, but barriers related to fear or family are less likely to be present.

Table 6.1

A Summary of the Relationship Between Case Characteristics and the Presence of Barriers and Facilitators

	Barrier theme								
Case characteristics	Social Network	Individual Feelings	Formal Services	Fear	Perception of Abuse	External Circumstances	Family	Cultural, Generational, or Religious	Facilitators
Victim									
Female			+				+		+
Male					+				
Younger (60-80)		+	+	+				+	+
Older (81-102)					+				
Physical health problems	+	+	+						
Physical disability		+							+
Mental health problems		+	+						+
Dementia		-	-	-		-			-
Previous victimisation									+
Abuse									
Physical		+	+	+	-				+
Psychological	+	+	+	+	-	+	+	+	+
Financial					+	+		-	
Neglect	+			-	-	-	-		-
Sexual									
Poly-victimisation	+	+	+	+		+			+
Multiple perpetrators							+		
Isolation	+					+	-		
Threats			+	+					+
Chronic	+	+		+	+	+			+
Victim-perpetrator relationship									
Partner	+	+			-				+
Adult child				+			+		
Other family member									
Friend				-	+		-		
Professional or other	-	-		-			-		-
Co-habitation	+	+	+	+	-		+	+	+
Victim dependency	+				-	+	-		-
Perpetrator dependency		+		+					+

It is important to remind the reader of the limitations acknowledged in Section 4.7.2 of this thesis. Specifically, that both the barriers and case characteristics have been drawn from the case descriptions written by staff, and that they are not the result of staff probing. Thus, there may be selective enquirer reporting and staff recording of barriers and case characteristics. Nonetheless, it is hoped that the table will be helpful in guiding further research in this area and in guiding practitioners interacting with alleged EA victims and perpetrators.

6.4.1. Introducing a Model of Help-Seeking in Elder Abuse

This section aims to describe a model of help-seeking in EA, based on the findings of this thesis and the integration of these findings with previous theory and research. Specifically, this section describes the nature and process of help-seeking.

The Nature of Help-Seeking for Elder Abuse. The findings indicate that help-seeking is a continuous process involving several disclosures, which may occur at an informal or formal level, may or may not involve requesting help, and may or may not lead to the offer and acceptance of help (Mowlam et al., 2007; Truong et al., 2019; Vrantsidis et al., 2016). Victims and concerned persons seek help with different goals in mind, as exemplified in Sections 4.5.5 and 5.5.3. The findings also stress that the responses that victims and concerned persons obtain when they seek help have an impact on further help-seeking attempts. Thus, responses from informal and formal sources can act as barriers to help-seeking. This is a dynamic that has been previously identified among intimate partner violence victims (e.g., Dichter et al., 2015; Voth Schrag et al., 2020). If aligning with the TPB, the way these responses could influence help-seeking would be through the feedback effects (Ajzen, 2020). After victims and concerned persons seek help, they experience negative or positive outcomes, as well as favourable and unfavourable reactions from others, such as informal and formal sources. This feedback is likely to change the person's beliefs (behavioural, normative, and control), which will then influence their intention to seek help in the future.

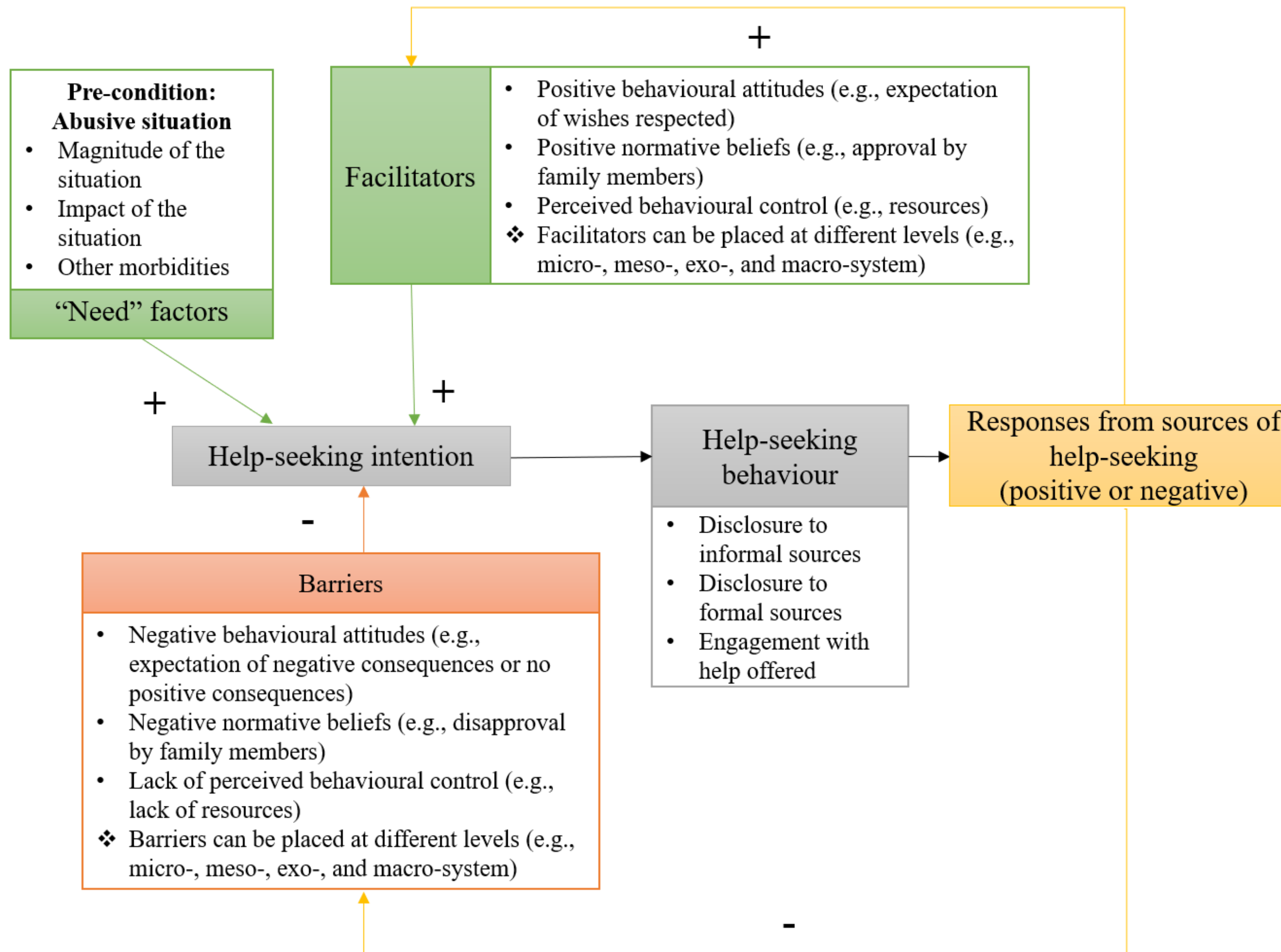
The Process of Help-Seeking. Considering the findings of this study, previous research findings, and also the TPB (Ajzen, 1985), the Behavioral Model of Health Services Use (Andersen, 1965), and the Ecological Systems Theory (Bronfenbrenner, 1979) as frameworks, a model of help-seeking in EA is proposed (see Figure 6.1).

According to this model, help-seeking by victims or concerned persons occurs as a result of the intention to seek help, in line with the TPB (Ajzen, 1985). Help-seeking is understood in this model as a continuum, rather than an isolated process, which may involve several attempts. It is also understood broadly as disclosing abuse to informal or formal sources, and/or asking for, accepting, and/or engaging with the help offered once abuse is disclosed. The intention to seek help is impacted by three main factors:

- "Need" factors: these can be understood as the circumstances leading to the intention to seek help, and they impact the intention to seek help by increasing the likelihood of doing so (represented by the "+" symbol). These factors are largely what would be considered the "need" factor in Andersen's Behavioral Model of Health Services Use (Andersen, 1965). Thus, the abusive situation would be considered in this factor, but also its magnitude, the impact of it, and other morbidities (e.g., physical or mental health problems) which may lead to seeking help (Burnes, Acierno, & Hernandez-Tejada, 2019). According to the proposed model, increased abuse frequency, intensity, and impact of the abuse would make the intention to seek help more likely. This is consistent with previous research (e.g., Burnes, Acierno, & Hernandez-Tejada, 2019; Mowlam et al., 2007; Tamutiene et al., 2013) and several findings in this thesis regarding the situations in which victims and concerned persons seek help. This factor also acts as a pre-condition to help-seeking, since the abusive situation is the primary reason to seek help.

Figure 6.1

Proposed Model of Help-seeking by Victims and Concerned Persons in Elder Abuse



Note. The model adapts some of the components of the Theory of Planned Behavior (Ajzen, 1985), Andersen's Behavioral Model of Health Services Use (Andersen, 1965), and the Ecological Systems Theory (Bronfenbrenner, 1979).

- Facilitators to help-seeking: these make help-seeking more likely by positively affecting the intention to seek help. Facilitators can be placed at different levels, consistent with the Ecological Systems Theory (Bronfenbrenner, 1979): micro-system (e.g., a feeling of readiness to seek help), meso-system (e.g., good formal support), exo-system (e.g., adequate systems to deal with EA), and macro-system (e.g., awareness of abuse). They can also be understood as behavioural and normative attitudes as per the TPB (Ajzen, 1985); for example, positive expectations of the experience and outcomes of seeking help, and perceptions of social approval for seeking help. Within facilitators, the perceived behavioural control (Ajzen, 1985) component is integrated. In this case, the availability of resources (e.g., money to pay for legal advice; evidence in support of abuse perpetration) would make help-seeking more likely.

- Barriers to help-seeking: these make help-seeking less likely by negatively affecting the intention to seek help. Like facilitators, they can be placed at different levels: micro-system (e.g., a feeling of shame or anxiety regarding seeking help), meso-system (e.g., isolation from services), exo-system (e.g., inadequate systems to deal with EA), and macro-system (e.g., ageism). They can also be understood as behavioural and normative attitudes. For example, negative expectations of the experience and outcomes of seeking help (e.g., thinking that it will lead to the victims being institutionalised), and perceptions of disapproval for seeking help (e.g., anticipation of denunciation by their community). In the case of barriers, the perceived behavioural control component would be integrated as well. For example, the lack of resources or the feelings of physical frailty would negatively impact the intention to seek help.

The Effect of Feedback According to the Model. In the model, the impact of feedback can be positive or negative, and the effect of feedback impacts the intention to seek help by influencing the barriers and facilitators present. This feedback effect is similar to that described by Ajzen (2020), who explains that performing a behaviour (i.e., help-seeking) may then modify the person's beliefs (e.g., behavioural, normative, control), and through this modification, impact future intentions to perform the same behaviour. In the proposed model, the effect will be positive or negative depending on whether there is a mismatch between what the victim or concerned person expected out of seeking help or not, as well as whether the expectations were negative or positive to begin with.

- The effect will be negative, leading to a lower likelihood of help-seeking behaviours and engagement with help, if:
  - The expectations were positive and there was a mismatch with the responses received (i.e., the responses were negative).
    - For example, a concerned person faced internal barriers (e.g., fear and anxiety) to seeking help for their mother suffering from psychological abuse, but decided to do so on the expectation that services would do what was best to protect the victim. Upon seeking help from the police, they responded negatively (e.g., by telling them that they could not do anything because there was no physical abuse involved). This response impacted the concerned person's expectations of formal services being able to help, and, as a result of this interaction, they were less likely to seek help from them again.
  - The expectations and the responses were negative.
    - For example, a victim had negative expectations of what would happen if they sought help from their friend for a situation of financial abuse by

their adult child. They expected that their friend would blame them for the situation, because they initially gave money away willingly. The victim decided to seek help regardless, prompted by the seriousness of the situation. Upon telling their friend about the situation, the friend reacted by telling them that they were not surprised about the situation and that the victim should not have been so generous with their adult child when they were young. As a result, the victim's negative expectations were confirmed, and they decided not to tell other friends for fear of the same reaction.

- The effect will be positive, leading to further engagement and help-seeking behaviours, if:
    - The expectations were negative, but the person sought help regardless, and there was a mismatch with the responses received (i.e., the responses were positive).
        - For example, a victim did not want to seek help because they expected that doing so would mean they would need to go to a care home, since they were living with the perpetrator. However, the abuse escalated and, in a situation of fear, they called social services. They found that, contrary to their expectations, they were consulted throughout the process, and supported to make informed choices. As a result, their beliefs about what happens when they seek help changed and they were more likely to engage in further help-seeking behaviour and engage with services.
    - The expectations and responses were positive.
        - For example, a concerned person expected that if they disclosed to their partner that the concerned person's father was being neglected in a care

> home, their partner would understand their worry and be sympathetic. Upon disclosing, the partner was very understanding and offered to help in any way in reporting to the care home. As a result, the concerned person was more likely to rely on their partner throughout the process of seeking help and confide in them.

Concluding Notes About the Model. It is necessary to mention that, as with the Ajzen (1985) TPB, which this model uses as a primary framework, victims' and concerned persons' decisions to perform a behaviour will not always be so rational. Sometimes victims and concerned persons will seek help in a situation of urgent or imminent danger, and fewer factors will have an impact on their decision to seek help. However, some victims seek help after suffering abuse for a long time, and so multiple barriers and facilitators may play a role. In addition, because seeking help is an ongoing process, rather than an isolated event, victims will need to engage with formal and informal sources of help throughout (Fraga Domínguez et al., 2020; Truong et al., 2019). Thus, even if victims seek help in a situation of emergency, without making an informed decision, they may have more time to think about the consequences once the emergency has passed. Hence, the model may be helpful in explaining further decisions to seek help. For example, in a case study described by MacKay (2017), an older adult, who was approached by social workers who offered choices on how to act next, described thinking about the consequences of accepting help. Similarly, a victim may call the police, but based on that interaction, may then refuse to press charges or engage with intervention offered.

6.5. Implications for Practice

One of the essential aspects of research is deriving applications for practice and policy. For this reason, the following section will discuss ways in which the findings of the three studies in this thesis can be applied to policy and practice.

Awareness Campaigns and Training for Practitioners

First, awareness campaigns should be targeted at those older adults less likely to disclose formally. According to the study findings, those who may need to be targeted are male victims, older victims, those suffering from dementia, and those suffering from neglect, being isolated, or being abused by their children or a friend.

There are some suggestions as to why male victims may be less likely to disclose, including more stigma associated to seeking help for this group (Band-Winterstein, 2012; Bates & Carthy, 2020; Kaye et al., 2007). Thus, awareness campaigns may need to focus on them specifically and highlight that males are also often victims of EA. Research on the effectiveness of broadening the profile of victims in awareness campaigns is scarce. However, in the field of child sexual abuse, increasing awareness about male victimisation has been identified as an important factor in encouraging male victims to disclose (Sivagurunathan et al., 2019).

Another target of awareness campaigns should be the general public. These awareness campaigns might highlight the characteristics of cases in which the older adult may be less likely to reach out formally and therefore bystander intervention may be essential. According to the findings of this thesis, these may be cases characterised by victims' increased age, vulnerabilities such as dementia, or the perpetrator isolating and neglecting the victim. These campaigns may integrate knowledge about the barriers and facilitators that are important in EA cases for both victims and concerned persons, as well as information about the rights of older adults, which participants in Study 3 highlighted could have helped them seek support sooner.

The results suggested that those victims with mental health problems may be more likely to seek help formally. Although a preliminary finding, it is possible that those who are suffering from psychological consequences of abuse, or those who already have some vulnerabilities, may reach out to services because of said vulnerabilities and may disclose during that contact (Burnes, Acierno, & Hernandez-Tejada, 2019). In addition, qualitative

findings indicate that victims may also reach out to services because of the needs (e.g., mental health problems) of perpetrators (Joosten et al., 2020). Thus, the findings highlight the need for training of a diverse range of professionals on the way EA victims disclose and seek help, including mental health professionals working with older adults, who may interact with victims who reach out due to the impact of abuse.

Related to the previous paragraph, more awareness and general training is still necessary amongst professionals. Some of the inadequate service responses received by victims and concerned persons were attributed by concerned persons to lack of knowledge about the dynamics of EA. As suggested previously in Chapter 3 (Section 3.6.2), professional training needs to encompass information about common barriers in this population and the situations in which victims and concerned persons often disclose, and it should emphasise the negative effect that inadequate responses can have for victims' and concerned persons' engagement.

Focus on Providing Support for Concerned Persons

Secondly, considering how many cases are reported by concerned persons, primarily family members but also friends and neighbours, it would be prudent for services and policymakers to place more attention on this group (Breckman et al., 2017; Kilaberia & Stum, 2020). The thesis shows that concerned persons frequently support EA victims or are aware of the situation, sometimes when services are unaware. However, the findings in this thesis, along with previous research in North America (Breckman et al., 2017; Kilaberia & Stum, 2020) demonstrate that concerned persons can be severely impacted by the situation, and sometimes abused by the perpetrator themselves. Following the steps of the New York City Elder Abuse Center (NYC EAC) in setting up a helpline for concerned persons (Elman et al., 2020; NYC EAC, 2018), other countries could try similar initiatives. Further ways of supporting concerned persons need to be explored, as they may be an essential point of connection between the

victims and services, but may not be able to support victims if they are burnt out or do not feel supported, respected, or believed by formal services. It is important to acknowledge the role of concerned persons as informal supporters and integrate them in service planning.

Caution is needed by professionals when concerns are reported by a family member, friend, or neighbour of the victim, as the alleged perpetrator may report that they are being harassed by the reporter, or that the reporter is the one abusing the victim. Some concerned persons in the studies in this thesis reported that this happened and, if this is a common occurrence, it may confuse professionals as to who is trying to help and who is harming the victim. In those cases, caution should be exercised, and alleged victims should be interviewed in a private place, away from the alleged perpetrator and from the person reporting concerns. In any case, concerns should be listened to, and, even if the victim refuses intervention, professionals should aim to remain in contact with concerned persons, as they may be the ones who know the victim best or who are closest to a victim who is in a situation of isolation. However, in all situations, professionals will have to abide by the relevant legislation, and consider mental capacity, safeguarding procedures, and data protection. In some cases, respecting the legislation will make it hard to engage with concerned persons because the victims' wishes for confidentiality will need to be respected. In those situations, providing information about relevant legislation regarding mental capacity may help in managing concerned persons' expectations from formal services. This information will make it easier for concerned persons to understand what formal services can and cannot do, and how it is their obligation to respect the older adult's wishes.

Embracing a Victim-Centred Approach

Research findings are consistent with other researchers' recommendation for a victim-centred approach in intervention planning (Spangler & Brandl, 2007). In line with this

approach, intervention should be based on an assessment of the clients' wishes, offering information to support informed choices, and tailoring intervention in line with those choices (Fraga Domínguez et al., 2020; Storey & Perka, 2018). The findings of this thesis provide support for understanding victims as a group with a diversity of wishes in terms of intervention outcomes; thus, practitioners cannot make assumptions about what victims will want out of intervention. Consistent with recent research (Burnes, Hsieh, et al., 2019), this thesis identified that victims have wishes (as well as outcomes that they want to avoid) concerning a variety of areas, such as the specific support they will get and from whom, their housing situation, and their relationship with others and the perpetrator. Interventions are most likely to be successful and secure the engagement of victims if victims' wishes in all those areas are explored and respected as much as possible in the intervention plan (Storey & Perka, 2018).

Intervention Options for Perpetrators

In order to promote victims' help-seeking, the focus cannot be solely on the victim, because, in many cases, victims' wishes also concern outcomes for the perpetrator and may be the reason why victims are contacting services. Thus, policymakers need to focus more on intervention targeted at perpetrators of EA. A recent systematic review found that most intervention aimed at perpetrators focused on caregivers (Rosen et al., 2019); however, caregivers are only a fraction of EA perpetrators. Intervention options are usually lacking for perpetrators, which means their needs are unlikely to be addressed and they may go on to perpetrate further harm to the victim or others. Furthermore, since some victims may not be successfully engaged unless the perpetrator is also receiving intervention, a failure to serve perpetrators is also a failure to serve victims (MacKay, 2017).

6.6. Implications for Future Research

Finally, it is important to summarise how the three studies presented in this thesis can inform future research in the area of help-seeking in EA. Based on the findings reported, as well as the gaps acknowledged, the researcher has identified a number of research priorities. It is important to highlight that, although research with victims is recommended, there are multiple challenges to implementation, and involving victims was not possible in this thesis.

1) Victims' and Concerned Persons' Views of Barriers and Facilitators

The challenges of involving victims in research have been acknowledged in this thesis, particularly due to vulnerabilities in this population and concerns about capacity to consent (see Appendix A). However, as much as possible, ideally by developing relationships with organisations working with older victims, future researchers should consider probing victims and concerned persons about the different barriers and facilitators to help-seeking. The nature of data in Study 2 (i.e., secondary data from a helpline) may have led to identifying that barriers in relation to formal services were the most common for concerned persons, and one of the most common for victims (see Section 4.7.2 for a discussion of this limitation). Hence, future research should probe victims and concerned persons about the diversity of barriers and facilitators they may face, and should also probe about the victim and abuse characteristics that have been tested in this thesis. A number of victim and abuse characteristics may not have been identified in Study 2 of this thesis due to lack of probing by staff of enquirers (Storey & Perka, 2018); thus, these characteristics could be more reliably measured in future research studies.

2) Research on Help-Seeking With Victims Living With Dementia

Future research with victims of EA should not automatically exclude people living with dementia. Although this thesis has paid more attention to victims living with dementia than a large proportion of previous research on EA and help-seeking, there are still areas to explore.

In other types of research, people living with dementia are being included safely in the research process (Clarke et al., 2018; Mann & Hung, 2019). There are obvious challenges to doing this and many ethical concerns to consider (Mann & Hung, 2019), including additional sensitivities related to abuse. In addition, older adults living with dementia in very advanced stages of cognitive impairment will not be able to consent. Nonetheless, with the appropriate safeguards, others with a milder impairment may still be able to participate and share their stories. In cases where it is not possible to involve victims with dementia, researching the perceptions of professionals and concerned persons close to these victims can be a suitable alternative.

3) Research About Older Victims of Sexual Abuse and Their Help-Seeking Experience

There were few helpline enquiries about sexual abuse (Study 2); however, during interview or survey reports by concerned persons (Study 3), sexual abuse was more prevalent than suggested by helpline enquiries. Nonetheless, the findings of these studies may not be as representative of help-seeking in sexual abuse cases as compared to other EA types, and sexual abuse remains under-researched in the field (Podnieks et al., 2010). There may be specific barriers relating to reporting sexual abuse cases, such as more shame and stigma, but also challenges from the perspective of professionals, who may be more reluctant to discuss sexual abuse with older adults (Bows, 2018). Ideally, future research should explore these barriers and challenges directly from victims and/or concerned persons in more detail.

4) Professionals' Perception of Concerned Persons' Efforts to Help

The findings in this thesis have highlighted several challenges from the perspective of concerned persons in their attempt to help EA victims. There were reports of retaliation when concerned persons sought help, such as being banned from visiting the older adult in a residential facility, or the perpetrator preventing the concerned person from visiting the victim at home. This suggests that speaking out on behalf of an abused older adult may result in losing

contact with the older adult or losing the right to visit them. In addition, there were also instances where the perpetrator alleged that the concerned person was the one perpetrating abuse. From the perspective of professionals, they may have to intervene in a situation where there are two family members or friends of the victim, both alleging abuse by the other person. In some cases, the perpetrator may manipulate formal services into believing that the concerned person is the one perpetrating abuse. For all these reasons, exploring how often these challenges are faced by practitioners—such as adult protection staff, health care professionals, or the police—would be helpful to understand this unique barrier. This understanding could help to guide the implementation of strategies that could aid the investigation in a way that protects professionals, the older adult, and those reporting concerns.

5) Research With Minorities and Under-Researched Communities in the UK

There is a need for EA research on help-seeking with victims and concerned persons belonging to minority ethnic groups in the UK, and with other potentially vulnerable populations, such as immigrants and those belonging to the LGBT+ (Lesbian, Gay, Bisexual, Transgender and other sexual identities) community (Dong & Wang, 2016; Gutman et al., 2020; Westwood, 2019). Although the studies herein were somewhat representative of some minority ethnic groups, data about race/ethnicity were missing for the majority of cases in Study 2. Research in other countries, such as the United States and Canada (e.g., Paranjape et al., 2008; Walsh et al., 2010), and research with older adults in the UK (e.g., Bowes et al., 2012), highlights that minority ethnic groups may have different experiences interacting with services. Barriers related to culture in Study 2 highlighted accessibility issues, particularly linked to language barriers and immigration status, suggesting that the experiences of immigrants should be investigated (Dong & Wang, 2016). In order to be representative of diverse experiences, further exploration of these issues directly from minority ethnic groups and immigrants in the UK, with experience seeking help for EA, either as victims or concerned

persons, is necessary. Finally, further research about help-seeking for EA in the LGBT+ community is needed, as there may be group-specific tactics that perpetrators can use to manipulate their victims (e.g., threats to "out" them) and ensure they do not report abuse (Cook-Daniels, 2017; Gutman et al., 2020).

6) Research With Perpetrators of Elder Abuse

More research with perpetrators is needed in order to inform interventional approaches and policy in the area of EA. Research with perpetrators of EA has been traditionally limited (Dong, 2015), even though there have been recent attempts to understand their needs and their diversity (DeLiema et al., 2018; Jackson, 2016; Labrum & Solomon, 2018). Nonetheless, the studies herein indicate that, in order to successfully engage some victims, services will need to intervene with perpetrators as well. Lack of knowledge about perpetrators' views towards intervention, and the reasons why they may reject it, means that targeted successful intervention will be a challenge.

6.7. Limitations and Strengths

The studies presented in this thesis have several limitations and strengths, which have already been addressed in Sections 3.7, 4.7.2, 4.7.4, 5.7.2, and 5.7.4. The current section aims to address some overall limitations and strengths of the general methodology and findings presented in this thesis.

First, there are limitations pertaining to the definition of EA throughout studies. There were instances in Studies 2 and 3 where it was clear that the older adult did not see themselves as abused; thus, it is possible that they did not perceive that they were being harmed. Hence, some of the cases included may reflect the perspective of concerned persons who perceived abuse in a situation where the victim did not identify it. However, in agreement with the definition utilised in this thesis, an important component of abuse is the harm to an older adult.

If a person is being severely harmed (e.g., they are giving all their money away to the perpetrator and may soon become homeless), an argument can be made that this is abuse, as it is a violation of their human right to live a life free from harm (Penhale, 2003). Nonetheless, older adults with mental capacity are free to give their money away, so this situation can be considered abuse while recognising that nothing can be done from the perspective of professionals or concerned persons. The aspect of choice in living with harm is complex and subject to much debate, and there are many reasons why an older adult may choose to endure a harmful situation (Enguidanos et al., 2017; Mackay, 2017). Further research exploring the definitions and views of abuse in different situations from the perspective of older adults will be helpful in adding to the literature.

Second, and in connection with the point above, one of the original aims of the researcher was to obtain data from victims directly, in order to give victims a voice. Due to challenges of implementation, it was not possible to do so. However, as much as possible and with the right safeguards, future research should aim to integrate the voices of victims, as they are the ones best placed to share their story, feelings, perceptions, and help-seeking experience. Developing a relationship with organisations supporting older adults and victims of abuse is identified as one of the potentially successful ways of safely involving victims in research.

Third, there are both limitations and strengths relating to the integration of findings from different countries in Studies 1 and 3. For example, legislation is different across countries, or across states within a country, and so is the legislation regarding EA, including whether it is considered a crime, or the services most likely to intervene (Dong, 2015; Podnieks et al., 2010). This diversity poses challenges in terms of integration of findings that may reflect very different experiences and circumstances. However, to address this, for Study 3, the researcher chose several countries with some similarities in how they intervened in EA cases, which made integration easier. The international approach, despite its challenges, has the

strength of including data from countries that are more under-represented in EA research, which was done in Study 1. Similarly, many commonalities were found in the barriers experienced by victims in very different countries (Study 1). This, together with the similar experiences by concerned persons (Study 3), may reflect that there is more in common across countries in their response to EA than previously thought.

Fourth, this thesis has generally considered help-seeking outcomes simply as a matter of occurrence and frequency of abuse (e.g., whether abuse had stopped, diminished, increased, or had not changed). As Burnes et al. (2021) recently pointed out in their scoping review, this is just one of the outcomes of EA, albeit one of the most frequently used. Future research could consider further outcomes, such as improvements in physical and psychological wellbeing. Studying a variety of outcomes of seeking help may offer a more nuanced understanding of this process.

Finally, this thesis has relied on convenience sampling for the studies presented, which is a common limitation in the field of EA (Burnes, Acierno, & Hernandez-Tejada, 2019). Future studies using random sampling, such as prevalence studies, could introduce sections with the aim of exploring help-seeking experiences in more detail.

Despite the acknowledged limitations, this thesis has many strengths. It has involved a mixed-methods approach, appropriate for tackling the complex issue of help-seeking in EA. After identifying gaps in a thorough systematic review of help-seeking behaviour by victims of EA, many of these gaps were addressed in a large national sample of EA cases from the only EA-specific helpline in the UK. Recognising the lack of attention paid to an important group of supporters—the family members, friends, neighbours, and acquaintances of EA victims—the role of these concerned persons was explored both through secondary data (i.e., helpline records) and primary data (i.e., surveys and interviews). Overall, this thesis has placed the focus

on help-seeking in EA and provided findings that can both inform future research and guide practitioners in providing more effective services for victims and those who support them informally.

6.8. Conclusions

This thesis used a mixed-methods approach to improve the understanding of help-seeking in EA, by focusing on victims of EA and others who help them informally ("concerned persons": family members, friends, neighbours, and acquaintances). Study 1 was a systematic review which presented a summary of the available research on victims' perspectives of help-seeking in EA and identified gaps of knowledge. Study 2 involved a secondary analysis of cases reported to a UK helpline over a year and provided research on several areas identified in Study 1 as missing in the literature. Study 2 also focused on the perspective of concerned persons, studying similar areas of help-seeking. Study 3 involved primary data gathered from concerned persons using a survey and semi-structured interview. Study 3 addressed some of the gaps in Study 2 and gave a voice to concerned persons.

All studies focused on barriers and facilitators to help-seeking, as well as circumstances leading to help-seeking. They also studied sources of and responses to help-seeking, and general attitudes towards third-party intervention. In addition, Studies 2 and 3 investigated the profile of concerned persons and the impact suffered by these individuals while knowing (and supporting) a victim of EA.

The main findings indicate that, although victims and concerned persons experience many barriers to help-seeking, they frequently reach out to others, informally and/or formally for help. Both victims and concerned persons seek help with different goals in mind, and the diversity of their wishes implies that a victim-centred and individualised approach from practitioners and policymakers will be most successful in engaging them. The responses

obtained by victims and concerned persons from formal sources in response to their help seeking are not always positive and impact their decision to seek help again or engage with the help offered, highlighting the importance of staff training in different services. While supporting victims, concerned persons face many challenges and a wide-ranging impact to their mental and physical health, as well as their financial status and their relationships with others, indicating the need to support this group.

This thesis has important contributions to knowledge, namely a more comprehensive understanding of help-seeking in EA from two groups who have generally lacked acknowledgement in EA research. A model of help-seeking, based on some of the components of the TPB (Ajzen, 1985), the Behavioral Model of Health Services Use (Andersen, 1965), and the Ecological Systems Theory (Bronfenbrenner, 1979), is presented. In addition, this thesis has outlined many gaps for future research, such as a focus on under-researched groups of victims, and more research on concerned persons and their interactions with services. It has also outlined several implications for practice, primarily, the need for a victim-centred approach (Spangler & Brandl, 2007) and further training encompassing knowledge about victims' and concerned persons' help-seeking.

In conclusion, this thesis has identified the problem of under-reporting in EA, and shifted the focus from professionals' reporting to the help-seeking behaviours of victims and those who support them. The studies and findings presented are the result of a comprehensive attempt to understand help-seeking in EA, in order to inform practice and research, and ultimately improve service provision for older adults and ensure that they receive adequate support when they are victimised. It is hoped that this thesis, and the findings presented, are the start of more research focused on EA victims' voices, and the voices of those who help them in an informal role.

References

Aas, G. (2018). The Norwegian police and victims of elder abuse in close and familial relationships. *Journal of Elder Abuse & Neglect*, *30*(1), 20-41. https://doi.org/10.1080/08946566.2017.1364683

Abrams, R. C., Ansell, P., Breckman, R., Karlawish, J., Lachs, M., Holt-Knight, D., Needell, N., Rogers, G., & LoFaso, V. (2019). The Interview for Decisional Abilities (IDA): A tool to assess the decisional capacity of abused and neglected older adults. *Journal of Elder Abuse & Neglect*, *31*(3), 244-254. https://doi.org/10.1080/08946566.2019.1573392

Acierno, R., Brady, K., Gray, M., Kilpatrick, D. G., Resnick, H., & Best, C. L. (2002). Psychopathology following interpersonal violence: A comparison of risk factors in older and younger adults. *Journal of Clinical Geropsychology*, *8*(1), 13-23. https://doi.org/10.1023/A:1013041907018

Acierno, R., Hernandez, M. A., Amstadter, A. B., Resnick, H. S., Steve, K., Muzzy, W., & Kilpatrick, D. G. (2010). Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The National Elder Mistreatment Study. *American Journal of Public Health, 100*(2), 292–297. https://doi.org/10.2105/AJPH.2009.163089

Acierno, R., Hernandez-Tejada, M. A., Anetzberger, G. J., Loew, D., & Muzzy, W. (2017). The National Elder Mistreatment Study: An 8-year longitudinal study of outcomes. *Journal of Elder Abuse & Neglect*, *29*(4), 254-269. https://doi.org/10.1080/08946566.2017.1365031

Acierno, R., Steedley, M., Hernandez-Tejada, M. A., Frook, G., Watkins, J., & Muzzy, W. (2020). Relevance of perpetrator identity to reporting elder financial and emotional mistreatment. *Journal of Applied Gerontology*, *39*(2), 221-225. https://doi.org/0733464818771208

Action on Elder Abuse (1995). *New definition of abuse.* Action on Elder Abuse Bulletin (issue no. 11). London: Action on Elder Abuse.

Action on Elder Abuse (2008). A profile of Action on Elder Abuse. *The Journal of Adult Protection, 10*(3), 35-38. https://doi.org/10.1108/14668203200800018

Adams, V. M., Bagshaw, D., Wendt, S., & Zannettino, L. (2014). Financial abuse of older people by a family member: A difficult terrain for service providers in Australia. *Journal of Elder Abuse & Neglect*, *26*(3), 270-290. https://doi.org/10.1080/08946566.2013.824844

Aday, R. H., Wallace, J. B., & Scott, S. J. (2017). Generational differences in knowledge, recognition, and perceptions of elder abuse reporting. *Educational Gerontology*, *43*(11), 568-581. https://doi.org/10.1080/03601277.2017.1376382

Addington, L. A. (2013). Who you calling old? Measuring "elderly" and what it means for homicide research. *Homicide Studies, 17*(2), 134-153. https://doi.org/10.1177/1088767912461784

Adib, M., Esmaeili, M., Zakerimoghadam, M., & Nayeri, N. D. (2019). Barriers to help-seeking for elder abuse: A qualitative study of older adults. *Geriatric Nursing*, *40*(6), 565-571. https://doi.org/10.1016/j.gerinurse.2019.04.003

Age UK (2015). *Financial abuse evidence review*. https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/money-matters/financial_abuse_evidence_review-nov_2015.pdf

Age UK (2018). *Financial resilience during retirement: Who is well placed to cope with life events? Summary and implications.* https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/money-matters/rb_apr18_financial_resillience_summary.pdf

Age UK (2019, December). *Safeguarding older people from abuse and neglect.* https://www.ageuk.org.uk/globalassets/age-uk/documents/factsheets/fs78_safeguarding_older_people_from_abuse_fcs.pdf

Age UK (2020, August 19). *Power of Attorney.* https://www.ageuk.org.uk/information-advice/money-legal/legal-issues/power-of-attorney/

Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In *Action control* (pp. 11-39). Springer.

Ajzen, I. (2002). Perceived behavioral control, self-efficacy, locus of control, and the theory of planned behavior. *Journal of Applied Social Psychology*, *32*(4), 665-683. https://doi.org/j.1559-1816.2002.tb00236.x

Ajzen, I. (2011). The theory of planned behaviour: Reactions and reflections. *Psychology and Health, 26,* 1113–1127. https://doi.org/10.1080/08870446.2011.613995

Ajzen, I. (2015). The theory of planned behaviour is alive and well, and not ready to retire: A commentary on Sniehotta, Presseau, and Araújo-Soares. *Health Psychology Review*, *9*(2), 131-137. https://doi.org/10.1080/17437199.2014.883474

Ajzen, I. (2020). The theory of planned behaviour: Frequently asked questions. *Human Behavior and Emerging Technologies*, *2*(4), 314-324. https://doi.org/10.1002/hbe2.195

Alaggia, R. (2010). An ecological analysis of child sexual abuse disclosure: Considerations for child and adolescent mental health. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *19*(1), 32-39. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2809444/pdf/ccap19_1p0032.pdf

Alaggia, R., Collin-Vézina, D., & Lateef, R. (2019). Facilitators and barriers to child sexual abuse (CSA) disclosures: A research update (2000–2016). *Trauma, Violence, & Abuse*, *20*(2), 260-283. https://doi.org/10.1177/1524838017697312

Alt, K. L., Nguyen, A. L, & Meurer, L. N. (2011). The effectiveness of educational programs to improve recognition and reporting of elder abuse and neglect: A systematic review of the literature. *Journal of Elder Abuse & Neglect, 23*(3), 213-233. https://doi.org/10.1080/08946566.2011.584046

Altman, D. G. (1999). *Practical statistics for medical research*. Chapman & Hall/CRC Press.

American Association on Intellectual and Developmental Disabilities (2020). Frequently asked questions on intellectual disability. https://www.aaidd.org/intellectual-disability/definition/faqs-on-intellectual-disability

Amstadter, A. B., Cisler, J. M., McCauley, J. L., Hernandez, M. A., Muzzy, W., & Acierno, R. (2011). Do incident and perpetrator characteristics of elder mistreatment differ by gender of the victim? Results from the National Elder Mistreatment Study. *Journal of Elder Abuse & Neglect*, *23*(1), 43-57. https://doi.org/10.1080/08946566.2011.534707

Andersen, R. M. (1968). A *behavioral model of families' use of health services (Research Series No. 25).* Center for Health Administration Studies, University of Chicago.

Andersen, R. M., & Newman, J. F. (1973). Societal and individual determinants of medical care utilization in the United States. *The Milbank Memorial Fund Quarterly: Health and Society*, *51*(1), 95-124. https://doi.org/10.1111/j.1468-0009.2005.00428.x

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior*, *36*(1), 1-10. https://doi.org/10.2307/2137284

Anetzberger, G. J. (2000). Caregiving: Primary cause of elder abuse? *Generations*, *24*(2), 46-52.

Avramidis, E., & Smith, B. (1999). An introduction to the major research paradigms and their methodological implications for special needs research. *Emotional and Behavioural Difficulties*, *4*(3), 27-36. https://doi.org/10.1080/1363275990040306

Bandura, A. (1978). Social learning theory of aggression. *Journal of Communication*, *28*(3), 12-29. https://doi.org/10.1111/j.1460-2466.1978.tb01621.x

Band-Winterstein, T. (2012). Narratives of aging in intimate partner violence: The double lens of violence and old age. *Journal of Aging Studies*, *26*(4), 504-514. https://doi.org/10.1016/j.jaging.2012.07.003

Band-Winterstein, T., Goldblatt, H., & Lev, S. (2021). Breaking the taboo: Sexual assault in late life as a multifaceted phenomenon—Toward an integrative theoretical framework. *Trauma, Violence, & Abuse*, *22*(1), 112-124. https://doi.org/1524838019832979

Barber, J. W. (2008). The kids aren't all right: The failure of child abuse statutes as a model for elder abuse statutes. *Elder Law Journal*, *16*, 107-134.

Barker, N. N., & Himchak, M. V. (2006). Environmental issues affecting elder abuse victims in their reception of community based services. *Journal of Gerontological Social Work, 48*(1-2), 233-255. https://doi.org/10.1300/J083v48n01_16

Barlow, C., Johnson, K., Walklate, S., & Humphreys, L. (2020). Putting coercive control into practice: Problems and possibilities. *The British Journal of Criminology*, *60*(1), 160-179. https://doi.org/10.1093/bjc/azz041

Bartko, J. J. (1966). The intraclass correlation coefficient as a measure of reliability. *Psychological Reports, 19*(1), 3-11. https://doi.org/10.2466/pr0.1966.19.1.3

Bates, E. A., & Carthy, N. L. (2020). “She convinced me I had Alzheimer’s”: Experiences of intimate partner violence in older men. *Psychology of Men & Masculinities, 21*(4), 675–685. https://doi.org/10.1037/men0000280

Baxter, L., Gordon, J., & Salmon, R. (2017). Developing an understanding of the national trading standards scams team. In A. L. Fenge, S. Lee, & K. Brown (Eds.), *Safeguarding adults: Scamming and mental capacity* (pp. 91–117). Sage.

Beach, S. R., Carpenter, C. R., Rosen, T., Sharps, P., & Gelles, R. (2016). Screening and detection of elder abuse: Research opportunities and lessons learned from emergency geriatric care, intimate partner violence, and child abuse. *Journal of Elder Abuse & Neglect*, *28*(4-5), 185-216. https://doi.org/10.1080/08946566.2016.1229241

Beach, S. R., Schulz, R., Williamson, G. M., Miller, L. S., Weiner, M. F., & Lance, C. E. (2005). Risk factors for potentially harmful informal caregiver behavior. *Journal of the American Geriatrics Society, 53*, 255–261. https://doi.org/10.1111/j.1532-5415.2005.53111.x

Beaulaurier, R. L., Seff, L. R., & Newman, F. L. (2008). Barriers to help-seeking for older women who experience intimate partner violence: A descriptive model. *Journal of Women & Aging*, *20*(3-4), 231-248. https://doi.org/10.1080/08952840801984543

Bennett, S., Banyard, V. L., & Edwards, K. M. (2017). The impact of the bystander’s relationship with the victim and the perpetrator on intent to help in situations involving sexual violence. *Journal of Interpersonal Violence*, *32*(5), 682-702. https://doi.org/10.1177/0886260515586373

Bennett, G., Jenkins, G., & Asif, Z. (2000). Listening is not enough: An analysis of calls to the Elder Abuse Response. *Journal of Adult Protection, 2*(1), 6-20. https://doi.org/10.1108/14668203200000003

Bergeron, L. R., & Gray, B. (2003). Ethical dilemmas of reporting suspected elder abuse. *Social Work, 48*(1), 96-105. https://doi.org/10.1093/sw/48.1.96

Blakely, B. E., & Dolon, R. (1999). A test of public reactions to alleged elder abuse. *Journal of Elder Abuse & Neglect*, *9*(4), 43-65. https://doi.org/10.1300/j084v09n04_03

Bogna, F., Raineri, A., & Dell, G. (2020). Critical realism and constructivism: Merging research paradigms for a deeper qualitative study. *Qualitative Research in Organizations and Management, 15*(4), 461-484. https://doi.org/10.1108/QROM-06-2019-1778

Booth, A., Clarke, M., Ghersi, D., Moher, D., Petticrew, M., & Stewart, L. (2011). An international registry of systematic review protocols. *The Lancet, 377*(9760), 108–109. https://doi.org/10.1016/S0140-6736(10)60903-8

Bowes, A., Avan, G., & Macintosh, S. (2008). *They put up with it what else can they do? Mistreatment of black and minority ethnic older people and the service response*. Age Concern Scotland. https://dspace.stir.ac.uk/bitstream/1893/7346/1/BowesReport.pdf

Bowes, A., Avan, G., & Macintosh, S. B. (2012). Cultural diversity and the mistreatment of older people in black and minority ethnic communities: Some implications for service provision. *Journal of Elder Abuse & Neglect*, *24*(3), 251-274. https://doi.org/10.1080/08946566.2011.653319

Bows, H. (2018). Practitioner views on the impacts, challenges, and barriers in supporting older survivors of sexual violence. *Violence Against Women, 24*(9), 1070-1090. https://doi.org/10.1177/1077801217732348

Bows, H. (2020). Violence and abuse of older people: A review of current proposals for criminalisation. *Criminal Law Review, 10*, 877-894.

Brank, E. M., Wylie, L. E., & Hamm, J. A. (2011). Potential for self-reporting of older adult maltreatment: An empirical examination. *Elder Law Journal*, *19*, 351-384.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2020). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*. Advanced online publication. https://doi.org/10.1080/14780887.2020.1769238

Breckman, R., Burnes, D., Ross, S., Marshall, P. C., Suitor, J. J., Lachs, M. S., & Pillemer, K. (2017). When helping hurts: Nonabusing family, friends, and neighbors in the lives of elder mistreatment victims. *The Gerontologist*, *58*(4), 719-723. https://doi.org/10.1093/geront/gnw257

Bronfenbrenner, U. (1979). *The ecology of human development*. Harvard University Press

Brownell, P., & Wolden, A. (2003). Elder abuse intervention strategies: Social service or criminal justice? *Journal of Gerontological Social Work*, *40*(1-2), 83-100. https://doi.org/10.1300/j083v40n01_06

Bryman, A. (2007). Barriers to integrating quantitative and qualitative research. *Journal of Mixed Methods Research, 1*(1), 8–22. https://doi.org/10.1177/2345678906290531

Burgess, A. W., & Phillips, S. L. (2006). Sexual abuse, trauma and dementia in the elderly: A retrospective study of 284 cases. *Victims and Offenders*, *1*(2), 193-204. https://doi.org/10.1080/15564880600663935

Burgess, A. W., Ramsey-Klawsnik, H., & Gregorian, S. B. (2008). Comparing routes of reporting in elder sexual abuse cases. *Journal of Elder Abuse & Neglect*, *20*(4), 336-352. https://doi.org/10.1080/08946560802359250

Burnes, D. (2017). Community elder mistreatment intervention with capable older adults: Toward a conceptual practice model. *The Gerontologist*, *57*(3), 409-416. https://doi.org/10.1093/geront/gnv692

Burnes, D., Acierno, R., & Hernandez-Tejada, M. (2019). Help-seeking among victims of elder abuse: Findings from the National Elder Mistreatment Study. *The Journals of Gerontology: Series B*, *74*(5), 891-896. https://doi.org/10.1093/geronb/gby122

Burnes, D., Breckman, R., Henderson Jr, C. R., Lachs, M. S., & Pillemer, K. (2019). Utilization of formal support services for elder abuse: Do informal supporters make a difference? *The Gerontologist*, *59*(4), 619-624. https://doi.org/10.1093/geront/gny074

Burnes, D., Hsieh, J., Scher, C., Zanotti, P., Burchett, C. O., Sirey, J. A., & Lachs, M. (2019). What does success mean in the context of elder abuse intervention from the perspective of victims? *Innovation in Aging*, *3*(S1), 864. https://doi.org/10.1093/geroni/igz038.3173

Burnes, D., Lachs, M. S., Burnette, D., & Pillemer, K. (2019). Varying appraisals of elder mistreatment among victims: Findings from a population-based study. *The Journals of Gerontology: Series B, 74*(5), 881-890. https://doi.org/10.1093/geronb/gbx005

Burnes, D., MacNeil, A., Nowaczynski, A., Sheppard, C., Trevors, L., Lenton, E., Lachs, M. S., & Pillemer, K. (2021). A scoping review of outcomes in elder abuse intervention

research: The current landscape and where to go next. *Aggression and Violent Behavior*, 101476. https://doi.org/10.1016/j.avb.2020.101476

Burnes, D., Rizzo, V. M., Gorroochurn, P., Pollack, M. H., & Lachs, M. S. (2016). Understanding service utilization in cases of elder abuse to inform best practices. *Journal of Applied Gerontology*, *35*(10), 1036-1057. https://doi.org/10.1177/0733464814563609

Burston, G. R. (1975). Granny-battering. *British Medical Journal, 3*, 592. https://doi.org/10.1136/bmj.3.5983.592-a

Butchart, A., & Mikton, C. (2014) *Global status report on violence prevention*. World Health Organization. http://eprints.uwe.ac.uk/30034

Campbell, R., Greeson, M. R., Fehler-Cabral, G., & Kennedy, A. C. (2015). Pathways to help: Adolescent sexual assault victims' disclosure and help-seeking experiences. *Violence Against Women*, *21*(7), 824-847. https://doi.org/10.1177/1077801215584071

Centers for Disease Control and Prevention. (2020). *Fact sheet: Preventing elder abuse.* https://www.cdc.gov/violenceprevention/pdf/elder/EA_Factsheet.pdf

Chabot, H. F., Gray, M. L., Makande, T. B., & Hoyt, R. L. (2018). Beyond sex: Likelihood and predictors of effective and ineffective intervention in intimate partner violence in bystanders perceiving an emergency. *Journal of Interpersonal Violence*, *33*(12), 1909-1930. https://doi.org/10.1177/0886260515621064

Chang, H. W. (2004). *Perceptions of elder abuse and help-seeking patterns among Taiwanese elderly women* [Unpublished doctoral dissertation]. University of Northern Colorado.

Chang, M. (2016). Experience of elder abuse among older Korean immigrants. *Journal of Elder Abuse & Neglect*, *28*(2), 76-94. https://doi.org/10.1080/08946566.2016.1156593

Chokkanathan, S., Natarajan, A., & Mohanty, J. (2014). Elder abuse and barriers to help seeking in Chennai, India: A qualitative study. *Journal of Elder Abuse & Neglect*, *26*(1), 60-79. https://doi.org/10.1080/08946566.2013.782786

Clarke, C. L., Wilkinson, H., Watson, J., Wilcockson, J., Kinnaird, L., & Williamson, T. (2018). A seat around the table: participatory data analysis with people living with

dementia. *Qualitative Health Research*, *28*(9), 1421-1433. https://doi.org/10.1177/1049732318774768

Clarke, A., Williams, J., & Wydall, S. (2016). Access to justice for victims/survivors of elder abuse: A qualitative study. *Social Policy and Society*, *15*(2), 207-220. https://doi.org/10.1017/S1474746415000202

Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurement*, *20*(1), 37-46. https://doi.org/10.1177/001316446002000104

Coker, A. L., Smith, P. H., Thompson, M. P., McKeown, R. E., Bethea, L., & Davis, K. E. (2002). Social support protects against the negative effects of partner violence on mental health. *Journal of Women's Health & Gender-Based Medicine*, *11*(5), 465-476. https://doi.org/10.1089/15246090260137644

Comas-Herrera, A., & Zalakaín, J. (2020). Mortality associated with COVID-19 outbreaks in care homes: Early international evidence. *LTCcovid. org, International Long-Term Care Policy Network*. https://alzheimeriberoamerica.org/wp-content/uploads/2020/04/Mortality-associated-with-COVID-12-April-3.pdf

Comijs, H. C., Pot, A. M., Smit, J. H., Bouter, L. M., & Jonker, C. (1998). Elder abuse in the community: Prevalence and consequences. *Journal of the American Geriatrics Society, 46*(7), 885-888. https://doi.org/10.1111/j.1532-5415.1998.tb02724.x

Cook-Daniels, L. (2017). Coping with abuse inside the family and out: LGBT and/or male victims of elder abuse. In X. Dong (Ed.), *Elder Abuse* (pp. 541-553). Springer. https://doi.org/10.1007/978-3-319-47504-2_25

Coombs, J. (2014). Scamming the elderly: An increased susceptibility to financial exploitation within and outside of the family. *Albany Government Law Review*, *7*, 243-266.

Cooper, C., & Livingston, G. (2016). Intervening to reduce elder abuse: Challenges for research, *Age and Ageing*, *45*(2), 184-185. https://doi.org/10.1093/ageing/afw007

Cooper, C., Selwood, A., & Livingston, G. (2008). The prevalence of elder abuse and neglect: A systematic review. *Age and Ageing, 37*(2), 151-160. https://doi.org/10.1093/ageing/afm194

Crichton, S. J., Bond Jr, J. B., Harvey, C. D., & Ristock, J. (1999). Elder abuse: Feminist and ageist perspectives. *Journal of Elder Abuse & Neglect*, *10*(3-4), 115-130. https://doi.org/10.1300/J084v10n03_06

Critical Appraisal Skills Program. (2018). *CASP qualitative checklist*. Retrieved September 14, 2018, from https://casp-uk.net/casp-tools-checklists/

Crome, P., Moulias, R., Sánchez-Castellano, C., Tilvis, R., Arora, A., Busby, F., Ribera Casado, J. M., & Cruz-Jentoft, A. J. (2014). Elder abuse in Finland, France, Spain and United Kingdom. *European Geriatric Medicine*, *5*(4), 277-284. https://doi.org/10.1016/j.eurger.2014.05.008

Crotty, M. (1998). Introduction: The research process. In M. J. Crotty (Ed.), *The foundations of social research: Meaning and perspective in the research process* (pp. 1-17). Allen & Unwin.

Dalley, G., Gilhooly, M. L., Gilhooly, K., Levi, M., & Harries, P. (2017). Researching the financial abuse of individuals lacking mental capacity. *The Journal of Adult Protection*, *19*(6), 394-405. https://doi.org/10.1108/jap-05-2017-0022

Daly, J. M., Merchant, M. L., & Jogerst, G. J. (2011). Elder abuse research: A systematic review. *Journal of Elder Abuse & Neglect, 23*(4), 348-365. https://doi.org/10.1080/08946566.2011.608048

Darawsheh, W. (2014). Reflexivity in research: Promoting rigour, reliability and validity in qualitative research. *International Journal of Therapy and Rehabilitation*, *21*(12), 560-568. https://doi.org/10.12968/ijtr.2014.21.12.560

Danermark, B., Ekström, M., & Karlsson, J. C. (2019). *Explaining society: Critical realism in the social sciences*. Routledge. https://doi.org/10.4324/9781351017831

Daniel, B., & Bowes, A. (2011). Re-thinking harm and abuse: Insights from a lifespan perspective. *British Journal of Social Work*, *41*(5), 820-836. https://doi.org/10.1093/bjsw/bcq116

De la Torre-Luque, A., Valero-Aguayo, L., & de la Rubia-Cuestas, E. J. (2017). Visuospatial orientation learning through virtual reality for people with severe disability. *International Journal of Disability, Development and Education*, *64*(4), 420-435. https://doi.org/10.1080/1034912X.2016.1274022

DeLiema, M., & Deevy, M. (2017). Aging and exploitation: How should the financial service industry respond? In O. S. Mitchell, P. B. Hammond, & S. P. Utkus (Eds.), *Financial Decisionmaking and Retirement Security in an Aging World* (pp. 153-184). Oxford University Press.

DeLiema, M., Yonashiro-Cho, J., Gassoumis, Z. D., Yon, Y., & Conrad, K. J. (2018). Using latent class analysis to identify profiles of elder abuse perpetrators. *The Journals of Gerontology: Series B*, *73*(5), e49-e58. https://doi.org/10.1093/geronb/gbx023

Department of Health and Social Care (2020). *Care and support statutory guidance: Safeguarding*. https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

Dichter, M. E., Wagner, C., Goldberg, E. B., & Iverson, K. M. (2015). Intimate partner violence detection and care in the Veterans Health Administration: Patient and provider perspectives. *Women's Health Issues, 25*(5), 555-560. https://doi.org/10.1016/j.whi.2015.06.006

Dong, X. (2015). Elder abuse: Systematic review and implications for practice. *Journal of the American Geriatrics Society*, *63*(6), 1214-1238. https://doi.org/10.1111/jgs.13454

Dong, X. (2017). Elder self-neglect: Research and practice. *Clinical Interventions in Aging*, *12*, 949-954. https://doi.org/10.2147/CIA.S103359

Dong, X., Chang, E. S., Wong, E., & Simon, M. A. (2014). Perceived barriers and facilitators to implement elder abuse intervention for victims and perpetrators: Views from US Chinese older adults. *The Journal of Adult Protection, 16*(5), 307-321. https://doi.org/10.1108/JAP-12-2013-0046

Dong, X., Chang, E. S., Wong, E., Wong, B., & Simon, M. A. (2011). How do US Chinese older adults view elder mistreatment? Findings from a community-based participatory research study. *Journal of Aging and Health*, *23*(2), 289-312. https://doi.org/10.1177/0898264310385931

Dong, X., & Wang, B. (2016). 2015 Rosalie Wolf Memorial Award Lecture: Past, present, and future of elder abuse. *Journal of Elder Abuse & Neglect*, *28*(4-5), 345-365. https://doi.org/10.1080/08946566.2016.1237318

Donnelly, S. (2019). Mandatory reporting and adult safeguarding: A rapid realist review. *The Journal of Adult Protection, 21*(5), 241-251. https://doi.org/10.1108/JAP-03-2019-0011

Dow, B., Gaffy, E., & Hwang, K. (2018). *Elder abuse community action plan for Victoria*. National Ageing Research Institute. https://apo.org.au/sites/default/files/resource-files/2018-02/apo-nid132771.pdf

Drisko, J. W., & Maschi, T. (2016). *Content analysis. Pocket guides to social work research methods.* Oxford University Press.

Dyer, C., Connoly, M., & McFeeley, P. (2003). The clinical and medical forensics of elder abuse and neglect. In R. Bonnie & R. Wallace (Eds.), *Elder Abuse: Abuse, neglect, and exploitation in an aging America* (pp. 339-381). National Academy Press.

Eisikovits, Z., Winterstein, T., & Lowenstein, A. (2004). *The national survey on elder abuse and neglect in Israel.* The Center for Research and Study of Aging, the University of Haifa and ESHEL.

Elman, A., Breckman, R., Clark, S., Gottesman, E., Rachmuth, L., Reiff, M., Callahan, J., Russell, L. A., Curtis, M., Solomon, J., Lok, D., Sirey, J. A., Lachs, M. S., Czaja, S., Pillemer, K., & Rosen, T. (2020). Effects of the COVID-19 outbreak on elder mistreatment and response in New York City: Initial lessons. *Journal of Applied Gerontology, 39*(7), 690-699. https://doi.org/0733464820924853

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing, 62*, 107–115. https://doi.org/10.1111/j.13652648.2007.04569.x

Enguidanos, S. M., DeLiema, M., Aguilar, I., Lambrinos, J., & Wilber, K. H. (2014). Multicultural voices: Attitudes of older adults in the United States of America about elder mistreatment. *Ageing & Society*, *34*(5), 877-903. https://doi.org/10.1017/s0144686x12001389

Erlingsson, C. L. (2007). Searching for elder abuse: A systematic review of database citations. *Journal of Elder Abuse & Neglect, 19*(3-4), 59-78. https://doi.org/10.1300/J084v19n03_04

Ernst, J. S., & Maschi, T. (2018). Trauma-informed care and elder abuse: A synergistic alliance. *Journal of Elder Abuse & Neglect*, *30*(5), 354-367. https://doi.org/10.1080/08946566.2018.1510353

Fleming, C. E., & Resick, P. A. (2017). Help-seeking behavior in survivors of intimate partner violence: Toward an integrated behavioral model of individual factors. *Violence and Victims*, *32*(2), 195-209. https://doi.org/10.1891/0886-6708.vv-d-15-00065

Fletcher, A. J. (2017). Applying critical realism in qualitative research: Methodology meets method. *International Journal of Social Research Methodology, 20*(2), 181–194. https://doi.org/10.1080/13645579.2016.1144401

Fraga, S., Lindert, J., Barros, H., Torres-González, F., Ioannidi-Kapolou, E., Melchiorre, M. G., Stankunas, M., & Soares, J. F. (2014). Elder abuse and socioeconomic inequalities: A multilevel study in 7 European countries. *Preventive Medicine*, *61*, 42-47. https://doi.org/10.1016/j.ypmed.2014.01.008

Fraga Domínguez, S. (2020, May 19). *Barriers for older adults seeking help in times of COVID-19 and social distancing.* Canadian Network for the Prevention of Elder Abuse blog. https://cnpea.ca/en/about-cnpea/blog/1125-barriers-for-older-adults-seeking-help-in-times-of-covid-19-and-social-distancing

Fraga Domínguez, S., Storey, J. E., & Glorney, E. (2021). Help-seeking behavior in victims of elder abuse. *Trauma, Violence, & Abuse, 22*(3), 466-480. https://doi.org/10.1177/1524838019860616

Fraga Domínguez, S., Valiquette, J., Storey, J. E., & Glorney, E. (2020). Elder abuse intervention and detection: Challenges for professionals and strategies for engagement from a Canadian specialist service. *Journal of Forensic Nursing, 16*(4), 199-206. https://doi.org/10.1097/JFN.0000000000000301

Fraser, S., Lagacé, M., Bongué, B., Ndeye, N., Guyot, J., Bechard, L., Garcia, L., Taler, V., CCNA Social Inclusion and Stigma Working Group, Adam, S., Beaulieu, M., Bergeron, C. D., Boudjemadi, V., Desmette, D., Donizzetti, A. R., Éthier, S., Garon, S., Gillis, M., Levasseur, M., … Tougas, F. (2020). Ageism and COVID-19: What

does our society's response say about us? *Age and Ageing, 49*(5), 692-695. https://doi.org/10.1093/ageing/afaa097

Gallione, C., Dal Molin, A., Cristina, F. B. V., Ferns, H., Mattioli, M., & Suardi, B. (2017). Screening tools for identification of elder abuse: A systematic review. *Journal of Clinical Nursing, 26*(15-16), 2154–2176. https://doi.org/10.1111/jocn.13721

Gerontological Society of America (n.d.). *Reframing aging journal manuscript guidelines.* Retrieved March 28, 2021, from https://www.geron.org/images/documents/Reframing_Aging_Journal_Manuscript_Guidelines.pdf

Gibson, S. C. (2013). *Understanding underreporting of elder financial abuse: Can data support the assumptions?* [Unpublished doctoral dissertation] University of Colorado at Colorado Springs. https://mountainscholar.org/bitstream/handle/10976/260/CUCS2013100001ETDSPHPG.pdf?sequence=1

Gil, A. P., Santos, A. J., & Kislaya, I. (2017). Self-reporting by older adults as victims of violence in Portugal: The remaining taboo issue. In M. Husso, T. Virkki, M. Notko, H. Hirvonen & J. Eilola (Eds.), *Interpersonal violence: Differences and connections* (pp. 170-184). Routledge.

Gilgun, J. F. (2008). Lived experience, reflexivity, and research on perpetrators of interpersonal violence. *Qualitative Social Work*, *7*(2), 181-197. https://doi.org/10.1177/1473325008089629

Gilhooly, M. L., Cairns, D., Davies, M., Harries, P., Gilhooly, K. J., & Notley, E. (2013). Framing the detection of financial elder abuse as bystander intervention: Decision cues, pathways to detection and barriers to action. *The Journal of Adult Protection*, *15*(2), 54-68. https://doi.org/10.1108/14668201311313578

Gilhooly, M. M., Dalley, G., Gilhooly, K. J., Sullivan, M. P., Harries, P., Levi, M., Kinnear, D. C., & Davies, M. S. (2016). Financial elder abuse through the lens of the bystander intervention model. *Public Policy & Aging Report*, *26*(1), 5-11. https://doi.org/10.1093/ppar/prv028

Goldblatt, H., Band-Winterstein, T., Lev, S., & Harel, D. (2020). “Who would sexually assault an 80-year-old woman?” Barriers to exploring and exposing sexual assault against women in late life. *Journal of Interpersonal Violence*. Advanced online publication. https://doi.org/10.1177/0886260520934440

Gordon, M. (2009). Toward a pragmatic discourse of constructivism: Reflections on lessons from practice. *Educational studies*, *45*(1), 39-58. https://doi.org/10.1080/00131940802546894

Guba, E., & Lincoln, Y. (1994). Competing paradigms in qualitative research, in N. K. Denzin & Y.S. Lincoln (Eds), *Handbook of Qualitative Research* (3rd ed., pp. 105-117). Sage.

Gutman, G. M., Robson, C., & Marchbank, J. (2020). Elder abuse in the LGBT community. In A. Phelan (Ed.), *Advances in Elder Abuse Research* (pp. 149-164). Springer. https://doi.org/10.1007/978-3-030-25093-5_11

Hacking, I. (1999). *The social construction of what?* Harvard University Press.

Hamby, S., Smith, A., Mitchell, K., & Turner, H. (2016). Poly-victimization and resilience portfolios: Trends in violence research that can enhance the understanding and prevention of elder abuse. *Journal of Elder Abuse & Neglect*, *28*(4-5), 217-234. https://doi.org/10.1080/08946566.2016.1232182

Harré, R., & van Langenhove, L. (1999). *Positioning theory*. Blackwell.

Hayman, S. (2011). Older people in Canada: Their victimization and fear of crime. *Canadian Journal on Aging/La Revue Canadienne du Vieillissement*, *30*(3), 423-436. https://doi.org/10.1017/s0714980811000225

Heaton, J. (2004). What is secondary analysis? In *Reworking qualitative data* (pp. 1-18). SAGE. https://www.doi.org/10.4135/9781849209878

Heisler, C. J. (2017). Moving forward: Recommendations for advancing late-life polyvictimization practice, policy, and research. *Journal of Elder Abuse & Neglect*, *29*(5), 351-363. https://doi.org/10.1080/08946566.2017.1388013

Henderson, D., Buchanan, J. A., & Fisher, J. E. (2002). Violence and the elderly population: Issues for prevention. In P. A. Schewe (Ed.), *Preventing violence in relationships:*

Interventions across the life span (pp. 223–245). American Psychological Association. https://doi.org/10.1037/10455-009

Hightower, J., Smith, M. J., & Hightower, H. C. (2006). Hearing the voices of abused older women. *Journal of Gerontological Social Work*, *46*(3-4), 205-227. https://doi.org/10.1300/J083v46n03_12

Homans, G. C. (1958). Social behavior as exchange. *American Journal of Sociology*, *63*(6), 597-606. http://dx.doi.org/10.1086/222355

Hourglass (n.d.). *What we stand for.* Retrieved March 28, 2021, from https://wearehourglass.org/node/27

Hourglass (2020). *Safe ageing press release.* https://www.wearehourglass.org/safer-ageing-press-release

Inelmen, E. M., Sergi, G., & Manzato, E. (2019). Elder abuse: Are we turning a blind eye to a crucial issue? *Internal and Emergency Medicine*, *14,* 503-505. https://doi.org/10.1007/s11739-019-02063-x

Isham, L., Bradbury-Jones, C., & Hewison, A. (2020). 'This is still all about love': Practitioners' perspectives of working with family carers affected by the harmful behaviour of the older person for whom they care. *The British Journal of Social Work*. Advanced online publication. https://doi.org/10.1093/bjsw/bcaa129

Jackson, S. L. (2016). All elder abuse perpetrators are not alike: The heterogeneity of elder abuse perpetrators and implications for intervention. *International Journal of Offender Therapy and Comparative Criminology*, *60*(3), 265-285. https://doi.org/10.1177/0306624x14554063

Jackson, S. L., & Hafemeister, T. L. (2011). *Financial abuse of elderly people vs. other forms of elder abuse: Assessing their dynamics, risk factors, and society's response.* https://www.ncjrs.gov/pdffiles1/nij/grants/233613.pdf

Jackson, S. L., & Hafemeister, T. L. (2014). How case characteristics differ across four types of elder maltreatment: Implications for tailoring interventions to increase victim safety. *Journal of Applied Gerontology, 33*(8), 982–997. https://doi.org/10.1177/0733464812459370

Jackson, S. L., & Hafemeister, T. L. (2015). The impact of relationship dynamics on the detection and reporting of elder abuse occurring in domestic settings. *Journal of Elder Abuse & Neglect, 27*(2), 121-145. https://doi.org/10.1080/08946566.2015.1008085

Jackson, S. L., & Hafemeister, T. L. (2016). Theory-based models enhancing the understanding of four types of elder maltreatment. *International Review of Victimology*, *22*(3), 289-320. https://doi.org/10.1177/0269758016630887

Jervis, L. L., Hamby, S., Beach, S. R., Williams, M. L., Maholmes, V., & Castille, D. M. (2016). Elder mistreatment in underserved populations: Opportunities and challenges to developing a contemporary program of research. *Journal of Elder Abuse & Neglect*, *28*(4-5), 301-319. https://doi.org/10.1080/08946566.2016.1245644

Johannesen, M., & LoGiudice, D. (2013). Elder abuse: A systematic review of risk factors in community-dwelling elders. *Age and Ageing*, *42*(3), 292-298. https://doi.org/10.1093/ageing/afs195

Johnson, B. & Gray, R. (2010). A history of philosophical and theoretical issues for mixed methods research. In A. Tashakkori & C. Teddlie (Eds.), *SAGE handbook of mixed methods in social & behavioral research* (pp. 69-94). SAGE. https://www.doi.org/10.4135/9781506335193

Joosten, M., Gartoulla, P., Feldman, P., Brijnath, B. & Dow, B. (2020). *Seven years of elder abuse data in Victoria.* Senior Rights Victoria. https://seniorsrights.org.au/wp-content/uploads/2020/08/SRVNARI_7_Years_Report_online.pdf

Kaye, L. W., Kay, D., & Crittenden, J. A. (2007). Intervention with abused older males: Conceptual and clinical perspectives. *Journal of Elder Abuse & Neglect*, *19*(1-2), 153-172. https://doi.org/10.1300/j084v19n01_10

Kennedy, A. C., & Prock, K. A. (2018). “I still feel like I am not normal”: A review of the role of stigma and stigmatization among female survivors of child sexual abuse, sexual assault, and intimate partner violence. *Trauma, Violence, & Abuse*, *19*(5), 512-527. https://doi.org/10.1177/1524838016673601

Kilaberia, T., & Stum, M. (2020). Concerned family members’ help-seeking in elder family financial exploitation. *Innovation in Aging*, *4*(1), 629. https://doi.org/10.1093/geroni/igaa057.2147

Killick, C., & Taylor, B. J. (2009). Professional decision making on elder abuse: Systematic narrative review. *Journal of Elder Abuse & Neglect*, *21*(3), 211-238. https://doi.org/10.1080/08946560902997421

Killick, C., Taylor, B. J., Begley, E., Anand, J. C., & O'Brien, M. (2015). Older people's conceptualization of abuse: A systematic review. *Journal of Elder Abuse & Neglect, 27*(2), 100-120. https://doi.org/10.1080/08946566.2014.997374

Kohn, N. A. (2012). Elder (in) justice: A critique of the criminalization of elder abuse. *American Criminal Law Review*, *49*(1), 1-29.

Koo, T. K., & Li, M. Y. (2016). A guideline of selecting and reporting intraclass correlation coefficients for reliability research. *Journal of Chiropractic Medicine*, *15*(2), 155-163. https://doi.org/10.1016/j.jcm.2016.02.012

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, *24*(1), 120-124. https://doi.org/10.1080/13814788.2017.1375092

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (2002). *World report on violence and health*. World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/42495/9241545615_eng.pdf?sequence=1

Labrum, T., & Solomon, P. L. (2018). Elder mistreatment perpetrators with substance abuse and/or mental health conditions: Results from the National Elder Mistreatment Study. *Psychiatric Quarterly*, *89*(1), 117-128. https://doi.org/10.1007/s11126-017-9513-z

Labrum, T., Solomon, P. L., & Bressi, S. K. (2015). Physical, financial, and psychological abuse committed against older women by relatives with psychiatric disorders: Extent of the problem. *Journal of Elder Abuse & Neglect, 27*(4–5), 377-391. https://doi.org/10.1080/08946566.2015.1092902

Lachs, M. S., & Berman, J. (2011). *Under the radar: New York State elder abuse prevalence study, self-reported relevance and documented case studies*. Lifespan of Greater Rochester, Inc., Weill Cornell Medical Center of Cornell University, and New York City Department for the Aging.

http://www.ocfs.state.ny.us/main/reports/Under%20the%20Radar%2005%2012%2011%20final%20report.pdf

Lachs, M. S., & Pillemer, K. A. (2015). Elder abuse. *New England Journal of Medicine*, *373*(20), 1947-1956. https://doi.org/10.1056/nejmra1404688

Lachs, M. S., Williams, C. S., O'Brien, S., & Pillemer, K. A. (2002). Adult protective service use and nursing home placement. *The Gerontologist*, *42*(6), 734-739. https://doi.org/10.1093/geront/42.6.734

Lachs, M. S., Williams, C. S., O'Brien, S., & Pillemer, K. A., & Charlson, M. E. (1998). The mortality of elder mistreatment. *Journal of American Medical Association, 280*(5), 428-432. https://doi.org/10.1001/jama.280.5.428

Lafferty, A., Treacy, M. P., & Fealy, G. (2013). The support experiences of older people who have been abused in Ireland. *The Journal of Adult Protection*, *15*(6), 290-300. https://doi.org/10.1108/JAP-02-2013-0007

Latané, B., & Darley, J. M. (1970). *The unresponsive bystander: Why doesn't he help?* Appleton-Century-Crofts.

Latta, R. E., & Goodman, L. A. (2011). Intervening in partner violence against women: A grounded theory exploration of informal network members' experiences. *The Counseling Psychologist*, *39*(7), 973-1023. https://doi.org/10.1177/0011000011398504

Lee, H. Y., & Eaton, C. K. (2009). Financial abuse in elderly Korean immigrants: Mixed analysis of the role of culture on perception and help-seeking intention. *Journal of Gerontological Social Work*, *52*(5), 463-488. https://doi.org/10.1080/01634370902983138

Lee, Y. S., Moon, A., & Gomez, C. (2014). Elder mistreatment, culture, and help-seeking: A cross-cultural comparison of older Chinese and Korean immigrants. *Journal of Elder Abuse & Neglect*, *26*(3), 244-269. https://doi.org/10.1080/08946566.2013.820656

Lee, H. Y., Yoon, H. S., Shin, N., Moon, J. Y., Kwon, J. H., Park, E. S., Nam, R., Kang, S. B., & Park, K. H. (2011). Perception of elder mistreatment and its link to help-seeking intention: A comparison of elderly Korean and Korean American immigrants.

Clinical Gerontologist, *34*(4), 287-304. https://doi.org/10.1080/07317115.2011.573407

Letherby, G., Scott, J., & Williams, M. (2013). Introduction. In G. Letherby, J. Scott, and M. Williams (Eds), *Objectivity and subjectivity in social research* (pp. 1-12). SAGE Publications Limited. https://www.doi.org/10.4135/9781473913929

Lin, M. C. (2018). Elder abuse and neglect: Examining caregiver characteristics and perceptions of their elderly care receiver's under-accommodative behavior. *Journal of Family Communication*, *18*(4), 252-269. https://doi.org/10.1080/15267431.2018.1489810

Lithwick, M., Beaulieu, M., Gravel, S., & Straka, S. M. (2000). The mistreatment of older adults: Perpetrator-victim relationships and interventions. *Journal of Elder Abuse & Neglect*, *11*(4), 95-112. https://doi.org/10.1300/j084v11n04_07

London, K., Bruck, M., Ceci, S. J., & Shuman, D. W. (2005). Disclosure of Child Sexual Abuse: What does the research tell us about the ways that children tell? *Psychology, Public Policy, and Law, 11*(1), 194–226. https://doi.org/10.1037/1076-8971.11.1.194

Lösel, F., & Schmucker, M. (2005). The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis. *Journal of Experimental Criminology*, *1*(1), 117-146.

Mackay, K. (2017). Choosing to live with harm? A presentation of two case studies to explore the perspective of those who experienced adult safeguarding interventions. *Ethics and Social Welfare*, *11*(1), 33-46. https://doi.org/10.1080/17496535.2017.1280069

Makaroun, L. K., Beach, S., Rosen, T., & Rosland, A. M. (2021). Changes in elder abuse risk factors reported by caregivers of older adults during the COVID-19 pandemic. *Journal of the American Geriatrics Society, 69*(3), 602-603. https://doi.org/10.1111/jgs.17009

Mann, J., & Hung, L. (2019). Co-research with people living with dementia for change. *Action Research*, *17*(4), 573-590. https://doi.org/10.1177/1476750318787005

Markovik, M., Peshevska, D. J., Sethi, D., Kisman, M., & Serafimovska, E. (2014). *Community survey of elder maltreatment: A report from the former Yugoslav*

Republic of Macedonia. WHO Regional Office for Europe. http://www.who.int/iris/handle/10665/144072

Maxwell, J. A. (2016). Expanding the history and range of mixed methods research. *Journal of Mixed Methods Research*, *10*(1), 12-27. https://doi.org/10.1177/1558689815571132

Maxwell, J. A., & Mittapalli, K. (2010). Realism as a stance for mixed methods research. In A. Tashakkori & C. Teddlie (Eds.), *SAGE handbook of mixed methods in social & behavioral research* (pp. 146-168). Sage. http://dx.doi.org/10.4135/9781506335193.n6

McClurg, A. J. (2013). Preying on the graying: A statutory presumption to prosecute elder financial exploitation. *Hastings Law Journal*, *65*, 1099-1144.

McDermott, S. (2010). Professional judgements of risk and capacity in situations of self-neglect among older people. *Ageing & Society*, *30*(6), 1055-1072. https://doi.org/10.1017/S0144686X10000139

MetLife (2009). *Broken trust: Elders, family, and finances*. https://www.giaging.org/documents/mmi-study-broken-trust-elders-family-finances.pdf

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *Annals of Internal Medicine, 151*, 264–269.

Moon, A., & Benton, D. (2000). Tolerance of elder abuse and attitudes toward third-party intervention among African American, Korean American, and White elderly. *Journal of Multicultural Social Work*, *8*(3-4), 283-303. https://doi.org/10.1300/j285v08n03_05

Moon, A., Tomita, S. K., & Jung-Kamei, S. (2002). Elder mistreatment among four Asian American groups: An exploratory study on tolerance, victim blaming and attitudes toward third-party intervention. *Journal of Gerontological Social Work*, *36*(1-2), 153-169. https://doi.org/10.1300/j083v36n01_09

Moon, A., & Williams, O. (1993). Perceptions of elder abuse and help-seeking patterns among African-American, Caucasian American, and Korean-American elderly women. *The Gerontologist*, *33*(3), 386-395. https://doi.org/10.1093/geront/33.3.386

Moschella, E. A., Bennett, S., & Banyard, V. L. (2018). Beyond the situational model: Bystander action consequences to intervening in situations involving sexual violence. *Journal of Interpersonal Violence*, *33*(20), 3211-3231. https://doi.org/10.1177/0886260516635319

Mowlam, A., Tennant, R., Dixon, J., & McCreadie, C. (2007). *UK study of abuse and neglect of older people: Qualitative findings.* King's College London and the National Centre for Social Research. https://www.lemosandcrane.co.uk/resources/NatCen%20-%20UK%20study%20of%20abuse%20and%20neglect.pdf

Munn, Z., Peters, M. D., Stern, C., Tufanaru, C., McArthur, A., & Aromataris, E. (2018). Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC Medical Research Methodology*, *18*(1), 143-149. https://doi.org/10.1186/s12874-018-0611-x

Mysyuk, Y., Westendorp, R. G., & Lindenberg, J. (2016). Older persons' definitions and explanations of elder abuse in the Netherlands. *Journal of Elder Abuse & Neglect, 28*(2), 95-113. https://doi.org/10.1080/08946566.2015.1136580

Nahmiash, D. (1999). From powerlessness to empowerment. In J. Pritchard (Ed.), *Elder abuse work: Best practice in Britain and Canada* (pp. 294-319). Jessica Kingsley Publishers.

National Institute for Care Excellence. (2014). *Domestic violence and abuse: How health services, social care and the organizations they work with can respond effectively.* https://www.nice.org.uk/guidance/ph50

National Institute on Aging. (2017, December 31). *What is dementia? Symptoms, types, and diagnosis*. https://www.nia.nih.gov/health/what-dementia-symptoms-types-and-diagnosis

National Institutes of Health. (2016). *Quality assessment tool for observational cohort and cross-sectional studies*. Retrieved September 14, 2018, from https://www.nhlbi.nih.gov/health-topics/study-quality-assessment-tools

National Research Council. (2003). *Elder mistreatment: Abuse, neglect, and exploitation in an aging America.* The National Academy Press.

Naughton, C., Drennan, J., Lyons, I., & Lafferty, A. (2013). The relationship between older people's awareness of the term elder abuse and actual experiences of elder abuse. *International Psychogeriatrics, 25*(8), 1257-1266. https://doi.org/10.1017/S1041610213000513

Navarro, A. E., Gassoumis, Z. D., & Wilber, K. H. (2013). Holding abusers accountable: An elder abuse forensic center increases criminal prosecution of financial exploitation. *The Gerontologist*, *53*(2), 303-312. https://doi.org/10.1093/geront/gns075

Neale, A. V., Hwalek, M. A., Goodrich, C. S., & Quinn, K. M. (1997). Reason for case closure among substantiated reports of elder abuse. *Journal of Applied Gerontology*, *16*(4), 442-458. https://doi.org/10.1177/073346489701600404

Newman, F. L., Seff, L. R., Beaulaurier, R. L., & Palmer, R. C. (2013). Domestic abuse against elder women and perceived barriers to help-seeking. *Journal of Elder Abuse & Neglect*, *25*(3), 205-229. https://doi.org/10.1080/08946566.2012.751836

New York City Elder Abuse Center (NYC EAC). (2014, June). *I'll stand by you: Recognizing concerned family, friends and neighbors in the lives of elder abuse victims*. NYCEAC eNewsletter. https://nyceac.org/wp-content/uploads/2011/03/Ill_Stand_by_-You.pdf

New York City Elder Abuse Center (NYC EAC). (2018). *NYC Elder Abuse Center's Helpline for Concerned Persons.* https://nyceac.org/wp-content/uploads/2018/11/Helpline-10.29.18.pdf

Nóbrega Pinto, A., Rodrigues, F., Dinis-Oliveira, R. J., & Magalhães, T. (2014). Sexual offenses against elderly people: Forensic evaluation and judicial outcome. *Journal of Elder Abuse & Neglect*, *26*(2), 189-204. https://doi.org/10.1080/08946566.2013.827951

O'Brien, M., Begley, E., Anand, J. C., Killick, C., & Taylor, B. J. (2011). *A total indifference to our dignity: Older people's understandings of elder abuse.* http://uir.ulster.ac.uk/18852/1/A_Total_Indifference_to_our_Dignity_-_Older_People%27s_Understandings_of_Elder_Abuse.pdf

O'Brien, M., O'Brien-Olinger, S., Boccaletti, L., Milianta, S., Caciula, I., Laurola, H., Perttu, S., Kadzik-Bartoszewska. A., Canning, A., & Quinn, S. (2016). *Elder abuse context*

and theory: Finland, Ireland, Italy and Romania. http://www.combatingelderabuse.eu/wp-content/uploads/2016/04/Booklet_stage.pdf

Ogg, J., & Bennett, G. (1992). Elder abuse in Britain. *BMJ: British Medical Journal, 305*(6860), 998-999. https://doi.org/10.1136/bmj.305.6860.998

O'Keeffe, M., Hills, A., Doyle, M., McCreadie, C., Scholes, S., Constantine, R., Tinker, A., Manthorpe, J., Biggs, S., & Erens, B. (2007). *UK study of abuse and neglect of older people: Prevalence survey report.* National Center for Social Research. https://www.researchgate.net/publication/242099186_UK_Study_of_Abuse_and_Neglect_of_Older_People_Prevalence_Survey_Report

ONS. (n.d.). *UK population by ethnicity: Age groups.* Retrieved March 28, 2021, from https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/age-groups/latest

ONS. (2018). *Living longer: Is age 70 the new age 65?* https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/livinglongerisage70thenewage65/2019-11-19

ONS. (2020). *Estimated of the very old, including centerians, UK: 2002 to 2019.* https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/bulletins/estimatesoftheveryoldincludingcentenarians/latest

Orfila, F., Coma-Solé, M., Cabanas, M., Cegri-Lombardo, F., Moleras-Serra, A., & Pujol-Ribera, E. (2018). Family caregiver mistreatment of the elderly: Prevalence of risk and associated factors. *BMC Public Health*, *18*(1), 167-180. https://doi.org/10.1186/s12889-018-5067-8

Pablo, S., & Braun, K. L. (1998). Perceptions of elder abuse and neglect and help-seeking patterns among Filipino and Korean elderly women in Honolulu. *Journal of Elder Abuse & Neglect*, *9*(2), 63-76. https://doi.org/10.1300/J084v09n02_06

Paranjape, A., Tucker, A., Mckenzie-Mack, L., Thompson, N., & Kaslow, N. (2007). Family violence and associated help-seeking behavior among older African American women. *Patient Education and Counseling*, *68*(2), 167-172. https://doi.org/10.1016/j.pec.2007.05.019

Payne, B. K. (2013). Elder physical abuse and failure to report cases: Similarities and differences in case type and the justice system's response. *Crime & Delinquency*, *59*(5), 697-717. https://doi.org/10.1177/0011128708317940

Payne, B. K., Berg, B. L., & Toussaint, J. (2001). The police response to the criminalization of elder abuse: An exploratory study. *Policing: An International Journal of Police Strategies & Management*, *24*(4), 605-626. https://doi.org/10.1108/eum0000000006500

Penhale, B. (2003). Older women, domestic violence, and elder abuse: A review of commonalities, differences, and shared approaches. *Journal of Elder Abuse & Neglect*, *15*(3-4), 163-183. https://doi.org/10.1300/J084v15n03_10

Penhale, B. (2008). Elder abuse in the United Kingdom. *Journal of Elder Abuse & Neglect*, *20*(2), 151-168. https://doi.org/10.1080/08946560801974653

Penhale, B., & Kingston, P. (1997). Elder abuse, mental health and later life: Steps towards an understanding. *Aging & Mental Health*, *1*(4), 296-304. https://doi.org/10.1080/13607869756985

Pickering, C. E. Z., & Rempusheski, V. F. (2014). Examining barriers to self-reporting of elder physical abuse in community-dwelling older adults. *Geriatric Nursing*, *35*(2), 120-125. https://doi.org/10.1016/j.gerinurse.2013.11.002

Pillemer, K., Burnes, D. & MacNeil, A. (2021). Investigating the connection between ageism and elder mistreatment. *Nature Aging, 1,* 159-164. https://doi.org/10.1038/s43587-021-00032-8

Pillemer, K., Burnes, D., Riffin, C., & Lachs, M. S. (2016). Elder abuse: Global situation, risk factors, and prevention strategies. *The Gerontologist*, *56*(S2), S194-S205. https://doi.org/10.1093/geront/gnw004

Pillemer, K. A., Mueller-Johnson, K. U., Mock, S. E., Suitor, J. J., & Lachs, M. S. (2007). Interventions to prevent elder mistreatment. In L. S. Doll, S. E. Bonzo, D. A. Sleet, & J. A. Mercy (Eds.), *Handbook of injury and violence prevention* (pp. 241–254). Springer US. http://dx.doi.org/10.1007/978-0-387-29457-5_13

Plano Clark, V. L., & Creswell, J. W. (2008). *The mixed methods reader*. Sage.

Ploeg, J., Lohfeld, L., & Walsh, C. A. (2013). What is “elder abuse”? Voices from the margin: The views of underrepresented Canadian older adults. *Journal of Elder Abuse & Neglect*, *25*(5), 396-424. https://doi.org/10.1080/08946566.2013.780956

Podnieks, E., Penhale, B., Goergen, T., Biggs, S., & Han, D. (2010). Elder mistreatment: An international narrative. *Journal of Elder Abuse & Neglect*, *22*(1-2), 131-163. https://doi.org/10.1080/08946560903436403

Pritchard, J. (2007). Identifying and working with older male victims of abuse in England. *Journal of Elder Abuse & Neglect*, *19*(1-2), 109-127. https://doi.org/10.1300/J084v19n01_08

Quinn, M. J., & Tomita, S. K. (1997). *Elder abuse and neglect: Causes, diagnosis, and interventional strategies* (2nd Ed.). Springer Publishing Company.

Ramsey-Klawsnik, H. (2017). Older adults affected by polyvictimization: A review of early research. *Journal of Elder Abuse & Neglect, 29*, 299–312. https://doi.org/10.1080/08946566.2017.1388019

Ramsey-Klawsnik, H., & Heisler, C. (2014). Polyvictimization in later life. *Victimization of the Elderly and Disabled, 17*(1), 3–6.

Ramsey-Klawsnik, H., & Miller, E. (2017). Polyvictimization in later life: Trauma-informed best practices. *Journal of Elder Abuse & Neglect, 29*(5), 339–350. https://doi.org/10.1080/08946566.2017.1388017

Rhodes, R. E. (2015). Will the new theories (and theoreticians!) please stand up? A commentary on Sniehotta, Presseau and Araújo-Soares. *Health Psychology Review*, *9*(2), 156-159. https://doi.org/10.1080/17437199.2014.882739

Ribot, V. C., Rousseaux, E., García, T. C., Arteaga, E., Ramos, M. E., & Alfonso, M. (2015). Psychological the most common elder abuse in a Havana neighborhood. *MEDICC Review*, *17*(2), 39-43.

Richmond, N. L., Zimmerman, S., Reeve, B. B., Dayaa, J. A., Davis, M. E., Bowen, S. B., Iasiello, J. A., Stemerman, R., Sham, R. B., Haukoos, S., Sloane, P. D., Travers, D., Mosqueda, L. A., McLean, S. A., & Platts-Mills, T. F., (2020). Ability of older adults to report elder abuse: An emergency department–based cross-sectional study. *Journal of the American Geriatrics Society, 68*(1), 170-175. https://doi.org/10.1111/jgs.16211

Roberto, K. A. (2016). The complexities of elder abuse. *American Psychologist*, *71*(4), 302-311. https://doi.org/10.1037/a0040259

Roberto, K. A. (2017). Perpetrators of late life polyvictimization. *Journal of Elder Abuse & Neglect*, *29*(5), 313-326. https://doi.org/10.1080/08946566.2017.1374223

Rosen, T., Elman, A., Dion, S., Delgado, D., Demetres, M., Breckman, R., Lees, K., Dash, K., Lang, D., Bonner, A., Burnett, J., Dyer, C.B., Snyder, R., Berman, A., Fulmer, T, & Lachs, M. (2019). Review of programs to combat Elder Mistreatment: Focus on hospitals and level of resources needed. *Journal of the American Geriatrics Society, 67*(6), 1286-1294. https://doi.org/10.1111/jgs.15773

Rowan, J. M., Yonashiro-Cho, J., Wilber, K. H., & Gassoumis, Z. D. (2020). Who is in the revolving door? Policy and practice implications of recurrent reports to adult protective services. *Journal of Elder Abuse & Neglect*, *32*(5), 489-508. https://doi.org/10.1080/08946566.2020.1852142

Ryan, J., & Roman, N. V. (2019). Family-centred interventions for elder abuse: A narrative review. *Journal of Cross-Cultural Gerontology*, *34*(3), 325-336. https://doi.org/10.1007/s10823-019-09377-5

Sanders, L. (2019, March 18). *LeadingAge NORC poll: Older baby boomers' preferences on aging*. LeadingAge. https://www.leadingage.org/press-release/leadingage-norc-poll-older-baby-boomers-preferences-aging

Santos, A. J., Nunes, B., Kislaya, I., Gil, A. P., & Ribeiro, O. (2019). Older adults' emotional reactions to elder abuse: Individual and victimisation determinants. *Health & Social Care in the Community*, *27*(3), 609-620. https://doi.org/10.1111/hsc.12673

Scaffold (n.d.). *The Keep.* Retrieved March 28, 2021, from https://scaffold.digital/work/the-keep/

Schiamberg, L. B., Barboza, G. G., Oehmke, J., Zhang, Z., Griffore, R. J., Weatherill, R. P., von Heydrich, L., & Post, L. A. (2011). Elder abuse in nursing homes: An ecological perspective. *Journal of Elder Abuse & Neglect*, *23*(2), 190-211. https://doi.org/10.1080/08946566.2011.558798

Schiamberg, L. B., & Gans, D. (2000). Elder abuse by adult children: An applied ecological framework for understanding contextual risk factors and the intergenerational

character of quality of life. *The International Journal of Aging and Human Development*, *50*(4), 329-359. https://doi.org/10.2190/dxax-8tj9-rg5k-mpu5

Schiamberg, L. B., Oehmke, J., Zhang, Z., Barboza, G. E., Griffore, R. J., von Heydrich, L., Post, L. A., Weatherill, R. P., & Mastin, T. (2012). Physical abuse of older adults in nursing homes: A random sample survey of adults with an elderly family member in a nursing home. *Journal of Elder Abuse & Neglect, 24*, 65-83. https://doi.org/10.1080/08946566.2011.608056

Schomerus, G., Matschinger, H., & Angermeyer, M. C. (2009). Attitudes that determine willingness to seek psychiatric help for depression: A representative population survey applying the Theory of Planned Behaviour. *Psychological Medicine*, *39*(11), 1855-1865. https://doi.org/10.1017/S0033291709005832

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*(2), 63-75.

Sirey, J. A., Halkett, A., Chambers, S., Salamone, A., Bruce, M. L., Raue, P. J., & Berman, J. (2015). PROTECT: A pilot program to integrate mental health treatment into elder abuse services for older women. *Journal of Elder Abuse & Neglect*, *27*(4-5), 438-453. https://doi.org/10.1080/08946566.2015.1088422

Sivagurunathan, M., Orchard, T., MacDermid, J. C., & Evans, M. (2019). Barriers and facilitators affecting self-disclosure among male survivors of child sexual abuse: The service providers' perspective. *Child Abuse & Neglect*, *88*, 455-465. https://doi.org/10.1016/j.chiabu.2018.08.015

Snowdon, L. C., Barton, E. R., Newbury, A., Parry, B., Bellis, M. A., & Hopkins, J. C. (2020). Addressing the "shadow pandemic" through a public health approach to violence prevention. *Journal of Community Safety and Well-Being*, *5*(2), 60-65. https://doi.org/10.35502/jcswb.141

Social Care Institute for Excellence. (2017, September). *Assessing capacity.* https://www.scie.org.uk/mca/practice/assessing-capacity

Sorsoli, L., Kia-Keating, M., & Grossman, F. K. (2008). "I keep that hush-hush": Male survivors of sexual abuse and the challenges of disclosure. *Journal of Counseling Psychology*, *55*(3), 333-345. https://doi.org/10.1037/0022-0167.55.3.333

Souto, R. Q., Merighi, M. A. B., Guruge, S., & Jesus, M. C. P. (2015). Older Brazilian women's experience of psychological domestic violence: A social phenomenological study. *International Journal for Equity in health, 14*(1), 44-50. https://doi.org/10.1186/s12939-015-0173-z

Spangler, D., & Brandl, B. (2007). Abuse in later life: Power and control dynamics and a victim-centered response. *Journal of the American Psychiatric Nurses Association*, *12*(6), 322-331. https://doi.org/10.1177/1078390306298878

Spencer, C. (2009). *Environmental scan and critical analysis of elder abuse screening, assessment and intervention tools for Canadian health care providers*. Public Health Agency of Canada.

Stall, N. M., Johnstone, J., McGeer, A. J., Dhuper, M., Dunning, J., & Sinha, S. K. (2020). Finding the right balance: An evidence-informed guidance document to support the re-opening of Canadian nursing homes to family caregivers and visitors during the coronavirus disease 2019 pandemic. *Journal of the American Medical Directors Association*, *21*(10), 1365-1370. https://doi.org/10.1016/j.jamda.2020.07.038

Stevens, M., Biggs, S., Dixon, J., Tinker, A., & Manthorpe, J. (2013). Interactional perspectives on the mistreatment of older and vulnerable people in long-term care settings. *The British Journal of Sociology*, *64*(2), 267-286. https://doi.org/10.1111/1468-4446.12017

Storey, J. E. (2020). Risk factors for elder abuse and neglect: A review of the literature. *Aggression and Violent Behavior*, *50*, 101339. https://doi.org/10.1016/j.avb.2019.101339

Storey, J. E., Hart, S., & Perka, M. R. (2021). Identifying interventions and their efficacy as used by a community agency managing and responding to elder abuse. *Journal of Applied Gerontology*. Advanced online publication. https://doi.org/10.1177/0733464821992606

Storey, J. E., & Perka, M. R. (2018). Reaching out for help: Recommendations for practice based on an in-depth analysis of an elder abuse intervention programme. *The British Journal of Social Work, 48*(4), 1052-1070. https://doi.org/10.1093/bjsw/bcy039

Straka, S. M., & Montminy, L. (2008). Family violence: Through the lens of power and control. *Journal of Emotional Abuse*, *8*(3), 255-279. https://doi.org/10.1080/10926790802262499

Sylaska, K. M., & Edwards, K. M. (2014). Disclosure of intimate partner violence to informal social support network members: A review of the literature. *Trauma, Violence, & Abuse*, *15*(1), 3-21. https://doi.org/10.1177/1524838013496335

Tamutiene, I., De Donder, L., Penhale, B., Lang, G., Ferreira-Alves, J., & Luoma, M. L. (2013). Help seeking behaviour of abused older women (Cases of Austria, Belgium, Finland, Lithuania and Portugal). *Filosifija Sociologija.*, *24*(4), 217-225.

Tang, C. S. K., Wu, A. M. S., Yeung, D., & Yan, E. (2009). Attitudes and intention toward old age home placement: A study of young adult, middle-aged, and older Chinese. *Ageing International*, *34*(4), 237-251. https://doi.org/10.1007/s12126-009-9047-2

Tatara, T. (1999). *Understanding elder abuse in minority populations*. Psychology Press.

Teaster, P. B. (2017). A framework for polyvictimization in later life. *Journal of Elder Abuse & Neglect, 29*, 289–298. https://doi.org/10.1080/08946566.2017.1375444

Teddlie, C., & Tashakkori, A. (2009). *Foundations of mixed methods research: Integrating quantitative and qualitative approaches in the social and behavioral sciences*. Sage.

Thompson-McCormick, J., Jones, L., Cooper, C., & Livingston, G. (2009). Medical students' recognition of elder abuse. *International Journal of Geriatric Psychiatry*, *24*(7), 770-777. https://doi.org/10.1002/gps.2209

Truong, C., Burnes, D., Alaggia, R., Elman, A., & Rosen, T. (2019). Disclosure among victims of elder abuse in healthcare settings: A missing piece in the overall effort toward detection. *Journal of Elder Abuse & Neglect*, *31*(2), 181-190. https://doi.org/10.1080/08946566.2019.1588182

UK Government. (n.d.). *Deputies: Make decisions for someone who lacks capacity.* Retrieved March 28, 2021, from https://www.gov.uk/become-deputy

United Nations. (2019). *World population ageing 2019 highlights*. ST/ESA/SER.A/430. United Nations. https://www.un.org/en/development/desa/population/publications/pdf/ageing/WorldPopulationAgeing2019-Highlights.pdf

Viergever, R. F., Thorogood, N., Wolf, J. R., & Durand, M. A. (2018). Supporting ALL victims of violence, abuse, neglect or exploitation: Guidance for health providers. *BMC International Health and Human Rights*, *18*(1), 39. https://doi.org/10.1186/s12914-018-0178-y

Voth Schrag, R. J., Ravi, K., Robinson, S., Schroeder, E., & Padilla-Medina, D. (2020). Experiences with help seeking among non–service-engaged survivors of IPV: Survivors' recommendations for service providers. *Violence Against Women*. Advanced online publication. https://doi.org/10.1177/1077801220963861

Vrantsidis, F., Dow, B., Joosten, M., Walmsley, M., & Blakey, J. (2016). The older person's experience: Outcomes of interventions into elder abuse. *National Ageing Research Institute and Seniors Rights Victoria*. https://seniorsrights.org.au/wp-content/uploads/2016/06/SRV-NARI-Outcomes-Report-2016-FINAL-Web-6-June-2016.pdf

Walsh, C. A., Olson, J. L., Ploeg, J., Lohfeld, L., & MacMillan, H. L. (2010). Elder abuse and oppression: Voices of marginalized elders. *Journal of Elder Abuse & Neglect*, *23*(1), 17-42. https://doi.org/10.1080/08946566.2011.534705

Weissberger, G. H., Goodman, M. C., Mosqueda, L., Schoen, J., Nguyen, A. L., Wilber, K. H., Gassoumis, Z. D., Nguyen, C. P., & Han, S. D. (2020). Elder abuse characteristics based on calls to the National Center on Elder Abuse resource line. *Journal of Applied Gerontology*, *39*(10), 1078-1087. https://doi.org/10.1177/0733464819865685

Werner, P., Eisikovits, Z., & Buchbinder, E. (2005). Lay persons' emotional reactions toward an abused elderly person. *Journal of Elder Abuse & Neglect*, *17*(2), 63-76. https://doi.org/10.1300/J084v17n02_04

Westwood, S. (2019). Abuse and older lesbian, gay bisexual, and trans (LGBT) people: A commentary and research agenda. *Journal of Elder Abuse & Neglect*, *31*(2), 97-114. https://doi.org/10.1080/08946566.2018.1543624

Wildeman, C., & Wang, E. A. (2017). Mass incarceration, public health, and widening inequality in the USA. *The Lancet*, *389*(10077), 1464-1474. https://doi.org/10.1016/s0140-6736(17)30259-3

Williams, J. L., Racette, E. H., Hernandez-Tejada, M. A., & Acierno, R. (2020). Prevalence of elder polyvictimization in the United States: Data from the national elder mistreatment study. *Journal of Interpersonal Violence*, *35*(21-22), 4517-4532. https://doi.org/10.1177/0886260517715604

Winters, G. M., Colombino, N., Schaaf, S., Laake, A. L., Jeglic, E. L., & Calkins, C. (2020). Why do child sexual abuse victims not tell anyone about their abuse? An exploration of factors that prevent and promote disclosure. *Behavioral Sciences & the Law, 38*(6), 586-611. https://doi.org/10.1002/bsl.2492

Wolgemuth, J. R., Erdil-Moody, Z., Opsal, T., Cross, J. E., Kaanta, T., Dickmann, E. M., & Colomer, S. (2015). Participants' experiences of the qualitative interview: Considering the importance of research paradigms. *Qualitative Research*, *15*(3), 351-372. https://doi.org/10.1177/1468794114524222

World Health Organization. (2001). *Putting women first: Ethical and safety recommendations for research on domestic violence against women*. World Health Organization. https://www.who.int/gender/violence/womenfirtseng.pdf

World Health Organization. (2017, March 9). *Violence against women.* https://www.who.int/en/news-room/fact-sheets/detail/violence-against-women

World Health Organization. (2020a, June 15). *Elder Abuse*. https://www.who.int/en/news-room/fact-sheets/detail/elder-abuse

World Health Organization (2020b, June 8). *Child maltreatment*. https://www.who.int/news-room/fact-sheets/detail/child-maltreatment

World Health Organization. (2020c, September 21). *Dementia: Key facts*. https://www.who.int/news-room/fact-sheets/detail/dementia

Wydall, S., & Zerk, R. (2017). Domestic abuse and older people: Factors influencing help-seeking. *The Journal of Adult Protection*, *19*(5), 247-260. https://doi.org/10.1108/JAP-03-2017-0010

Yan, E. (2015). Elder abuse and help-seeking behavior in elderly Chinese. *Journal of Interpersonal Violence*, *30*(15), 2683-2708. https://doi.org/10.1177/0886260514553628

Yan, E., & Chan, K. L. (2012). Prevalence and correlates of intimate partner violence among older Chinese couples in Hong Kong. *International Psychogeriatrics*, *24*(9), 1437-1446. https://doi.org/10.1017/S1041610212000294

Yon, Y., Mikton, C. R., Gassoumis, Z. D., & Wilber, K. H. (2017). Elder abuse prevalence in community settings: A systematic review and meta-analysis. *The Lancet Global Health*, *5*(2), e147-e156. https://doi.org/10.1016/s2214-109x(17)30006-2

Yon, Y., Ramiro-Gonzalez, M., Mikton, C. R., Huber, M., & Sethi, D. (2018). The prevalence of elder abuse in institutional settings: A systematic review and meta-analysis. *European Journal of Public Health*, *29*(1), 58-67. https://doi.org/10.1093/eurpub/cky093

Yonashiro-Cho, J., Rowan, J. M., Gassoumis, Z. D., Gironda, M. W., & Wilber, K. H. (2019). Toward a better understanding of the elder abuse forensic center model: Comparing and contrasting four programs in California. *Journal of Elder Abuse & Neglect*, *31*(4-5), 402-423. https://doi.org/10.1080/08946566.2019.1647326

Yunus, R. M., Hairi, N. N., & Choo, W. Y. (2019). Consequences of elder abuse and neglect: A systematic review of observational studies. *Trauma, Violence, & Abuse*, *20* (2), 197-213. https://doi.org/1524838017692798

Zannettino, L., Bagshaw, D., Wendt, S., & Adams, V. (2015). The role of emotional vulnerability and abuse in the financial exploitation of older people from culturally and linguistically diverse communities in Australia. *Journal of Elder Abuse & Neglect*, *27*(1), 74-89. https://doi.org/10.1080/08946566.2014.976895

APPENDICES

Appendix A. Reflection

Several changes have occurred throughout the planning and writing of this thesis. Here, I reflect on these changes by writing about what I initially wanted to achieve, what I was able to achieve in the end, and what I have learnt about the research process as a result. I will also briefly address how I can apply what I have learnt in my future research.

I had two main aims from the beginning of the PhD process, which were to improve research on help-seeking, and to bring light to the experiences of two groups that, upon reviewing the literature, were identified as under-represented in the field of elder abuse. These were: 1) older adults who had been victimised, and 2) individuals who had helped them in an informal capacity. While victims had received attention throughout the years, I, as well as other researchers (e.g., Chokkanathan et al., 2014; Gibson, 2013), recognised that this attention was not sufficient, especially when compared to other areas of research, and also when considering the importance of representation of those whom elder abuse affects the most. Regarding the second group, my interest was developed through reviewing the literature and becoming aware that they were often the ones reporting abuse and trying to support victims, and that their involvement was associated with experiencing distress (Breckman et al., 2017).

Original Plan. My research was originally planned with these two aims in mind. With one of my studies, based on secondary data from a national helpline (Study 2), I would be able to advance research on help-seeking by both groups with a large sample that would allow me to conduct several quantitative analyses not possible in small samples. However, while these data contained, to a certain degree, the views of older people and those who helped them, it would not be an opportunity to gather these views directly from older people and their supporters. For this reason, in a different study (Study 3), my plan was to interview both victims

and their supporters, to 1) gather their views on help-seeking, 2) address research questions that could not be answered using secondary data, and, most importantly, 3) give them a voice.

Study 3 was planned with the consideration that the topic was sensitive and that, especially for victim participants, there could be a double sensitivity, due to both suffering abuse and other potential vulnerabilities. Due to age and the effect of the victimisation, the incidence of cognitive problems and other vulnerabilities may be higher in this group than among the general population. To participate in a research study, one needs to have the capacity to make an informed decision and consent to participate; therefore, assessing for those vulnerabilities in my study would be essential.

In order to ensure that I only included participants in my study who were able to consent, the original plan was to recruit older victims with the help of an organisation. The organisation would tell their clients about my study, while screening for vulnerabilities related to participation (e.g., lack of capacity). I would also be able to refer participants back to the organisation if they needed further support. When it became clear that I would not be able to recruit through an organisation, I, and my supervisors, thought of alternative ways of engaging older victims. We considered the possibility of recruiting older victims from the general population; however, we agreed that there were too many risks associated with this approach, including 1) difficulties assessing capacity to consent, 2) the possibility that I could be the first point of disclosure for an older adult and would not have the resources to direct them to support (e.g., counselling), and 3) the fact that those participants would not have an existing relationship with an organisation that could provide support if necessary.

New Plan. I decided to reconsider how the voices of older adults could be represented in the thesis. My supervisors and I agreed that the likelihood of participants lacking capacity and having age- and abuse-related vulnerabilities was lower for non-victim concerned persons.

Thus, we decided to follow through with part of Study 3, recruiting concerned persons from the general population. Even though I would not be interviewing victims, concerned persons would be able to provide some insight on the experiences of victims. To further explore the voices of older victims, I decided to emphasise the qualitative data in Study 2 so that victims' views could be represented.

Recruitment Challenges and Impact of the COVID-19 Pandemic. As I started recruiting, I experienced some challenges reaching out to potential participants. I became aware of the fact that there are many obstacles to recruiting when one does not have a specific organisation that can serve as gatekeeper to participants and endorse the research project. In light of these recruitment challenges, I made several adaptations. Namely, I decided to expand recruitment to countries outside the UK and I created a survey as an alternative to the interview, as explained in Chapter 2. From this experience, I learnt that having alternate plans is important in any research project, as is being flexible while remaining committed to the research aims.

In March 2020, after the survey had been designed and received ethical approval, the pandemic and its impact on society added further challenges to recruitment. For example, it decreased the ability of organisations and charities to share information about the study on their website or social media. The pandemic restrictions also halted my plans to distribute the survey information via leaflets in several places in London, Egham, and surrounding areas. In talks with other researchers in the field—for example, with a researcher in Canada interviewing elder abuse victims about their help-seeking behaviours—they said that the most successful way of recruiting was being present and being seen and recognised by potential participants. This researcher had the experience of sharing information about their study in different ways and supported by a large research team; however, they identified that what proved really successful was being physically present in organisations and developing relationships with the target population. Although this was not possible because of the pandemic, the importance of

developing relationships with organisations and their clients over time is something that I will consider in the planning of future research projects.

The countries where I was recruiting—particularly the UK, United States, and Spain—where I had most of my connections, were quite badly affected by the first wave of the pandemic and this had an impact on my approach to recruitment. When recruiting for a project that deals with a sensitive topic, it is important that people are able to, and feel safe to, disclose their experiences. However, during the onset of the pandemic, when many people were worried about their health, the health of their loved ones, and their financial situation, they may not have been in a position to disclose sensitive experiences. I acknowledged this, and recruited less actively during the first months of the pandemic, while people were adapting. During those first months, I prioritised other activities and had conversations with other researchers about their approaches to recruitment. Whenever I shared information with organisations, I acknowledged the pressures and impact of the pandemic.

The situation improved slightly around May and June 2020, when some of the countries included in the study saw a decrease in the number of cases and began easing lockdowns. This meant that organisations had more capacity to share my research. I also sought other ways of disseminating information about my research. For example, when I wrote a blog post about elder abuse and COVID-19 for a Canadian organisation in May 2020, I included information about the study. In those two months, I saw an increase in the number of participants. At the end of June 2020, in order to allow time for data collection, I decided to close my survey. Even though the sample size was smaller than initially planned, I was able to gather rich qualitative data from a number of participants. Because, comparatively, Study 3 had less data than Study 2, when writing up, I made the decision to separate my chapters by target groups (victims and concerned persons) and present and integrate the findings from secondary and primary data in

both chapters. This structure allowed me to further complement the findings and better represent the views of victims and concerned persons.

In summary, I did not implement Study 3 as initially planned, and I also made some changes to the overall thesis as a result. Nonetheless, I was still able to answer my research questions and fulfil the overarching aims of this thesis. I also learnt invaluable lessons about the research process, such as the importance of building relationships with organisations and clients, as well as being flexible in the face of obstacles, and planning ahead for potential challenges.

Appendix B. Example of Email sent to Organisations

Initial recruitment (via interview)

Good morning,

I hope this email finds you well. I am a PhD student at Royal Holloway, University of London whose PhD thesis focuses on elder abuse.

I am conducting a study looking at the experiences of people who help older adults who have been victimised. This could be family, friends, or others who help older people outside of a professional context. The objective is to understand the barriers they find and how we can better support older victims of abuse.

My study has received ethical approval and I am now recruiting by using social media and email. I have a flyer (attached) and a website www.supportexperiences.weebly.com with further information and contact information.

I am emailing to ask if you could kindly share this within the organisation. I am not sure if this is possible, but if you could somehow share this on your website, that would be extremely helpful.

I could also provide you with leaflets if that is useful.

Many thanks in advance.

Kind regards,

Silvia

Amended recruitment (survey)

Good morning,

I hope this email finds you well. I am a PhD student at Royal Holloway, University of London whose PhD thesis focuses on elder abuse.

I am conducting a study looking at the experiences of people who help older adults who have been victimised. This could be family, friends, or others who help older people outside of a professional context. The objective is to understand the barriers they find and how we can better support older victims of abuse.

My study has received ethical approval and I am now recruiting by using social media and email. I have a flyer (attached) and a website www.supportexperiences.weebly.com with further information and contact information. The website also specifies eligibility.

So far, I have interviewed participants on the phone, but now participants can also take part on a 30-min online survey. This is a more flexible way of participating.

I am emailing to ask if you could kindly share this within the organisation. I am not sure if this is possible, but if you could somehow share this on your website, that would be extremely helpful and could have a major impact on recruitment. Alternatively, I would appreciate any help or advice in reaching out to this population.

Many thanks in advance.

Best,

Silvia

Appendix C. Planned Steps to Determine Consent and to Manage Emergency Situations

The following paragraphs describe the protocol for dealing with interviews if the first "consent screen" had raised concerns about the person's ability to consent:

The researcher would enquire further to understand whether somebody else made decisions over the participant's financial situation or wellbeing (e.g., an active Power of Attorney). If that were the case, the researcher would ask the person whether it would be better if this adviser received information about the study and then would ask that the researcher's details are provided to the adviser and that they contact the researcher. If the person did not want to let the adviser know, the researcher would inform them that their participation was not possible and would thank them for their time.

For example, "It sounds like you're a bit unclear about what the study is about today and what it'll involve. Can I call you back another time?" The researcher would then consult with her supervisors on how to proceed or by asking Hourglass for advice. If it became clear during the call that they did not have capacity to consent, the researcher would ask if it would be helpful for someone else to be present with them during the interview. In which case, the researcher would repeat their name and contact number and ask the person to provide these details to the adviser, with a request for them to get in touch with the researcher to discuss the research. If the person did not want a third party to have knowledge of their participation or did not want them to be involved in the interview process, then the researcher would thank the person for their time and inform them that she was unable to proceed with the interview.

The following paragraphs describe the researcher's protocol for dealing with emergency situations:

The researcher was advised by helpline workers during the piloting about how they manage emergency situations. Because the researcher did not have any other details about the participant, such as address, it would not be possible to call the police on their behalf. If the participant was at risk but the risk was not immediate, the researcher would signpost the participant to Hourglass' free helpline for advice on their situation. Participants outside the UK would be directed to the relevant helpline or information number in their country.

Upon finishing the call, the researcher would contact Hourglass to discuss the concerns. In order to facilitate this, interviews were preferably conducted during Hourglass' operating times (Monday to Friday from 9:00 until 17:00, excluding holidays). The researcher would also make sure that one of her supervisors was available during the time of the calls scheduled and would inform supervisors of any call scheduled in advance. This ensured that any worries or concerns could be confidentially discussed before calling Hourglass.

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Appendix D. Debriefing Information

STUDY TITLE: SUPPORT EXPERIENCES IN ELDER ABUSE CASES

Thank you for participating in this study. Your answers will help in improving the support experiences of other people experiencing similar circumstances. I understand that it has been difficult to remember and write about some of your experiences and I thank you for sharing them with me.

If you feel distressed or you want to seek advice from somebody regarding your situation or how to access further support, I advise that you contact the following services:

In the UK
Action on Elder Abuse's free helpline on **0808 8088141**. Please remember that if you find yourself at risk of immediate harm, you should call the police on number 999. If you want to contact the police but it is not an emergency, you should dial 101.

Additional helplines:
Silverline: **0800 4708090** *free confidential helpline providing information, friendship and advice to older people, open 24 hours a day, every day of the year*.
Age UK Advice line: **0800 0556112** *free, confidential, national phone service for older people, their families, friends, carers and professionals.*

Resources outside of UK and emergency numbers
Australia:
Call Elder Abuse Helpline on **1300 651 192** (Interstate: (07) 3867 2525)
Or **1800 353 374** (national free call phone number that automatically redirects callers seeking information and advice on elder abuse with existing phone line service in their jurisdiction)
In an emergency call **000**
Canada:
Visit the Government of Canada's website to find services and support in your province or territory. Go to seniors.gc.ca and search for "Elder Abuse"; or call **1-800-622-6232**.
In an emergency call **911** or your local police
Ireland:
Call the HSE (Health Service Executive) information line on **1850 24 1850** (Monday to Saturday – 8am to 8pm) or your local safeguarding team
In an emergency call **999** or **112**
New Zealand:
Call Age Concern 24-hour helpline on **0800 326 6865**

In an emergency call **111**

Spain:

Call the Spanish Ombudsman ("Defensor del Pueblo") on 900 101 025 (Monday to Friday- 9:00- 14:00 and 16:00-18:00 or via email registro@defensordelpueblo.es

In an emergency call the national Spanish police on 091, the local police on 092 or 112

United States:

Information and referral is available from the national Eldercare Locator, a public service of the U.S. Administration on Aging. Call toll-free **1-800-677-1116**. This number is available from Monday through Friday 9 AM-8 PM (except U.S. federal holidays).

In an emergency call **911** or your local police

Withdrawing participation

As I said at the beginning, if you want to withdraw your participation you may do so within two months by emailing the principal researcher at Silvia.FragaDominguez.2017@live.rhul.ac.uk or calling the following number: **01784 276283**. You can also contact me if you want to see the final results of this research project and these will be provided once they are ready.

Appendix E. Interview Guide

STUDY TITLE: SUPPORT EXPERIENCES IN ELDER ABUSE CASES

(IN PARENTHESES, BOLD, AND CAPITAL LETTERS: INSTRUCTIONS THAT SHOULD NOT BE READ OUT LOUD) [In brackets and bold: modifications for the interview with non-victims] (In parentheses without capital letters: further questions to obtain more information if necessary)

INTRODUCTION

As I explained earlier, this research study is about the support experiences of people who have experienced mistreatment **[/who have helped somebody experiencing mistreatment]**. The interview will be about an hour long but we can stop or take a break any time you like. **(IF THEY AGREED TO BE RECORDED):** I will start to audio-record the interview now so that I can pay attention to what you say. In order to preserve confidentiality, please do not refer to people by their full name when you talk to me about somebody. You can use their first name or their relationship to you instead (e.g., husband/wife, son/daughter). **(IF THEY DIDN'T AGREE TO BE RECORDED):** I will be writing down the responses that you give me so please bear with me if at any point I take some time before asking you my next question. **(IN BOTH CASES):** I am interested in understanding your experience, so I may sometimes be checking that I understood what you said or asking further questions to clarify. I just want to ensure I see your experience the way you do.

As I said earlier, please let me know if at any point you are no longer in a private place and need some time to find a private place or want to arrange a call for a different day. If somebody arrives and you don't want to disclose the motive of the call, we can arrange now for a word or phrase that you can say to notify me so we can change the subject or end the call. Would you like to do that?

Do you have any questions about anything that I just explained? Are you happy to start?

SECTION 1: Participant's demographics

First, I would like to ask you a few questions that will allow me to get to know you **[add: and the person you supported]** better.

1. Can you please tell me your gender?

0 ☐ Male
1 ☐ Female
2 ☐ Other
88 ☐ Refused

2. Can I ask how old you are? ______

3. What is your relationship status? Are you…?

1 ☐ Married
2 ☐ Single
3 ☐ Widowed
4 ☐ Divorced/separated
5 ☐ Living with a partner
88 ☐ Refused

Country of residence:

4. Can I ask what your race/ethnicity is?

1 ☐ Asian or Asian British- Bangladeshi
2 ☐ Asian or Asian British- Indian
3 ☐ Asian or Asian British- Pakistani
4 ☐ Asian or Asian British- Any other Asian background
5 ☐ Black or Black British- African
6 ☐ Black or Black British- Caribbean
7 ☐ Black or Black British- Any other Black background
8 ☐ Mixed- White and Asian
9 ☐ Mixed- White and Black African
10 ☐ Mixed- White and Black Caribbean
11 ☐ Mixed- Any other mixed background
12 ☐ White British
13 ☐ White Irish
14 ☐ White- any other White background:______________
15 ☐ Other ethnic group- Any other ethnic group: ______________
88 ☐ Refused

5. Do you live alone?

0 ☐ No
1 ☐ Yes
88 ☐ Refused

6. (IF NO) Who do you live with?

____

(IF VICTIM SKIP TO QUESTION 19)

7. **[Can you please tell me the gender of the person you supported?]**

0 ☐ Male
1 ☐ Female
2 ☐ Other
88 ☐ Refused

8. **[Can I ask how old that person was at the time?]** _______

9. **[What was their relationship status? Were they…?]**

1 ☐ Married
2 ☐ Single
3 ☐ Widowed
4 ☐ Divorced/separated
5 ☐ Living with a partner
88 ☐ Refused
99 ☐ Unknown

Country of residence:

10. **[Can I ask you what their race/ethnicity is?]**

1 ☐ Asian or Asian British- Bangladeshi
2 ☐ Asian or Asian British- Indian
3 ☐ Asian or Asian British- Pakistani
4 ☐ Asian or Asian British- Any other Asian background
5 ☐ Black or Black British- African
6 ☐ Black or Black British- Caribbean
7 ☐ Black or Black British- Any other Black background
8 ☐ Mixed- White and Asian
9 ☐ Mixed- White and Black African
10 ☐ Mixed- White and Black Caribbean
11 ☐ Mixed- Any other mixed background
12 ☐ White British
13 ☐ White Irish
14 ☐ White- any other White background
15 ☐ Other ethnic group- Any other ethnic group
88 ☐ Refused
99 ☐ Unknown

11. [Did they live alone?]

0 ☐ No
1 ☐ Yes
88 ☐ Refused
99 ☐ Unknown

12. (IF NO) [Who did they live with?]

____

13. [Did they have mental capacity at the time?] (FOLLOW UP IF NECESSARY)

0 ☐ No
1 ☐ Yes
88 ☐ Refused
99 ☐ Unknown

14. [Did a medical professional determine that they had no capacity at the time?]

0 ☐ No
1 ☐ Yes
88 ☐ Refused
99 ☐ Unknown

15. [What was your relationship with that person?]

1 ☐ Family member
2 ☐ Friend
3 ☐ Neighbour
4 ☐ Partner
5 ☐ Professional

6 ☐ Acquaintance
7 ☐ Other:
88 ☐ Refused

16. [If a family member:]

1 ☐ Son/Daughter
2 ☐ Grandson/Granddaughter
3 ☐ Partner/Spouse
4 ☐ Niece/Nephew
5 ☐ Sibling
6 ☐ Aunt/Uncle
7 ☐ Parent
8 ☐ Other:
77 ☐ Not applicable
88 ☐ Refused

17. [How long have you known the victim?]

____

18. [How long had you known the victim when you supported them?]

____

SECTION 2: Abuse experience

Now I would like to know a little bit about your experiences…

19. **(IF RECRUITED THROUGH ACTION ON ELDER ABUSE):** I understand that you have been in contact with Action on Elder Abuse/other services because of concerns of abuse or mistreatment. Can you please tell me a bit about the situation and why you were in contact? **(IF NON-VICTIM RECRUITED THROUGH OTHER MEANS): I understand that you have volunteered to participate in this study because you have supported an older person due to concerns of abuse or mistreatment. Can you please tell me a bit about this situation?** (DEPENDING ON INITIAL DETAIL, PROBE WITH QUESTIONS: WHAT HAPPENED? WHEN? WHERE? WHO WAS INVOLVED? MAKE SURE TO UNDERSTAND WHAT THE RELATIONSHIP WITH THE PERPETRATOR IS, AS WELL AS TYPE OF ABUSE)

____

(AFTER THE DESCRIPTION, CHECK THE TYPE(S) OF ABUSE)

1 ☐ Physical abuse
2 ☐ Psychological abuse
3 ☐ Financial abuse
4 ☐ Neglect
5 ☐ Sexual abuse

(CHOOSE THE RELATIONSHIP BETWEEN VICTIM AND ABUSER)

1 ☐ Family member
2 ☐ Friend
3 ☐ Neighbour

4 ☐ Professional:
5 ☐ Other:
88 ☐ Refused
99 ☐ Unknown

If family member:

1 ☐ Stepson/daughter
2 ☐ Nephew/niece
3 ☐ Sibling
4 ☐ Aunt/Uncle
5 ☐ Other:
77 ☐ Not applicable
99 ☐ Unknown

(CHOOSE THE PLACE THE PERSON WAS HARMED)

1 ☐ Their own home
2 ☐ Sheltered accommodation
3 ☐ Care home
4 ☐ Nursing home
5 ☐ Hospital
6 ☐ Somewhere else
99 ☐ Doesn't know

(CHOOSE THE RELATIONSHIP BETWEEN NON-VICTIM AND ABUSER)

1 ☐ Family member
2 ☐ Friend
3 ☐ Neighbour
4 ☐ Professional:
5 ☐ Other:
99 ☐ Unknown

If family member:

1 ☐ Stepson/daughter
2 ☐ Nephew/niece
3 ☐ Sibling
4 ☐ Aunt/Uncle
5 ☐ Other:
77 ☐ Not applicable
99 ☐ Unknown

20. Looking back, how serious/severe would you say this situation was? How serious would you say the situation was from 1 to 10, with 10 being very serious and 1 the least serious?

____

21. How often did (*behaviours described*) occur? How long did this go on? **(IF SEVERAL BEHAVIOURS, TRY TO GET AN IDEA OF THE FREQUENCY OF DIFFERENT BEHAVIORS)**

Behaviour 1: description ____
☐ once, ☐ > once: ____________________; duration: ____________________________________

Behaviour 2: description ____
☐ once, ☐ > once: ____________________; duration: ____________________________________

Behaviour 3: description ____
☐ once, ☐ > once: ____________________; duration: ____________________________________

Behaviour 4: description ____
☐ once, ☐ > once: ____________________; duration: ____________________________________

Behaviour 5: description ____
☐ once, ☐ > once: ____________________; duration: ____________________________________

22. How did this experience make you feel? (How did it impact you?) **[Instead: How did this experience make the person feel? (What impact did it have on them?)] (PROBE FOR FINANCIAL, PHYSICAL OR MENTAL HEALTH)**

____

23. (IF NON-VICTIM CALLER). [How did knowing about this situation affect you?]

____

24. Did you and the person who harmed you live together at the time of the mistreatment? **[Did the victim and the person who harmed them live together at the time of the mistreatment?]**

0 ☐ No
1 ☐ Yes
88 ☐ Refused
99 ☐ Unknown

25. Do you live together now? **[Do they live together now?]**

0 ☐ No
1 ☐ Yes
88 ☐ Refused
99 ☐ Unknown

26. How close was your relationship with the person who harmed/exploited/neglected you? How close would you say it was from 1 to 10, with 10 being very close and 1 being not close at all? **[Instead: How close was the relationship between the person you supported and the person who harmed/exploited/neglected them? How close would you say it was from 1 to 10, with 10 being very close and 1 being not close at all?]**

____

27. Were you dependent on that person? **[Was the victim dependent on that person?]**

0 ☐ No
1 ☐ Yes
88 ☐ Refused
99 ☐ Unknown

28. (IF YES) In which ways? (For example, financially, for housing, for care, emotionally, socially…)

____

29. (IF YES) How dependent would you say you were from 1 to 10, with 10 being very dependent and 1 the least dependent? **[Instead: How dependent would you say they were from 1 to 10, with 10 being very dependent and 1 the least dependent?**

____

30. Was that person dependent on you? **[Was that person dependent on the victim?]**

0 ☐ No
1 ☐ Yes
88 ☐ Refused
99 ☐ Unknown

31. If yes, in which ways? (For example, financially, for housing, for care, emotionally, socially…)

____

32. (IF YES) How dependent would you say that person was from 1 to 10, with 10 being very dependent and 1 the least dependent? **[Instead: How dependent would you say that person was from 1 to 10, with 10 being very dependent and 1 the least dependent?**

____

33. **(VICTIM ONLY, IF THEY DIDN'T LIVE WITH THE PERPETRATOR):** Did you live alone at the time of the mistreatment?

0 ☐ No
1 ☐ Yes
88 ☐ Refused

34. (IF NO) Who were you living with?

____

(ASK IF THEY NEED BREAK)

SECTION 3: Seeking support

Now I would like to ask you some questions regarding your experience seeking support and accessing this support.

35. What did you understand elder abuse to be at the time (of the situation you were describing)? What do you understand it to be now?

____

36. Did you identify your experience as elder abuse at the time? Do you identify it as such now? (If no) How do you identify it? **[Did you identify** *(the person you supported)***'s experience as elder abuse at the time? Do you identify it as such now? (If no) How do you identify it?]**

0 No
1 Yes
88 Refused
99 Doesn't know

____

37. Did you know where you could seek help for this situation? **(IF YES)** Where?

0 No
1 Yes
88 Refused
99 Doesn't know

---

38. Did you tell anyone about the abuse? **(IF YES)** Who did you first tell about the abuse?

0 No
1 Yes
88 Refused
99 Doesn't know

(IF VICTIM PARTICIPANT AND DID NOT TELL ANYONE, SKIP TO QUESTION 46)

39. What was their response? (What did they say?)

---

40. Did you tell anyone about the abuse afterwards? (If yes, who? What was their response?)
- Person/organisation 1: ________________Response:________________
- Person/organisation 2: ________________Response:________________
- Person/organisation 3: ________________Response:________________
- Person/organisation 4: ________________Response:________________
- Person/organisation 5: ________________Response:________________

41. **(NON-VICTIMS ONLY): [How did you find out about the abuse? Did the victim tell you?]**

---

42. **(NON-VICTIMS ONLY, IF VICTIM TOLD THEM) [How did you react when the victim told you? (Do you remember what you said to them?)]**

---

43. **(IF VICTIM DID NOT TELL THEM) [What made you think that abuse was occurring? (How did you find out about the situation?)]**

---

44. What made you decide to talk about it with someone or seek formal help? Would you say that the situation had gotten worse shortly before you disclosed the abuse or sought help?

---

0 No
1 Yes
88 Refused
99 Doesn't know

[NON-VICTIM, IF VICTIM TOLD THEM, ADD: Would you say that the situation had gotten worse shortly before the victim told you about the abuse?]

0 No
1 Yes
88 Refused

99 Doesn't know

45. Approximately, how long after the abuse started did you tell somebody about the abuse? [**Approximately, how long after you became aware of the situation did you seek help?**]

___

46. **(VICTIMS ONLY):** Did anybody try to help you? Did anybody (else) contact formal services?

___

47. Were you worried about disclosing the abuse or seeking help? [**add: on behalf of the victim?**]

0 No
1 Yes
88 Refused
99 Doesn't know

48. (IF YES) What were you worried about? (**VICTIM WHO DID NOT DISCLOSE/SEEK HELP:** "what do you think prevented you from talking about it?") **(PROBE FOR ANY FEAR, PROBLEMS WITH INFORMAL OR FORMAL NETWORKS, BARRIERS RELATED TO FAMILY, CULTURE. FOR NON-VICTIMS, ROLE OF MENTAL CAPACITY IN SEEKING HELP. CHECK IF DIFFERENT WORRIES/BARRIERS FOR INFORMAL DISCLOSURE AND FORMAL HELP-SEEKING)**

___

- Specific barriers relating to informal disclosure: ___
- Specific barriers relating to formal help-seeking: ___

49. Did the person who harmed/exploited/neglected you [**instead: the victim**] do anything to prevent you [**add: and/or the victim**] from talking about what was happening/the situation/the abuse? (What did they do?)

___

(IF VICTIM AND DID NOT SEEK HELP, SKIP TO 54)

50. How did talking about the situation make you feel?

___

51. Do you think talking about the abuse with *(relationship with person/organisation they mentioned as first disclosure/help-seeking)* impacted your decision about whether to make further disclosures?

0 No
1 Yes
88 Refused
99 Doesn't know

52. If yes, in which ways?

___

53. Was that effect…?

1 Positive
2 Negative
3 Mixed (positive and negative)
77 Not applicable

88 Refused
99 Doesn't know

54. **(IF VICTIM DID NOT SEEK HELP):** What do you think could have helped you talk about what you were going through with somebody or seek formal support? (Is there anything that you know now that you wished you had known at the time and that could have helped you disclose/seek help?) **(CHECK IF DIFFERENT RESPONSES FOR INFORMAL DISCLOSURE AND FORMAL HELP-SEEKING)**

___

- Specific facilitators relating to informal disclosure: ___
- Specific facilitators relating to formal help-seeking: ___

SECTION 4: Attitudes towards intervention

Now I would like to ask you a few questions about what you thought was going to happen if/when you disclosed your situation **[before you sought support/advice on behalf of the victim]** (PROBE FOR FORMAL –E.G., POLICE, SOCIAL SERVICES, LEGAL- AND INFORMAL SOURCES)

55. If you think back to before you told anyone about the situation, what did you think was going to happen when you told someone? (Can you develop a bit more?) **(IF NOT MENTIONED, PROBE FOR EXPECTATIONS OF FORMAL SERVICES/INTERVENTION) (IF THE VICTIM DIDN'T TELL ANYBODY, ASK: What did you think was going to happen if you told somebody about the situation?)**

___

Specific sources:

- Formal: ___
  - 1: ___
  - 2: ___
- Informal: ___
  - 1: ___
  - 2: ___

56. How did you think others would react when you told them about the situation?

1 Positively
2 Negatively
3 Neither positively nor negatively
88 Refused
99 Doesn't know

57. What did you think they would think of you when you told them about the situation?

___

58. **(ONLY NON-VICTIMS): [How did you think the victim would react to you trying to help?]**

___

59. **(ONLY VICTIMS WHO SOUGHT HELP AND NON-VICTIMS):** What do you think could have helped you seek support sooner? (Is there anything that you know now that you wished you had known at the time and that could have helped you disclose/seek help earlier?) **(CHECK IF DIFFERENT RESPONSES FOR INFORMAL DISCLOSURE AND FORMAL HELP-SEEKING)**

- Specific facilitators relating to informal disclosure: ______________________________
- Specific facilitators relating to formal help-seeking: ______________________________

(ASK IF THEY NEED BREAK)

SECTION 5: Help received

60. What kind of support did you receive once you sought help? **[What kind of help did the person receive?]**

---

61. Are you satisfied with this support? (Why?/ Why not?) **[Were they satisfied? Were you satisfied? (Why?/ Why not?)]**

    0 No
    1 Yes
    88 Refused
    99 Doesn't know

---

62. Are you in touch with the person who harmed/exploited/neglected you? How does this make you feel? **[Are they in touch with the person who harmed/exploited/neglected them? How do you think this makes them feel?]**

    0 No
    1 Yes
    88 Refused
    99 Doesn't know

---

63. Do you wish your current relationship with the person who harmed/exploited/neglected you was different? **[Do you think they wish their current relationship with (*person who harmed them*) was different?]**

---

64. (IF YES), in which ways?

---

65. What happened to that person (**REPLACE FOR RELATIONSHIP WITH VICTIM OR NON-VICTIM CALLER**)? Were there any consequences to their behaviour?

---

66. What do you wish had happened to that person (**REPLACE FOR RELATIONSHIP WITH VICTIM OR NON-VICTIM CALLER**)? **[What do you think they wished had happened to that person?]**

---

67. **(ONLY NON-VICTIMS): [As a person that supported the victim, what were you asked or advised to do? (by the victim or by services)]**

---

68. **[What did you do to support the victim?]**

69. (IF THEY WERE ABLE TO ACT): [What impact did (*any activities they mention*) have on you?]

70. (IF THEY WERE UNABLE TO ACT, E.G., BECAUSE OF VICTIM'S MENTAL CAPACITY, LACK OF EVIDENCE): [How did not being able to help make you feel?]

These are all the questions that I have for you today.

71. Is there anything else about your experience that you would like to share with me?

Thank you very much for finding the time to talk to me. Do you have any questions?

(PROCEED TO READ DEBRIEFING)

Appendix F. Survey Guide

Support experiences in elder abuse

English (United Kingdom)

Study description and consent

My name is Silvia Fraga Dominguez and I am a PhD researcher at the School of Law and Social Sciences at Royal Holloway, University of London. This research study aims to investigate the support experiences of people who seek help in elder abuse cases on behalf of an abused adult (aged 60 or older) in an informal capacity.

You are eligible to participate if you:

- Have supported a victim of elder abuse (e.g., provided help, advice) aged 60 or older
- In a non-professional capacity (as that person's family member, friend, neighbour)
- In the UK, Ireland, United States, Canada, Australia, New Zealand or Spain.

Elder abuse is "a single or repeated act or lack of appropriate action, which occurs within a relationship of trust, and which causes harm or distress to an older person (WHO, 2018)". Elder abuse can be financial, physical, emotional or psychological, sexual or neglect.

If you want to discuss eligibility, please email me:
Silvia.Fragadominguez.2017@live.rhul.ac.uk

What taking part in this research study means

- Participation involves the completion of an online survey.
- The estimated time completion of the survey is 30 minutes.
- This survey includes several sections with questions aimed at understanding your experience of seeking support or talking about the experience of mistreatment/abuse of other people. The aim is to understand any barriers to support you may have encountered, as well as anything that may have helped you in accessing support. This will allow me to explore how services and the responses of others can be improved and will hopefully help in improving the support experiences of other people in similar situations.
- This survey asks sensitive questions, so it is advised that you are in a private place when you complete it.
- Your participation in this study is voluntary.

- You may decide not to respond to any question in the survey. You can also take a break and finish completing the survey at a later date. You must continue completing it within a week. If you do not finish completing the survey, the data will not be used.
- You may withdraw your participation at any time for a period of two months after completing the survey, without giving any reason. A participant ID will be generated. You can email me or my supervisors with that ID in order to withdraw participation.
- After two months, your responses will have already been anonymously integrated with the rest of the participant responses obtained, and thus we will not be able to identify your individual responses to destroy them.

Confidentiality

The information provided will be treated anonymously and confidentially and may only be discussed by the researchers: PhD student Silvia Fraga Dominguez, and her supervisors Dr Emily Glorney and Dr Jennifer Storey. All the data will be stored securely in line with the Data Protection Act (2018).

I will write a report based on your responses and those of others, however, this report will not identify any individuals. For example, if many other people mention a common barrier that they found in accessing support, I will write about that without identifying who said those things. In order to disseminate research to the public and academic community, your anonymised data may also be part of a research publication, conference presentation or public talk.

More information

You may make a note of this information for future reference or if you want to contact us with any queries. If you have any questions, please feel free to contact us:

Silvia Fraga Dominguez (Silvia.FragaDominguez.2017@live.rhul.ac.uk), PhD researcher

Supervisors:

Dr Emily Glorney (Emily.Glorney@rhul.ac.uk)

Dr Jennifer Storey (Jennifer.Storey@rhul.ac.uk)

You can also call the following number 01784 276283. If calling from abroad, this will bear the cost of an international call. Unfortunately, we are unable to provide a toll-free number.

If you would prefer to be interviewed by phone rather than answer these questions online, please email me (Silvia Fraga Dominguez) at Silvia.Fragadominguez.2017@live.rhul.ac.uk

I will email you back as soon as possible. For more information about the study click here

Have you read the information on this page?

- ◯ No
- ◯ Yes

INFORMED CONSENT

I confirm that:

- I am 18 years of age or older
- I have had time to think about this study
- I have had the opportunity to email the researcher(s) with questions if I had them
- I have received satisfactory answers to my questions (if I asked them)
- I have understood that I am free to withdraw from the study at any time today and up to two months after completing this survey, without giving any reason
- I understand that in order to withdraw I will need to email or call the researchers and indicate the ID generated in this survey
- I agree to participate in this study and proceed with the survey

- ◯ No
- ◯ Yes

Here is your unique ID: ${e://Field/RandomID} You will need to provide the researchers with this ID if you want to withdraw your data.

Instructions

INSTRUCTIONS

This research study is about the support experiences of people who have helped a person 60 or older experiencing mistreatment. In order to preserve confidentiality and anonymity, please do not refer to anyone using their full name. You can use first names or in the case of the mistreated person refer to them based on their relationship to you (e.g., my husband/wife, son/daughter).

Participant demographics

SECTION 1.

DEMOGRAPHIC INFORMATION

This section's questions are about you and the person you supported (referred to as 'victim' in this survey).

What is your gender?

- ○ Female
- ○ Male
- ○ Other
- ○ Prefer not to say

How old are you?

[ ]

What is your relationship status?

- ○ Married
- ○ Single
- ○ Widowed
- ○ Divorced/Separated
- ○ Living with a partner
- ○ Other (please specify) [ ]
- ○ Prefer not to say

What is your country of residence?

- ☐ United Kingdom: (Please specify if you live in England, Scotland, Wales, or Northern Ireland) [ ]
- ☐ United States
- ☐ Canada
- ☐ Ireland
- ☐ Australia
- ☐ New Zealand
- ☐ Spain

What is your race/ethnicity?

[▾]

What is your ancestry? (e.g., English, Australian, Irish...)

Are you indigenous (Aboriginal Australian or Torres Strait Islander)?

- No
- Yes
- Unknown
- Prefer not to say

What is your race/ethnicity?

What is your race/ethnicity?

What is your ethnicity?

What is your race?

Are you Hispanic or Latino?

- No
- Yes
- Prefer not to say
- Unknown

Where were you born?

- Spain
- Outside of Spain: Please specify the country
- Prefer not to say

Do you live alone?

- ☐ No
- ☐ Yes
- ☐ Prefer not to say

Who do you live with?

What was or is your relationship with the victim? You are their ______

- ○ Family member (please specify)
- ○ Friend
- ○ Neighbour
- ○ Acquaintance
- ○ Other:
- ○ Prefer not to say

How long have you known the victim?

How long had you known the victim when you began supporting them in relation to the mistreatment?

What is the gender of the victim you supported?

- ○ Female
- ○ Male
- ○ Other
- ○ Prefer not to say

How old was the victim at the time?

*Please provide an age bracket (e.g., 60-64) if you have supported this person over several years.

What is/was the victim's relationship status?

- ◯ Married
- ◯ Single
- ◯ Widowed
- ◯ Divorced/separated
- ◯ Living with a partner
- ◯ Prefer not to say
- ◯ Unknown
- ◯ Other (please specify)

What is/was the victim's country of residence?

- ◯ United Kingdom (Please specify if the victim lives/lived in England, Wales, Scotland, or Northern Ireland)
- ◯ United States
- ◯ Canada
- ◯ Ireland
- ◯ Australia
- ◯ New Zealand
- ◯ Spain

What is/was their race/ethnicity?

What is/was their ancestry? (e.g., English, Australian, Irish...)

Are/were they indigenous (Aboriginal Australian or Torres Strait Islander)?

- ◯ No
- ◯ Yes
- ◯ Unknown
- ◯ Prefer not to say

What is/was their race/ethnicity?

What is/was their race/ethnicity?

What is/was their ethnicity?

What is/was their race?

Are/were they Hispanic or Latino?

- No
- Yes
- Prefer not to say
- Unknown

Where were they born?

- Spain
- Outside of Spain: Please specify the country
- Prefer not to say
- Unknown

Did the victim live alone?

- No
- Yes
- Prefer not to say
- Unknown

Who did the victim live with?

Did the victim have mental capacity at the time (you supported them)?
*The capacity to make their own decisions.

- No
- Yes
- Prefer not to say
- Unknown

- ◯ Other

Did a medical professional determine that the victim had no (mental) capacity at the time?

- ◯ No
- ◯ Yes
- ◯ Prefer not to say
- ◯ Unknown
- ◯ Other

Abuse experiences

SECTION 2.

ABUSE EXPERIENCES

This section is about the situation of abuse, harm, or mistreatment that prompted you to help the victim.

I understand that you have volunteered to participate in this study because you have supported an older person due to concerns that they were being abused or mistreated or harmed in some way. Can you please tell me a bit about this situation? For example, what happened? When? Where? Who was involved?

Would you say the victim you supported suffered any of the following? (Select all that apply)

- ☐ Financial abuse
- ☐ Physical abuse
- ☐ Psychological or emotional abuse
- ☐ Neglect
- ☐ Sexual abuse
- ☐ Other: please specify

How often did the harmful behaviours described occur?

How long did the harmful situation go on?

Looking back, how serious/severe would you say this situation was from 1 to 10, with 10 being very serious and 1 the least serious?

How is the person who committed the harm related to the victim? E.g., they are the _____ of the victim.

- ○ Family member: please specify
- ○ Friend
- ○ Neighbour
- ○ Professional
- ○ Other: please specify
- ○ Prefer not to say
- ○ Unknown

In what locations was the person harmed? (Select all that apply)

- ☐ In their home
- ☐ Sheltered accommodation
- ☐ Care home
- ☐ Nursing home
- ☐ Hospital
- ☐ Somewhere else: please specify
- ☐ Prefer not to say
- ☐ Unknown

What is/was your relationship with the person who committed the harm? They are your/a _______

- ○ Family member: please specify
- ○ Friend
- ○ Neighbour

- ○ Professional
- ○ Acquaintance
- ○ Other: please specify
- ○ Prefer not to say
- ○ Unknown

IMPACT

How did this harmful situation make the older person feel? (What impact did it have on them?)
*For example, did it have a financial impact or an impact on their physical or mental health?

How did knowing about this harmful situation affect you personally?

RELATIONSHIP BETWEEN THE VICTIM AND THE PERSON WHO HARMED THEM

Did the victim and the person who harmed them live together at the time of the mistreatment?

- ○ No
- ○ Yes
- ○ Prefer not to say
- ○ Unknown

Do they live together now?

- ○ No
- ○ Yes
- ○ Prefer not to say
- ○ Unknown

How close was the relationship between the person you supported and the person who harmed them from 1 to 10, with 10 being very close and 1 not close at all?

Was the victim dependent on the person who harmed them?

- ○ No

- Yes
- Prefer not to say
- Unknown

In which ways? (Select all that apply)

- Financially
- For housing
- For care
- Emotionally
- Socially
- Other: please specify

How dependent would you say they were from 1 to 10, with 10 being very dependent and 1 the least dependent?

Was the person who perpetrated the harm dependent on the victim?

- No
- Yes
- Prefer not to say
- Unknown

In which ways? (Select all that apply)

- Financially
- For housing
- For care
- Emotionally
- Socially
- Other:please specify

How dependent would you say they were from 1 to 10, with 10 being very dependent and 1 the last dependent?

Seeking support

SECTION 3.

EXPERIENCES OF SEEKING SUPPORT

This section includes some questions regarding your experience seeking support on behalf of the victim and accessing this support for the victim.

What did you understand elder abuse to be at the time of the situation you are describing?

What do you understand it to be now?

Did you identify the victim's experience as elder abuse at the time?

- ○ No
- ○ Yes
- ○ Prefer not to say
- ○ Unknown

How did you identify this experience?

Do you identify as elder abuse now?

- ○ No
- ○ Yes
- ○ Prefer not to say
- ○ Unknown

How do you identify this experience?

Did you know where you could seek help on behalf of the victim for this harmful situation?

- ○ No
- ○ Yes
- ○ Prefer not to say

- ◯ Unknown

Where?

Did you tell anyone about the harmful situation?

- ◯ No
- ◯ Yes
- ◯ Prefer not to say
- ◯ Unknown

Who did you first tell about the harmful situation?

What was the response of the first person you told about the harm? (What did they say?)

If you told anyone about the harmful situation after you told this first person, can you write down who it was and what their response was? (As many persons/organisations as you would like to indicate)

How did you find out about the harmful situation? (Select all that apply)

- ☐ The victim told me
- ☐ I found out in a different way
- ☐ Prefer not to say
- ☐ Unknown

How did you react when the victim told you about the harm? Do you remember what you said to them?

Did the older person share with you that the harmful situation had gotten worse shortly before they told you about it?

- ○ No
- ○ Yes
- ○ The situation had just started
- ○ Prefer not to say
- ○ Unknown

What made you think that harm was occurring? How did you find out about the harmful situation?

What made you decide to talk about the harmful situation with someone or seek formal help?

Would you say the harmful situation had gotten worse shortly before you sought help on behalf of the victim?

- ○ No
- ○ Yes
- ○ I had just become aware
- ○ Prefer not to say
- ○ Unknown

Approximately, how long after you became aware of the harmful situation did you seek help?

Were you worried about seeking help on behalf of the victim?

- ○ No
- ○ Yes
- ○ Prefer not to say
- ○ Unknown

What were you worried about? Please specify whether you were worried about disclosing to informal (e.g., a friend) or formal (e.g., police) sources, and what your worries were for each:

☐ Informal sources

☐ Formal sources

☐ Other

Did the person who harmed the victim do anything to prevent you and/or the victim from talking about what was happening?

○ No
○ Yes: Please specify
○ Prefer not to say
○ Unknown

How did talking about the harmful situation make you feel?

Do you think that talking about the harmful situation with the first person/organisation you discussed it with impacted your decision about whether to make further disclosures?

○ No
○ Yes
○ Prefer not to say
○ Unknown

In which ways did talking about the harm with that person/organisation have an effect?

Was that effect...?

- ○ Positive
- ○ Negative
- ○ Mixed (positive and negative)
- ○ Prefer not to say
- ○ Unknown

Attitudes towards intervention

SECTION 4.

ATTITUDES TOWARDS INTERVENTION

This section includes questions about what you thought was going to happen if you sought support/advice on behalf of the victim.

If you think back to before you told anyone about the situation, what did you think was going to happen when you told someone? Please specify if you had expectations from informal (e.g., a friend) or formal (e.g., police) sources, and what your expectations were from each:

- ☐ Expectations from informal sources:
- ☐ Expectations from formal sources:
- ☐ Other

How did you think others would react when you told them about the harmful situation?

- ○ Positively
- ○ Negatively
- ○ Neither positively nor negatively
- ○ Prefer not to say
- ○ Unknown

How did you think the victim would react to you trying to help?

What do you think could have helped you seek support sooner? Is there anything you know now that you wished you had known at the time and could have helped you seek support earlier?

Help received

SECTION 5.

HELP RECEIVED

This section includes questions about the help received by the victim and any support you provided to them.

As a person that supported the victim, what were you asked or advised to do? (By the victim or by services?)

What did you do to support the victim?

What impact did these activities have on you?

Would you say that you struggled to help?

- No
- Yes
- Prefer not to say

How did not being able to help make you feel?

What kind of help did the victim receive?

Was the victim satisfied with the help received?

- No: please specify the reasons
- Yes
- The victim was satisfied with some of the help they received but not other (please specify):
- Prefer not to say
- Unknown

Were you satisfied with the help they received?

- No: please specify the reasons

- ○ Yes
- ○ I was satisfied with some of the help they received but not other (please specify):
- ○ Prefer not to say
- ○ Unknown

Is the victim in touch with the person who harmed them?

- ○ No
- ○ Yes
- ○ Prefer not to say
- ○ Unknown

How do you think the victim feels about them being in touch?

How do you think the victim feels about them no longer being in touch?

Do you think the victim wishes their current relationship with the person who harmed them was different?

- ○ No
- ○ Yes
- ○ Prefer not to say
- ○ Unknown

In which ways do you think that the victim wishes their relationship was different?

Were there any consequences to the behaviour of the person who harmed the victim? Please specify.

What do you wish had happened to that person?

What do you think the victim wished had happened to that person?

Comments

Is there anything else about your experience that you would like to share with me?

If you would like to speak further on the phone about your answers, please email me:
Silvia.Fragadominguez.2017@live.rhul.ac.uk

Debriefing

DEBRIEFING: SUPPORT EXPERIENCES IN ELDER ABUSE CASES

After you have read this page, please make sure you click on the arrow to submit your response.

Thank you for participating in this study. Your answers will help in improving the support experiences of other people experiencing similar circumstances. I understand that it has been difficult to remember and write about some of your experiences and I thank you for sharing them with me.

If you feel distressed or you want to seek advice from somebody regarding your situation or how to access further support, I advise that you contact the following services:

In the UK
Action on Elder Abuse's free helpline on **0808 8088141**.
Please remember that if you find yourself at risk of immediate harm, you should call the police on number 999. If you want to contact the police but it is not an emergency, you should dial 101.

Additional helplines:
Silverline: **0800 4708090** *free confidential helpline providing information, friendship and advice to older people, open 24 hours a day, every day of the year.*
AgeUK Advice line: **0800 0556112** *free, confidential, national phone service for older people, their families, friends, carers and professionals.*

Resources outside of UK and emergency numbers
Australia:
Call Elder Abuse Helpline on **1300 651 192** (Interstate: (07) 3867 2525)
Or **1800 353 374** (national free call phone number that automatically redirects callers seeking information and advice on elder abuse with existing phone line service in their jurisdiction)
In an emergency call **000**
Canada:
Visit the Government of Canada's website to find services and support in your province or territory. Go to seniors.gc.ca and search for "Elder Abuse"; or call **1-800-622-6232**.
In an emergency call **911** or your local police
Ireland:
Call the HSE (Health Service Executive) information line on **1850 24 1850** (Monday to Saturday – 8am to 8pm) or your local safeguarding team
In an emergency call **999** or **112**
New Zealand:
Call Age Concern 24-hour helpline on **0800 326 6865**
In an emergency call **111**
Spain:
Call the Spanish Ombudsman ("Defensor del Pueblo") on 900 101 025 (Monday to Friday- 9:00- 14:00 and 16:00-18:00 or via email registro@defensordelpueblo.es
In an emergency call the national Spanish police on **091**, the local police on **092** or **112**
United States:
Information and referral is available from the national Eldercare Locator, a public service of the U.S. Administration on Aging. Call toll-free **1-800-677-1116**. This number is available from Monday through Friday 9 AM-8 PM (except U.S. federal holidays).
In an emergency call **911** or your local police

Withdrawing participation

If you want to withdraw your participation you may do so within two months by emailing me, the principal researcher at Silvia.FragaDominguez.2017@live.rhul.ac.uk or calling the following number: **01784 276283**. You can also contact me if you want to see the final results of this research project and these will be provided once they are ready.

Appendix G. Quality Assessment Tool Adaptation for Quantitative Studies

Adaptation of the NIH tool for cohort, observational, and cross-sectional studies (National Institute of Health, 2016)

1. Was the research question or objective in this paper clearly stated?
2. Was the study population clearly specified and defined?
3. Was the participation rate of eligible persons at least 50%?
4. Were all the subjects selected or recruited from the same or similar populations (including the same time period)? Were inclusion and exclusion criteria for being in the study pre-specified and applied uniformly to all participants?
5. Was a sample size justification, power description, or variance and effect estimates provided?
6. For exposures that can vary in amount or level, did the study examine different levels of the exposure as related to the outcome (e.g., categories of exposure, or exposure measured as continuous variable)?

   In this question, exposures were understood as "elder abuse victimisation" and its measurement, and, in those studies where it was applicable, other independent variables in relation to help-seeking (dependent variable).
7. Were the exposure measures (independent variables) clearly defined, valid, reliable, and implemented consistently across all study participants?
8. Were the outcome measures (dependent variables) clearly defined, valid, reliable, and implemented consistently across all study participants?

   Because most studies use self-report to measure this question, the answer to this question was "yes" if there was a consistent way of assessing help-seeking behaviour, i.e., same question asked to all participants or same conceptualisation applied to all cases if looking at data already gathered.
9. Were key potential confounding variables measured and adjusted statistically for their impact on the relationship between exposure(s) and outcome(s)?

Appendix H. Further Methodological Details for Study 2

Focus of the Data Gathering

The collection tool was coded based on the most recent information related to the abusive situation. For example, if the perpetrator and the victim had not been living together at the start of the abuse but were living together at the time of the enquiry, and the abuse was ongoing, the variable "are the victim and perpetrator living together" was coded as "yes". In cases where abuse was no longer happening, the information was gathered based on the information relating to the abuse while it was happening.

Identification of Repeat Enquiries

Repeat enquiries were usually identified by the helpline. In most cases, the helpline workers identified the case enquiry number of the previous enquiries in the new case enquiry. In other cases, the helpline workers added the new enquiry in the free text of the first enquiry, below the first enquiry's information (identified by the date of the second enquiry). If the case enquiry number was not provided but the call was identified as a repeat call, the cases were matched by looking at the enquirer's and/or victim's name, age, and other matching characteristics, using the helpline's database search functions. If unsure of whether the cases were linked, the enquiry was coded as a new case. If the enquiry was a repeat enquiry but the previous enquiry had happened prior to the period examined, as indicated in the free text (e.g., in 2016), no efforts were made to identify the previous enquiry, and this was coded as a new case.

Treatment of Unknown Data

Most variables were coded as "present" or "absent" (e.g., financial abuse, isolation patterns). However, some variables had an unknown category, such as "employment status of the perpetrator" and "relationship status". The variables with an unknown category can be

identified in the data collection tool in Appendix J. In cases with unknown data, the frequencies were provided based on valid cases, and also identifying the amount of missing data. For other analyses, the unknown data were treated as missing data.

Complete List of Inter-Rater Reliability Results

In Chapter 4, only the average inter-rater reliability results are provided. In Table H1, the reader can find the results for every variable.

Table H1

Inter-rater Reliability Results by Variable

Section	Kappa	ICC_1	% agreement
Case and enquirer characteristics	**.82**	**.99**	
Case inclusion	.71		
Multiple victims	.85		
Number of victims		1	
Multiple perpetrators	.81		
Number of perpetrators		.99	
Enquirer identity (victims vs non-victim)	.94		
Enquirer's gender	.77		
Enquirer's relationship with the victim	.88		
Enquirer's type of familial relationship with the victim	.94		
Enquirer's relationship with the perpetrator	.74		
Enquirer's type of familial relationship with the perpetrator	.77		
Victim characteristics	**.82**	**1**	**100**
Gender	.99		
Age		1	
Deceased	.88		
Relationship status	.95		
Physical health problems	.78		
Physical disability	.72		
Intellectual disability			100
Mental health problems	.70		
Dementia	.90		
Lack of capacity according to enquirer	.75		
Professional assessment of lack of capacity	.56		
Substance abuse	1		
Previous victimisation	.74		
Perpetrator characteristics	**.87**	**.99**	**99.8**
Gender	.94		
Age		.99	
Relationship status	.82		
Physical health problems	1		

Section	Kappa	ICC_1	% agreement
Physical disability			100
Intellectual disability	1		
Mental health problems	.80		
Dementia			100
Substance abuse	.95		
Previous victimisation			99.4
Antisocial attitudes	.62		
Victim-perpetrator relationship characteristics	**.70**		
Victim-perpetrator relationship	.84		
Victim-perpetrator family relationship	.81		
Co-habitation	.81		
Victim's dependency on the perpetrator (any)	.72		
Victim's dependency on the perpetrator (care)	.78		
Victim's dependency on the perpetrator (socially or emotionally)	.61		
Perpetrator is victim's main caregiver	.57		
Perpetrator is victim's POA	.63		
Perpetrator's dependency on the victim (any)	.65		
Perpetrator's dependency on the victim (housing)	.56		
Perpetrator's dependency on the victim (financial)	.70		
Abuse characteristics	**.74**	**.80**	**98.3**
Financial abuse	.90		
Physical abuse	.86		
Psychological abuse	.74		
Neglect	.81		
Sexual abuse	1		
Number of abuse types		.80	
Abuse location	.67		
Abuse ongoing	.77		
One-time incident	.50		
Perpetrator isolation	.84		
Use of threats	.59		
Substantiated			97.1
Long-standing IPV	.80		
Bi-directional			99.4
Financial impact	.63		
Physical impact	.67		
Psychological impact	.65		
Previous help-seeking and facilitators	**.68**		**100**
Abuse reached threshold	.66		
Victim's fear for safety	.79		
Victim's informal support	.83		
Victim's formal support	.56		
Abuse escalation	.61		
Lack of emotional attachment			100
Feelings of betrayal			100
Victim's previous disclosure	.63		
Victim's source	.63		
Victim's response	.63		
Victim's success	.62		

Section	Kappa	ICC$_1$	% agreement
Non-victim's previous disclosure	.85		
Non-victim's source	.72		
Non-victim's response	.65		
Non-victim's success	.69		
Perpetrator confrontation	.63		
Barriers	**.74**		**99.6**
Fear of consequences for themselves	.79		
Fear of isolation	1		
Fear of not being believed	1		
Fear of institutionalisation			99.4
Fear of retaliation			99.4
Fear of abandonment			100
Fear of rejection by community			100
Fear due to perpetrator's threats			99.4
Fear of being blamed			100
General fear of authorities			100
Fear of others knowing			100
Fear of 'making a fuss'			100
Fear of consequences for the perpetrator	.88		
Fear of worsening the relationship with the perpetrator	1		
Wanting to help or protect the perpetrator	.77		
Fear of harm to the perpetrator	.66		
Low self-confidence	1		
Physical frailty	.74		
Ambivalence	.61		
Helplessness	.50		
Embarrassment/shame			99.4
Self-blame			100
Stigma of seeking help			100
Anxiety			98.2
Bereavement	.71		
Socioeconomic dependency	.79		
Lack of knowledge of where to seek help			99.4
Lack of trust in professionals	.66		
Doubts about services' capacity to help			100
Service inadequacy	.66		
Services' accessibility problems			98.8
Perpetrator's dependency on the victim	.66		
Importance of family			99.4
Victim's parental duty			99.4
Lack of effective social support	.61		
Isolation	.65		
Perpetrator is only significant relationship	.66		
Anticipation of denunciation			100
Belief that social network cannot help			98.8
Lack of awareness	.66		
Difficulties labelling behaviour as abusive	.74		
Belief that abuse is not serious enough			100
Barriers related to culture, generational, or religious	.60		
Advice	**.78**		

Section	Kappa	ICC_1	% agreement
Safeguarding	.80		
Police	.81		
Legal	.80		
Management	.58		
Care Quality Commission	.92		
Other services	.76		

Appendix I. Ethics Self-Assessment

Ethics Self Assessment

Your answers indicate that you do not need ethical approval. If your research includes use of animals as research subjects, you will have been emailed separate guidance which must be followed before you begin your research. Should the circumstances of your research alter in any way please revisit this process to validate your project.

Applicant details

Declaration

By clicking the 'submit form' button, I declare that the questions above have been answered truthfully and to the best of my knowledge and belief, and that I take full responsibility for these responses. I undertake to observe ethical principles throughout the research project and to report any changes that affect the ethics of the project to the University Research Ethics Committee for review.

Project type:	Royal Holloway postgraduate research project/grant
Name:	Fraga Dominguez, Silvia (2017)
Email:	PETL002@live.rhul.ac.uk
Academic supervisor:	Jennifer Storey
Department:	Law
Title of research project or grant:	Understanding help-seeking in elder abuse: Barriers, facilitators, and the influence of attitudes towards intervention.
Email address of Academic Supervisor:	Jennifer.Storey@rhul.ac.uk
Funding Body Category:	No external funder
Funding Body:	

Information about the Research Project

Will the research project involve the use of human participants or human tissue (with or without their knowledge or consent at the time)?, No

Are the results of the research project likely to expose any person or community to physical or psychological harm?, No

Will the research project involve the use of animals as research subjects?, No

Will you have access to personal information that allows you to identify individuals or company confidential information (that is not covered by confidentiality terms within an agreement or by a separate confidentiality agreement)?, No

Does the conduct of the research project present a significant risk to the environment or society?, No

Are there any other ethical issues raised by this research project that in the opinion of the PI require further ethical review?, No

Does the PI believe that the results of this research could reasonably lead to legal action or negative press coverage, for which the PI would require University support?, No

Certificate produced for user ID PETL002

Certificate dated 7/5/2018 12:13:36 PM

Appendix J. Data Collection Tool for Study 2

Case number: Click or tap here to enter text.

INCLUSION CRITERIA

1. In your opinion, how certain are you that there is abuse in this case?

0 ☐ No abuse
1 ☐ Suspicion
2 ☐ Abuse

2. Is there enough information to determine the following?

1 ☐ The victim-perpetrator relationship (e.g., family, professional)
2 ☐ The victim's gender
3 ☐ The identity of the caller (victim vs. other)
4 ☐ The type(s) of abuse suffered by the victim
5 ☐ At least one aspect of help-seeking

---

1. Are there several victims mentioned?

0 ☐ No
1 ☐ Yes

2. If the answer is yes, how many? Click or tap here to enter text.

3. Are there several perpetrators mentioned?

0 ☐ No
1 ☐ Yes

4. If the answer is yes, how many? Click or tap here to enter text.

SECTION 1: Caller characteristics

1. Is this a repeat caller?

0 ☐ No
1 ☐ Yes

2. Is the caller the victim?

0 ☐ No
1 ☐ Yes

3. If the caller is not the victim, the caller is a _______ of the victim:

1 ☐ Family member
2 ☐ Friend
3 ☐ Neighbour
4 ☐ Partner
5 ☐ Professional
6 ☐ Acquaintance
7 ☐ Other: Click or tap here to enter text.
77 ☐ Not applicable
99 ☐ Unknown

4. If the caller is a family member, the relationship with the victim is:

1 ☐ Son/Daughter
2 ☐ Grandson/Granddaughter
3 ☐ Partner/Spouse
4 ☐ Niece/Nephew
5 ☐ Sibling
6 ☐ Aunt/Uncle
7 ☐ Parent
77 ☐ Not applicable
8 ☐ Other: Click or tap here to enter text.

5. If the caller is not the victim, the caller's relationship with the perpetrator is _______:

1 ☐ Family member
2 ☐ Friend
3 ☐ Neighbour
4 ☐ Partner
5 ☐ Professional
6 ☐ Acquaintance
7 ☐ Stranger
77 ☐ Not applicable
8 ☐ Other: Click or tap here to enter text.
99 ☐ Unknown

6. If the caller is a family member, the relationship with the perpetrator is:

1 ☐ Son/Daughter
2 ☐ Grandson/Granddaughter
3 ☐ Partner/Spouse
4 ☐ Niece/Nephew
5 ☐ Sibling
6 ☐ Aunt/Uncle
7 ☐ Parent
77 ☐ Not applicable
8 ☐ Other: Click or tap here to enter text.

7. If the caller is NOT the victim, the caller's gender is:

0 ☐ Male
1 ☐ Female
2 ☐ Other
77 ☐ Not applicable
99 ☐ Unknown

SECTION 2: Victim characteristics

1. Victim approximate age: Click or tap here to enter text. 999. ☐Victim's age unknown.

2. Is the victim deceased?

0 ☐ No
1 ☐ Yes

3. Victim gender:

0 ☐ Male
1 ☐ Female
2 ☐ Other
99 ☐ Not known

4. Is the victim…?

1 ☐ Single
2 ☐ Married
3 ☐ Living with partner
4 ☐ Widowed
5 ☐ Divorced
99 ☐ Unknown

5. Does the victim have any of the following vulnerabilities?

1 ☐ Mental health problems
2 ☐ Intellectual disability
3 ☐ Physical health problem
4 ☐ Physical disability
5 ☐ Dementia
6 ☐ Other: Click or tap here to enter text.

6. Does the victim lack capacity according to caller?

0 ☐ No
1 ☐ Yes

7. Has the victim been assessed to be lacking capacity by a professional?

0 ☐ No
1 ☐ Yes
99 ☐ Unknown

8. Is victim abusing substances (alcohol, drugs)?

0 ☐ No
1 ☐ Yes

9. Was the victim previously victimised?

0 ☐ No
1 ☐ Yes

SECTION 3: Abuse

1. In your opinion, the victim is subject to

1 ☐ Physical abuse
2 ☐ Psychological abuse
3 ☐ Financial abuse
4 ☐ Neglect
5 ☐ Sexual abuse

2. Please describe the abusive situation: Click or tap here to enter text.

3. Has the abuse been substantiated?

0 ☐ No
1 ☐ Yes

4. Is the perpetrator trying to isolate the victim?

0 ☐ No
1 ☐ Yes

5. Has the perpetrator used threats or intimidation?

0 ☐ No
1 ☐ Yes

6. Is the abuse ongoing?

0 ☐ No
1 ☐ Yes
99 ☐ Unknown

7. Was the abusive situation a one-time incident, i.e., it only occurred once?

0 ☐ No
1 ☐ Yes
99 ☐ Unknown

8. Is the abuse chronic?

0 ☐ No
1 ☐ Yes
99 ☐ Unknown

9. Abuse location

1 ☐ Own home
2 ☐ Sheltered accommodation
3 ☐ Care home
4 ☐ Nursing home
5 ☐ Hospital
6 ☐ Somewhere else: Click or tap here to enter text.
99 ☐ Unknown

10. Can you describe the impact the abuse has had on the victim (i.e., consequences)? Click or tap here to enter text.

11. Has it impacted any of the following…?

1 ☐ Psychological health
2 ☐ Physical health
3 ☐ Financially

12. Can you describe the impact the abuse or seeking help has had on the non-victim caller (i.e., consequences)? Click or tap here to enter text.

13. Given the information provided in-text, is this a case of long-standing intimate-partner violence (i.e., intimate-partner violence that started before the victim was >60 years old)?

0 ☐ No
1 ☐ Yes

14. Given the information provided in-text, is this a case of bidirectional abuse (i.e., has the victim been abusive towards the perpetrator during the period of abuse perpetrator-victim)?

0 ☐ No
1 ☐ Yes

SECTION 4: Relationship with perpetrator

1. What is the relationship of the abuser with respect to the victim?

1 ☐ Family member other than partner, child, or grandchild
2 ☐ Partner
3 ☐ Son/Daughter
4 ☐ Friend
5 ☐ Neighbour
6 ☐ Professional
7 ☐ Grandson/daughter
8 ☐ Other: Click or tap here to enter text.

2. If the perpetrator is a relative other than a partner or child/grandchild, what is the specific relationship with respect to the victim?

1 ☐ Stepson/daughter
2 ☐ Nephew/niece
3 ☐ Sibling
4 ☐ Aunt/Uncle
5 ☐ Other: Click or tap here to enter text.
77 ☐ Not applicable
99 ☐ Unknown

3. Do the perpetrator and the victim live together?

0 ☐ No
1 ☐ Yes
99 ☐ Unknown

4. Does the victim live alone?

0 ☐ No
1 ☐ Yes
99 ☐ Unknown

5. Is the victim dependent on the perpetrator?

0 ☐ No
1 ☐ Yes

6. If dependent, in which ways?

1 ☐ Financially
2 ☐ For care
3 ☐ Socially or emotionally
4 ☐ For housing
4 ☐ Other: Click or tap here to enter text.
77 ☐ Not applicable
99 ☐ Unknown

7. If “dependent for care”, is the perpetrator the victim’s main or sole caregiver?

0 ☐ No
1 ☐ Yes
77 ☐ Not applicable
99 ☐ Unknown

8. Does the perpetrator have Power of Attorney (POA)?

0 ☐ No
1 ☐ Yes
99 ☐ Unknown

9. Is the perpetrator dependent on the victim?

0 ☐ No
1 ☐ Yes

10. If dependent, in which ways?

1 ☐ Financially
2 ☐ For care
3 ☐ Socially or emotionally
4 ☐ For housing
4 ☐ Other: Click or tap here to enter text.
77 ☐ Not applicable
99 ☐ Unknown

SECTION 5: Perpetrator variables

1. Perpetrator gender:

0 ☐ Male
1 ☐ Female
2 ☐ Other
99 ☐ Not known

2. Perpetrator age**.** Click or tap here to enter text. 999. ☐ Unknown

3. Is the perpetrator…?

1 ☐ Single
2 ☐ Married
3 ☐ Living with partner
4 ☐ Widowed
5 ☐ Divorced
99 ☐ Unknown

4. Does the perpetrator have any of the following?

1 ☐ Mental health problems
2 ☐ Intellectual disabilities
3 ☐ Physical health problems
4 ☐ Physical disabilities
5 ☐ Dementia
6 ☐ Other: Click or tap here to enter text.

5. Does the perpetrator display the following problematic attitudes?

1 ☐ Antisocial attitudes

6. Is the perpetrator employed?

0 ☐ No
1 ☐ Yes
99 ☐ Unknown

7. Is perpetrator abusing substances (alcohol, drugs)?

0 ☐ No
1 ☐ Yes

8. Was the perpetrator previously victimised as a child?

0 ☐ No
1 ☐ Yes

SECTION 6: Help needed/Reasons to call/Facilitators

1. What were the reasons for calling? What is the caller expecting to achieve by calling/What help do they need?
Click or tap here to enter text.

2. Are there any facilitators for help-seeking (anything that made it easier to report, seek help, **either to the helpline or in earlier attempts by the victim or the caller**) identified in the call?

0 ☐ No
1 ☐ Yes

3. If the answer is YES, was that any of the following?

☐	The abuse reached a threshold that became unbearable for the victim (or too serious as perceived by the caller)
☐	The victim fears for their safety.
☐	The victim has good informal support that made it easier to seek help.
☐	The victim has good formal support (from a professional, organisation) that made it easier to seek help.
☐	The victim lacked emotional attachment toward the perpetrator and that made it easier to seek help.
☐	The victim felt betrayed and that made it easier to seek help.
☐	The abuse escalated shortly before seeking help (in intensity/frequency or severity).

4. In your opinion, is there anything else that made seeking help easier for the victim or caller?
Click or tap here to enter text.

SECTION 6: Prior help-seeking

1. Did the victim disclose the abuse to anybody else or seek help from anybody else?

0 ☐ No
1 ☐ Yes
2 ☐ Probably
99 ☐ Unknown

2. Who did the victim disclose the abuse to?
Click or tap here to enter text.

3. Was this a(n)…?

1 ☐ Informal source
2 ☐ Formal source
3 ☐ Both
77 ☐ Not applicable
99 ☐ Not specified

4. If the answer is Both (3), which one was contacted first?

1 ☐ Informal source
2 ☐ Formal source
77 ☐ Not applicable
99 ☐ Not specified

5. What were the responses to victim's disclosure or help-seeking?
Click or tap here to enter text.

6. In your opinion, were these responses overall…? Choose an item.

7. Was the victim successful (in stopping the abuse, resolving the situation, or improving it)?
Choose an item.

8. If caller is NOT the victim, did the caller seek help from anybody else or discuss it with anybody prior to calling the helpline?

0 ☐ No
1 ☐ Yes
77 ☐ Not applicable
99 ☐ Unknown

9. Who did the caller seek help from?
Click or tap here to enter text.

10. Was this a(n)…?

1 ☐ Informal source
2 ☐ Formal source
3 ☐ Both
77 ☐ Not applicable
99 ☐ Not specified

11. If the answer is Both (3), which one was contacted first?

1 ☐ Informal source
2 ☐ Formal source
77 ☐ Not applicable
99 ☐ Not specified

12. What were the responses to caller's help-seeking? Click or tap here to enter text.

13. In your opinion, were these responses overall…? Choose an item.

14. Was the caller successful (in stopping the abuse, resolving the situation, or improving it)?
Choose an item.

15. Has either the victim, the caller or somebody else confronted the alleged perpetrator (i.e., challenged this person about their behaviour or requested a change)?
Choose an item.

16. If the perpetrator has been confronted, what has been their response? Click or tap here to enter text.

SECTION 7: Barriers to help-seeking

1. Are there any barriers mentioned/described in the free text?

0 ☐ No
1 ☐ Yes

2. Is the victim afraid of consequences for self?

0 ☐ No
1 ☐ Yes

3. If victim is **afraid of consequences for self**, is s/he afraid of any of the following?

☐	Being placed in a care home/being institutionalised
☐	Retaliation by the perpetrator or the abuse worsening as a result of reporting
☐	Being abandoned
☐	Becoming isolated
☐	Being rejected by their community
☐	Afraid due to threats by the perpetrator
☐	Being blamed
☐	Fear of not being believed
☐	In general, of authorities' involvement
☐	Others knowing about the abuse
☐	Making a fuss

4. Is the victim afraid of the **consequences for the perpetrator** or in relation to the perpetrator?

0 ☐ No
1 ☐ Yes

1. If victim is **afraid of consequences related to the perpetrator**, is she afraid of any of the following?

☐	The perpetrator being harmed or getting in trouble
☐	Worsening the relationship that the victim has with the perpetrator

2. Does the victim want to help or protect the perpetrator?

0 ☐ No
1 ☐ Yes

3. Does the victim or non-victim enquirer specify any other fears regarding self/perpetrator? Please specify:
Click or tap here to enter text.

5. In your opinion, does the victim's experience of any of the following **individual feelings and external circumstances** impact their desire to seek help?

☐	The victim is embarrassed or feels shame

☐	The victim blames him/herself.
☐	The victim has low self-confidence or low self-esteem.
☐	The victim is frail physically.
☐	The victim thinks it is stigmatising to seek help.
☐	The victim feels ambivalence regarding seeking help.
☐	The victim feels anxious.
☐	The victim feels helpless.
☐	Other individual feeling for victim or non-victim enquirer: Click or tap here to enter text.
☐	Any individual-related barriers
☐	The victim is going through bereavement
☐	The victim depends on others
☐	Other external circumstances for victim or non-victim enquirer: Click or tap here to enter text.
☐	Any external circumstance that acts as a barrier

6. In your opinion, does the victim express any of the following regarding **services**?

☐	The victim does not know where to seek help.
☐	The victim does not think services can help.
☐	The victim does not trust professionals.
☐	Services are not adequate for the victim.
☐	Services cannot be adequately accessed by victim.
☐	Other barrier related to services for victim or non-victim enquirer: Click or tap here to enter text.
☐	Any barrier related to services

7. In your opinion, does the victim express any of the following barriers related to **family**?

☐	Importance of the relationship with the perpetrator and other relatives.
☐	The perpetrator's dependency on the victim.
☐	The importance of parental duty (if the perpetrator is an adult child).
☐	Other barriers related to family for victim or non-victim enquirer: Click or tap here to enter text.
☐	Any barrier related to family.

8. In your opinion, does the victim experience any of the following barriers related to their **social network**? (*All No: 0, Yes: 1)*

☐	The victim lacks effective support.
☐	The victim is isolated.
☐	Their only significant relationship is with the perpetrator.
☐	The victim anticipates denunciation by the community.
☐	The victim believes that their social network cannot help.
☐	Other barriers related to social network for victim or non-victim enquirer: Click or tap here to enter text.
☐	Any barrier related to their social network.

9. In your opinion, does the victim display any of the following regarding the **perception of abuse**? (*All No: 0, Yes: 1)*

☐	The victim lacks awareness regarding the abusive situation.
☐	The victim has difficulty labelling the abusive behaviour as such.
☐	The victim believes the abuse is not serious enough.
☐	Other barriers related to the perception of abuse for victim or non-victim enquirer: Click or tap here to enter text.
☐	Any barrier related to the perception of the abuse.

10. **CRG.** Are there any barriers related to culture, religion or generational?

0 ☐ No
1 ☐ Yes: specify: Click or tap here to enter text.

11. In your opinion, is there anything else that made seeking help more difficult for the victim or caller? Click or tap here to enter text.

SECTION 8: Advice offered & outcomes

1. What is the advice offered?
Click or tap here to enter text.
2. Is the advice offered…?

☐	Adult safeguarding, social services.
☐	Police
☐	Legal services such as solicitors, Solicitors for the Elderly (SFE), the Court of Protection, etc.
☐	Management services such as the management of a care home or a housing complex, or the line manager of a social worker.
☐	CQC (Care Quality Commission: https://www.cqc.org.uk/)
☐	Any other services

SECTION 9: Victim's attitudes towards intervention

1. Does the victim or caller express any views regarding intervention (positive or negative)? (e.g., because of past experience with services, or expectations of what is going to happen.)
Click or tap here to enter text.

Finally, is there anything else that you consider important about the case (as described in the free text) and that doesn't fit in any of the previous fields or questions? Click or tap here to enter text.

Please indicate reason for exclusion

What is the most important reason for excluding this case?

1 ☐ Not a case of elder abuse as per definition
2 ☐ Out of remit (younger than 60)
3 ☐ No information about required key variables
4 ☐ Could be a case of elder abuse but the description is unclear or there is not enough detail to be sure that it is
5 ☐ Call to ask for information or a number
6 ☐ Systemic abuse (formal services not acting accordingly but it seems to fall outside of the EA definition)

7	☐	Repeat case, added to a previous case
8	☐	Test case, entered twice
9	☐	Other

Appendix K. Additional Findings From Study 2

Table K1

Victims' Source of Disclosure (n = 466)

	Cases	
	n	%
Informal	294	66.1
Family member	206	46.3
Adult child	124	27.8
Grandchild	19	4.3
Unspecified	17	3.8
Niece/nephew	15	3.4
Adult child in-law	14	3.1
Sibling	4	0.9
Other (e.g., stepchild, cousin, partner/spouse)	11	2.0
Friend	49	11.0
Neighbour	24	5.4
Acquaintance	8	1.8
Ex-neighbour	3	0.7
Ex-partner/spouse	3	0.7
Church/congregation member	2	0.5
Relative of ex-care home resident	1	0.2
Formal	165	37.1
Police	42	9.4
Organisations for older persons	31	7.0
Legal services or organisations	22	5.0
Social services, including adult safeguarding	19	4.3
Charities (e.g., Victim Support, Samaritans)	15	3.4
Domestic violence organisations	9	2.0
General Practitioner	9	2.0
Mental health services	7	1.6
Banking staff	6	1.3
Clergyman or church	6	1.3
Hospital staff (including Accident & Emergency)	6	1.3
Management (e.g., care home, property)	6	1.3
Carer	5	1.1
Social worker	5	1.1
Professional unspecified	4	0.9
Other workers (e.g., shopkeeper, beauty salon, salesman, driver)	4	0.9
Refuge	3	0.7
Housing officer or housing department	3	0.7
Sheltered accommodation employee	3	0.7
Advocacy service	2	0.5
Care home	2	0.5
Council	2	0.5
Other	16	3.6

Note. 21 cases unknown. Percentages are calculated over cases where the source is known (*n* = 445).

The percentage sum exceeds 100 because among those who contacted informal (294) or formal (165) sources, many contacted several sources.
The frequencies for informal and formal sources include the cases in which victims contacted both informal and formal sources; thus, they differ from those presented in text.

Table K2

Chi-square Findings for the Association Between Barriers Related to the Social Network and Case Characteristics That Violated Assumptions

			Barriers Related to the Social Network	
			n	%
Victim Characteristics	Intellectual disability	No	451	27.9
		Yes	4	44.4
	Substance abuse	No	450	27.9
		Yes	5	41.7

Table K3

Chi-square Findings for the Association Between Barriers Related to Individual Feelings and Case Characteristics That Violated Assumptions

			Barriers Related to Individual Feelings	
			n	%
Victim Characteristics	Intellectual disability	No	309	19.1
		Yes	1	11.1
	Substance abuse	No	306	19.0
		Yes	4	33.3
	Previous victimisation	No	299	18.9
		Yes	11	28.2
Abuse Type	Sexual	No	206	12.9
		Yes	2	7.4

Table K4

Chi-square Findings for the Association Between Barriers Related to Services and Case Characteristics That Violated Assumptions

			Barriers Related to Services	
			n	%
Victim Characteristics	Intellectual disability	No	301	18.6
		Yes	1	11.1
	Substance abuse	No	300	18.6
		Yes	2	16.7
Abuse Type(s)	Sexual	No	127	8.0
		Yes	1	3.7

			Barriers Related to Services	
			n	%
Abuse Characteristics	Threats	No	122	7.8
		Yes	6	12.0

Table K5

Chi-square Findings for the Association Between Fear-Related Barriers and Case Characteristics That Violated Assumptions

			Barriers Related to Fear	
			n	%
Victim Characteristics	Intellectual disability	No	206	12.8
		Yes	2	22.2
	Substance abuse	No	207	12.8
		Yes	1	8.3
	Previous victimisation	No	199	12.6
		Yes	9	23.1

Table K6

Chi-square Findings for the Association Between Barriers Related to the Perception of Abuse and Case Characteristics That Violated Assumptions

			Barriers Related to the Perception of Abuse	
			n	%
Victim Characteristics	Intellectual disability	No	160	9.9
		Yes	5	55.6
	Substance abuse	No	164	10.2
		Yes	1	8.3
	Previous victimisation	No	161	10.2
		Yes	4	10.3
Abuse Type(s)	Sexual	No	162	10.2
		Yes	3	11.1

Table K7

Chi-square Findings for the Association Between Barriers Related to External Circumstances and Case Characteristics That Violated Assumptions

			Barriers Related to External Circumstances	
			n	%
Victim Characteristics	Intellectual disability	No	128	7.9
		Yes	0	0

			Barriers Related to External Circumstances	
			n	%
	Substance abuse	No	127	7.9
		Yes	1	8.3
	Previous victimisation	No	126	8.0
		Yes	2	5.1
Abuse Type(s)	Sexual	No	127	8.0
		Yes	1	3.7
Abuse Characteristics	Threats	No	122	7.8
		Yes	6	12.0

Table K8

Chi-square Findings for the Association Between the Presence of Barriers Related to Family and Case Characteristics That Violated Assumptions

			Barriers Related to Family	
			n	%
Victim Characteristics	Physical disability	No	59	3.9
		Yes	1	0.8
	Intellectual disability	No	60	3.7
		Yes	0	0
	Substance abuse	No	60	3.7
		Yes	0	0
	Previous victimisation	No	58	3.7
		Yes	2	5.1
Abuse Type(s)	Sexual	No	60	3.8
		Yes	0	0
Abuse Characteristics	Threats	No	56	3.6
		Yes	4	8.0

Table K9

Chi-square Findings for the Association Between the Presence of Cultural, Generational or Religious Barriers and Case Characteristics That Violated Assumptions

			Cultural, Generational, or Religious Barriers	
			n	%
Victim Characteristics	Physical disability	No	34	2.3
		Yes	5	4.1
	Intellectual disability	No	39	2.4
		Yes	0	0
	Mental health problems	No	34	2.2
		Yes	5	4.8
	Substance abuse	No	39	2.4
		Yes	0	0

			Cultural, Generational, or Religious Barriers	
			n	%
	Previous victimisation	No	35	2.2
		Yes	4	10.3
Abuse Type(s)	Physical	No	30	2.1
		Yes	9	4.6
	Sexual	No	39	2.4
		Yes	0	0
Abuse Characteristics	Isolation	No	29	2.0
		Yes	10	5.4
	Threats	No	36	2.3
		Yes	3	6.0

Table K10

Victims' Wishes Towards Third-Party Intervention (continuation)

Things Victims Want (*n* = 195)					
Area of Focus	*n*	%	Most Common Categories	*n*	%
Specific support	76	39.0	• Support from Hourglass or Hourglass services	5	2.6
			• Informal or formal support being a bridge to other services	4	2.1
			• Recovering money lost	4	2.1
			• Help from police	3	1.5
			• Continued and ongoing helpline or telephone support	3	1.5
			• (Practical) information	3	1.5
			• Counselling services or mental health services	3	1.5
			• Banking or finances-related support, including someone to manage finances	3	1.5
			• CCTV cameras or recording devices	2	1.0
			• Support from social workers or social services	2	1.0
			• Support from other survivors	2	1.0
			• A letter in case authorities do not believe them	1	0.5
			• Church support	1	0.5
			• Help to be able to separate	1	0.5
			• "Take things further" (e.g., prosecution)	1	0.5
			• All assets to go to charity	1	0.5
			• Care (people to stay and look after them)	1	0.5
			• Mediation	1	0.5
Housing or living arrangements	61	31.3	• Staying with supportive family or friends, permanently or temporarily	4	2.1
			• Continue living with perpetrator	2	1.0
			• Live independently	2	1.0
			• Leave the place where abuse is happening (home or residential facility)	2	1.0
			• Live at home with support (by concerned persons or paid carers)	2	1.0
			• Sell house	1	0.5

Things Victims Want (*n* = 195)					
Area of Focus	*n*	%	Most Common Categories	*n*	%
Relationship with the perpetrator	17	8.7	• Stand up to perpetrator or tell them to stop	2	1.0
			• Maintain the positive aspects of their relationship with the perpetrator	1	0.5
			• Understand why perpetrator did what they did	1	0.5
Support from and relationship with CPs	15	7.7	• Support from CPs or staying close to them	6	3.1
			• CPs actively supporting them, being POAs or looking after finances	5	2.6
			• CPs being with them in accepting support, as their bridge to support	4	2.1
Disclosure of abuse and outcomes from it	10	5.1	• Disclose partially	3	1.5
			• Disclose to GP	1	0.5
			• Publicise experience	1	0.5
			• "Report"	1	0.5
			• Speak to someone face to face	1	0.5
			• Be taken seriously	1	0.5
			• Their experience to be recorded somewhere	1	0.5
The perpetrator	10	5.1	• Support in getting the perpetrator help	1	0.5
			• Support for perpetrator and to protect the perpetrator from jail	1	0.5
			• An alternative for the perpetrator from social services	1	0.5

Things Victims do not Want (*n* = 251)					
Area of Focus	*n*	%	Most Common Categories	*n*	%
Specific support from services	100	39.8	• Any further help at this stage	13	5.2
			• Talking to or engaging with a GP	9	3.6
			• Hourglass to raise a safeguarding alert	3	1.2
			• Legal advice	3	1.2
			• Financial measures (e.g., revoking Power of Attorney)	3	1.2
			• Assessment of mental capacity or their care and needs	2	0.8
			• Contact with Hourglass or the help that they offer	2	0.8
			• Carers coming into the house	2	0.8
			• Any advice or help that comes from external services	2	0.8
			• Speaking (with strangers) on the phone	2	0.8
			• Befriending services	1	0.4
			• Monitoring camera	1	0.4
			• Counselling	1	0.4
			• Complaint to the landlord	1	0.4
			• Meeting with sheltered accommodation	1	0.4
Housing or living arrangements	27	10.7	• Continue living at home with the perpetrator	3	1.2
			• Living alone	3	1.2
			• Staying with a friend long term	1	0.4
			• Moving to an adult child's house	1	0.4
			• Losing their home	1	0.4
Relationship with the perpetrator	22	8.8	• Being in touch with the perpetrator (e.g., the perpetrator returning, visiting)	4	1.6
			• Challenging the perpetrator or saying no to them	2	0.8

Things Victims do not Want (*n* = 251)					
Area of Focus	*n*	%	Most Common Categories	*n*	%
Support from and relationship with CPs	18	7.2	• CPs checking their accounts or obtaining Power of Attorney • CPs to contact services on their behalf	3 2	1.2 0.8
Disclosure of abuse and outcomes from it	37	14.7	• Reporting or doing so yet • "Making a fuss" or "making a scene" • Saying anything against the perpetrators • Disclosing to police once they arrive • Giving evidence • Making a complaint • Talking about the abuse or financial issues • Getting emotional • "Crossing" perpetrator • Acting after disclosing	3 3 2 1 1 1 1 1 1 1	1.2 1.2 0.8 0.4 0.4 0.4 0.4 0.4 0.4 0.4
Other negative outcomes for themselves	8	3.2	• For example, loneliness and others knowing about abuse		
Family or others around them	6	2.4	• Conflict or negative impact on family • Losing contact with grandchildren	5 1	2.0 0.4

Note. CP = concerned person.

Table K11

Concerned Persons' Source of Disclosure (n = 460)

	Cases	
	n	%
Formal	435	94.9
Social services or adult safeguarding	180	39.3
Police	112	24.5
Legal advice (e.g., solicitor)	49	10.7
Office of the Public Guardian (OPG)	42	9.2
General Practitioner	35	7.6
Banking staff	33	7.2
Care or nursing home staff	22	4.8
Social worker	19	4.1
Care or nursing home manager	19	4.1
Care Quality Commissioner	15	3.3
Staff in order to set up a Power of Attorney or a deputyship	14	3.1
Manager or leader of a service	13	2.8
Member of Parliament	10	2.2
Care company or agency	9	2.0
Safeguarding unit at an organisation (e.g., OPG, hospital)	8	1.7
Age UK	8	1.7
Citizens Advice Bureau	7	1.5
Court of Protection	6	1.3
Ombudsman	5	1.1

	Cases	
	n	%
Local council	5	1.1
Hospital staff	4	0.9
Action on Elder Abuse	3	0.6
Alzheimer's Society	3	0.6
Department for Work and Pension	3	0.6
Action Fraud	3	0.6
Agency unspecified	3	0.6
Patient Advice and Liaison Service	3	0.6
Court	2	0.4
Authority unspecified	2	0.4
Complaints department	2	0.4
National Health Service	2	0.4
Community navigator	1	0.2
Funeral directors	1	0.2
Occupation Therapist	1	0.2
Office for Standards in Education	1	0.2
Independent Police Complaints Commission	1	0.2
Police Commissioner	1	0.2
Post office	1	0.2
Independent Mental Capacity Advocate	1	0.2
National Centre for Domestic Violence	1	0.2
Counselor	1	0.2
Rehabilitation unit	1	0.2
Crown Prosecution Service	1	0.2
Respite	1	0.2
Financial ombudsman	1	0.2
Commissioner	1	0.2
Financial body	1	0.2
Local health care services	1	0.2
Priest	1	0.2
Citizens Advice Scotland	1	0.2
Elderly care specialist	1	0.2
Person in charge of care	1	0.2
Silverline	1	0.2
Regulator	1	0.2
Move victim out of a care home	1	0.2
Carer to be replaced	1	0.2
Area manager	1	0.2
Fraud prevention	1	0.2
Victim's consultant	1	0.2
Ward manager	1	0.2
Domestic Violence team	1	0.2
National Fraud	1	0.2
Day centre	1	0.2
Vulnerable missing persons alert	1	0.2
Housing sheltered accommodation	1	0.2
Rental for victim	1	0.2
British Heart Foundation	1	0.2

	Cases	
	n	%
Police Criminal Investigation Unit	1	0.2
Newspapers	1	0.2
Senior members of staff	1	0.2
Regulation and Quality Improvement Authority	1	0.2
Informal	23	5.0
Family unspecified	6	1.3
Neighbours	4	0.9
Siblings	4	0.9
Victim's family	2	0.4
Friends	1	0.2
Nephews	1	0.2
Adult children	1	0.2
Victim's bishop	1	0.2
Cousin	1	0.2
Synagogue	1	0.2
Other families	1	0.2

Note. 2 cases unknown. Percentages are calculated over cases where the source is known (n = 458). The percentage sum exceeds 100 because among those who contacted formal (446) or informal (23) sources, many contacted several sources.
The frequencies for informal and formal sources include the cases in which concerned persons contacted both informal and formal sources; thus, they differ from those presented in text.

Table K12

Concerned Persons' Wishes Towards Third-Party Intervention (continuation)

Things CPs Want (*n* = 168)					
Area of Focus	*n*	%	Most Common Categories	*n*	%
Specific support from services	122	72.6	• Help from health care (e.g., GP, nurses)	6	3.6
			• To act in victim's best interests and support them	6	3.6
			• Someone to assess situation and victim's conditions	4	2.4
			• Involvement from CQC and for a care home to be checked or assessed	3	1.8
			• Help from the bank	3	1.8
			• Advocacy services	1	0.6
			• Counselling for the victim	1	0.6
			• Contacting the health ombudsman	1	0.6
			• Mediation	1	0.6
			• Help from Action Fraud	1	0.6
			• Get professionals with authority in the home as a "wake-up call" to the perpetrator	1	0.6
			• Protect other older adults from being victimised	1	0.6
			• Immediate action after a safeguarding alert	1	0.6
			• Help with housing	1	0.6
			• Forwarding complaint to the Parliamentary and Health Ombudsman	1	0.6
			• Putting an end to the deprivation of liberty	1	0.6

Things CPs Want (*n* = 168)					
Area of Focus	*n*	%	Most Common Categories	*n*	%
			• Taking up this issue with their Member of Parliament	1	0.6
			• Sending a formal letter to the perpetrator's solicitor	1	0.6
			• A carer coming several times a week	1	0.6
			• Joining campaign work	1	0.6
			• Getting justice for the victim and their family	1	0.6
			• Agencies to work together so that concerns are properly raised	1	0.6
			• Care home to deal with victim's needs	1	0.6
			• Get live-in carer for victim	1	0.6
Victims' housing or living arrangements	22	13.1	• Victim to move and live with them	1	0.6
			• Victim to move abroad for a better quality of life	1	0.6
			• Victim to move to a smaller home without the perpetrator	1	0.6
Disclosure and outcomes of disclosure	17	10.1	• "Report" abuse	1	0.6
			• Talking to the victim's family	1	0.6
			• Disclosing to the other Power of Attorney	1	0.6
			• Reporting to authorities	1	0.6
			• Informing Hourglass	1	0.6
			• Speaking to people outside of the family	1	0.6
			• Talking about the situation	1	0.6
The perpetrator	10	6.0	• Being held accountable	1	0.6
			• To be prevented from abusing other older people	1	0.6

Things CPs do not Want (*n* = 70)					
Area of Focus	*n*	%	Most Common Categories	*n*	%
Specific support from services	34	48.6	• Involving authorities	4	5.7
			• Mediation	1	1.4
			• To be co-appointed Power of Attorney with the perpetrator	1	1.4
			• Discussing situation with the care home manager	1	1.4
			• Receiving a computer-generated response from services	1	1.4
			• Involving other relatives	1	1.4
			• Social worker not taking enough time to assess victim's capacity	1	1.4
			• To receive contradictory information from services regarding victim's capacity	1	1.4
			• "Taking action"	1	1.4
			• Taking legal action	1	1.4
			• Becoming deputy	1	1.4
			• Taking responsibility for victim's finances	1	1.4
			• Making complaint against the care home itself	1	1.4

Note. CP = concerned Person.