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The Relationship Between the Perception of Stress for care and the Elderly Abuse

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Abstract

The study is to clarify the relationship among the positive and negative recognition of stress and physical and psychological abuse and neglect aiming at getting the material. They are to prevent elder abuse at the main care worker for frail and dementia elderly. The degree of fitness to the data where positive and negative recognition of main care worker was located as dependent variable. The casual model in which main care worker was located as independent variable. The degree of fitness of casual model was GFI=0.772, CFI=0.795, RESEA=0.067. Among path coefficient included in the previous model, three of figures going toward three of abuse to the elder were statistically significant.

▸ Keyword : elderly abuse, care worker, elderly dementia , stress perception

I. Introduction

In this Article Many elderly adults are abused in their own homes, in relatives' homes, and even in facilities responsible for their care. If you suspect that an elderly person is at risk from a neglectful or overwhelmed care-worker, or being preyed upon financially, it's important to speak up. Learn about the warning signs of elder abuse, what the risk factors are, and how you can prevent and report the problem. The elder abuse is serious social issue which expose their fundamental human right and life of themselves in danger. Previous research have reported that care for frail and dementia elderly give physical and psychiatric impact to the family members. [1]

Elderly abuse victims and a non-abused control group were compared to test the widely accepted proposition that such abuse results from the burden and stress placed on those caring for infirm and dependent elderly people. The study found substantially more support for the idea that abuse is associated with personality problems of the care-worker. As elders become more physically frail, they're less able to stand up to bullying and or fight back if attacked. They may not see or hear as well or think as clearly as they used to, leaving openings for unscrupulous people to take advantage of them. Mental or physical ailments may make them more trying companions for the people who live with them.[2]

Previous studies the factors related to the occurrence of elder abuse were classified into the factor related to the elders, a factor related to care-worker social factor.

Especially the finding is supported that psychological stress as a factor related to family care-worker was firmly related to aging abuse all the way. However psychological abuse is complicated. More detailed study is necessary to consider the way adapting to each factor of occurrence of elderly abuse. The trend of the study about the recent care giving appraisal pointed out not only negative recognition of the stress but also the importance of people by the family

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member clarified the importance.[3] Moreover, those studies suggested possibility that positive recognition would decrease the degree of the negative recognition accompanied with care of frail and dementia elderly. However few study focused on both of positive and negative recognition among previous studies related evaluation of care. In korea, the service of insurance, medical treatment and welfare for frail and dementia elderly have not systematized sufficiently. It is important subject to clarify the relationship between evaluation of stress involved care of family and elderly abuse. The focus of this paper is on the aimed at clarifying the relationship of positive and negative recognition of stress going with care for frail and of dementia elderly and physical, contribute a development of social system psychological and neglect. This paper consists of families of frail and dementia elderly living in Seoul metropolitan city, related contents, data collection and sample description, results and discussion.

II. Theory & Related contents

Healthy ageing is about optimizing opportunities for good health, so that older people can take an active part in society and enjoy an independent and high quality of life. Imagine a marathon you did not sign up for, and yet, you are told you have to run the race until the end. To add to the challenge, you are to carry a heavy load on your shoulders, and the load will get heavier and heavier as the race goes on. This is what the dementia journey is like for most family care-worker. Keeping with the marathon metaphor, what is needed is a way for care-worker to develop the strength that will be required of them over the long run. The Presence Care program is a new, integrative approach that combines mindfulness and compassion practices with understanding of the dementia experience. Its goals are to ease care burden and stress, and to help foster greater well-being for both care-worker and the persons in their care.[4] The more we can learn about the disease, the better equipped we are to understand what the person needs and why they are behaving in certain ways. Dementia affects different parts of the brain, each responsible for different cognitive domains such as memory, language, behavior, executive function, or movement. Not all dementias affect the same domains, and we need to know which ones are impacted and what that means in terms of the person's interactions with us. For instance someone struggling with executive function will have trouble initiating tasks and will be dependent on others to get engaged into activities. We also need to guard from our tendency to position the person with dementia as less able than they really are. Many abilities are preserved throughout dementia.

In many cases, emotional intelligence is even heightened. Using Jon Kabat-Zinn's definition, mindfulness is being fully aware of the present moment, on purpose, and without judgment.[5] The validity of mindfulness as a powerful stress-reduction tool is no longer in question. That benefit alone makes it worthwhile for stressed out dementia care-worker to undertake mindfulness practice. The other, equally important reason has to do with the way in which mindful attention allows us to notice what is happening moment to moment, that may impact the person's experience. What do we bring into the situation? What do we hear? What do we see? What is the person telling us with her body language? Armed with that awareness, we then have a chance to act in a way that is most beneficial to the person. Of course, remembering to be mindful does not come naturally. We need to train our mind to come back to the present moment. Previous research have reported that care for frail and dementia elderly give physical and psychiatric impact to the family members.[6] The difference among of other papers, elderly`s activity of daily living, age, cognitive functioning, self-esteem, participation of social activity, family cohesion were the casual factors of all categories and subtypes of elderly abuse. The family size, supports of family and informal network, familism had the different effect on the elderly abuse by its categories and subtypes.

III. Methods

1. Data collection and sample descriptive

Families of frail and dementia elderly living in Seoul metropolitan city and Gyeonggi-do Province participated the research. The object was picked out as a simple by social worker among the main care-worker for the family of frail and dementia elderly utilize the facilities of welfare of aged.

Those social workers distributed questionnaire after certifying cooperation of research. The examiner asked for research only to the subject who gave the consent after confirmation of cooperation for the research beforehand. The contents of the research are basic attribute of trail and dementia

elderly, kind and frequency of care, basic attribute of main care worker, positive and negative recognition accompanied with care and abuse.[9]

2. Measures

The type and frequency of care to the frail and dementia elderly given by the man care worker are measured by using 11 items related to ADL and IADL. The question to the main care worker are "please answer about the frequency during recent one month ". Then the responses are received using the way of 5 conditions. Concerning negative recognition of main care worker accompanied by care for frail and dementia elderly. Family care giver burden inventory with factor and 11 item(Table 1). Such as negative feelings to the care recipient and financial constrains were used among 3 factors. [7] Positive recognition of main care worker accompanied by care for frail and dementia elderly were measured using 8 items composing satisfaction caused by care(Table 2).[8]

The kind of abuse to the elderly was defined by 3 side that were physical abuse, psychological abuse and neglect(Table3). The psychological abuse was constructed of rejection (4items) and verbal aggression (4items) by taking into account the scale for psychological abuse that the authors made following definition of National Center on Elder Abuse.(Table 4)

3. Research Model

In the analysis of statistics, the construct validity used at the beginning of this study was evaluated. The factor model of negative recognition of stress had 2 factors of refusal the feeling to the elderly who needed the care and economically strained feeling and second factor was negative recognition, namely relation above was the model of second factor.[10] Concerning the recognition to the care, positive recognition was one first factorial model in which potential variable is physical abuse and neglect respectively, then it was first factorial model.[11] Psychological abuse is the second factor model where factor of "refusal" and "verbal offense" were 2 factors and psychological abuse was the second factor. Secondly, we constructed the causal model where positive recognition of stress to care and negative recognition of stress of care were independent factor, physical abuse, psychological abuse and neglect were depending factor then, analyzed the degree of fitness of the model and relationship among each factor by the structural equation models. Yet in order to control the variables of background where attributes were supposed to effect the positive and negative recognition to the care. We added age and sex of the main care worker to the factor model described previously. Regarding sex, we used dummy variable such like "1" was male, "0" is female. We adopted the maximum likelihood estimation for the estimation of parameter. The degree of the fitness of individual model, we assessed the degree of the fitness of individual by Comparative Fit Index(CFI), Root Mean Square Error of Approximation(RMSEA). Thirdly we evaluated of the reliability for the scale used in this study was assessed with a coefficient of Cronbach. the software of SPSS for the WIN 17.0 program was used for these analyses.

Ⅳ. Results and Discussion

1. The Characteristics of Variables

Male of frail elderly was 148(24.6%), female was 452(75.4%) the average of male was 75.2 years old, standard deviation 7.23 range 65-90) Sex of main care worker was male 122(23.5%), female was 478(76.5%) the average of main care worker was 52.3 years old, standard deviation 13.21 range 22-90. It was consist of male main care of worker that son was 104(70.3%), his spouse was 37(25.2%). Also, it was consist of female main care worker that the daughter law was 294(65%), daughter was 83(18.4%), his wife was 75(16.6%).

2. The Characteristics of Response of Care Worker of Abuse to the Elderly

The degree of frequency of main care worker was showed in Table1. It presents stress frequency of negative recognition.[6] The frequency of negative and positive recognition to the stress was showed in Table1. The response of elderly daily life was showed in negative of response category

Stress frequency of negative recognition related

to physical care for patients and not emotion and economic tense feeling aging patients .

Namely, X1, X2, X3, X4, X5 X.....X11 showed 'not at all.' next once or twice a week.

Table1. category of response care for 11item, n=600, (%)
Unit = people(%)

index of questions	category of response				
	not at all	once or twice a month	once or twice a week	three or four times a week	every day or time
frequency of care content					
X1 washing face	264(44)	22(3.5)	55(9.2)	47(7.8)	22(35.5)
X2 oral wash	294(49)	18(3.0)	35(5.8)	48(8.0)	205(34.2)
X3 clean body	186(31)	127(21.2)	125(20.4)	76(12.6)	89(14.8)
X4 shampoo	192(32)	67(11.2)	193(32.2)	85(14.2)	62(10.4)
X5 changing clothes	204(34)	41(6.8)	101(16.7)	111(18.5)	144(24)
X6 help bathing	152(25.2)	189(31.5)	166(27.6)	58(9.8)	35(5.9)
X7 change position	307(51.2)	23(3.8)	35(5.8)	36(6.0)	199(33.2)
X8 help excretion	330(55.0)	27(4.5)	21(3.4)	40(6.8)	182(30.3)
X9 meal preparation	51(8.5)	14(2.4)	22(3.6)	52(8.7)	461(76.8)
X10 helping habe meal	186(31)	15(2.5)	27(4.5)	44(7.3)	328(54.7)
X11 take medicine	199(33.2)	27(4.5)	29(4.8)	33(5.5)	312 (52)

Table2 presents Stress frequency of negative recognition. Stress frequency of negative recognition. They showed negative recognition of index questions. Namely, Xa1, Xa2, Xa3, Xa4 showed 'not at all' 'sometimes' of response category. Stress frequency of negative recognition related to refusal emotion for patients and economic tense feeling aging.

Table2.Stress frequency of negative recognition(n=600, %)
Unit = people(%)

index of questions	category of response		
	not at all	sometimes	often
refusal emotion for patients			
Xa1 not to be thanked for care	254(42.4)	264(44)	82(13.6)
Xa2 irritated by seeing the patient	231(38.5)	303(50.5)	66(11)
Xa3 hot blood in anger for patient	273(45.5)	260(43.4)	67(11.1)
Xa4 not understand what patients act	193(32.2)	323(53.8)	84(14)
economic tense feeling			
Xb1feel expense heavily for care	145(24.2)	308(51.3)	147(24.5)
Xb2 cann't live because care fee	194(32.4)	254(42.4)	152(25.2)
Xb3 incapable of comfort life	193(32.2)	273(45.5)	134(22.3)
Xb4 worry about life in the future	266(44.4)	241(40.2)	93(15.4)

Table3 showed stress frequency of positive recognition in the correlation index question matrix among variables. Stress frequency of positive recognition showed us care patient, enjoy care of patient. Stress frequency of positive recognition showed us care patient, enjoy care of patient, glad to see the patients were confirmative and positively in elderly asocial activity.

Otherwise, for the non-participated elderly, the greatest correlation with well-being aging was mental health.

Table3. Stress frequency of positive recognition (n=600)
Unit = people(%)

index of questions	category of response		
	not at all	sometimes	often
Xc1 willing to care patients	144(24)	330(55)	126(21)
Xc2 enjoy care of patients	96(16)	276(46)	228(38)
Xc3 something to live for care	171(28.5)	360(60)	69(11.5)
Xc4 satisfying patients care	167(27.8)	414(69)	19(3.2)
Xc5 becoming close to patient	150(25)	354(59)	96(16)
Xc6 glad to see the patients	60(10)	372(62)	168(28)
Xc7 cheer up by taking care	144(24)	408(68)	48(8)
Xc8 thanks for your care	126(21)	354(59)	120(20)

Table4 presents correlation Response of abuse tendency for care. Xd1, Xd2, Xd3, Xd4, Xd5 of variables show us negative of categories. Namely, tie to beds, throw something, hit with fist, push down, care for roughly were significantly and not accepted related to physical and psychological abuse refusal in both.

Table4. Response of abuse tendency for care n=600, (%)
Unit = people(%)

index of questions	category of response			
	never done and thought	thought but never done	sometimes	often done
physical abuse				
Xd1 tie to beds	552(92)	33(5.5)	7(1.2)	8(1.3)
Xd2 throw something	529(88.2)	37(6.2)	18(3.0)	16(2.6)
Xd3 hit with fist	546(91.0)	43(7.2)	6(1.0)	5(0.8)
Xd4 push down	540(90)	26(4.4)	13(2.2)	21(3.4)
Xd5 care for roughly	517(86.2)	43(7.2)	29(4.8)	11(1.8)
psychological abuse refusal				
Xe1 not believe to say	366(61)	96(16)	120(20)	18(3)
Xe2 not talk back the patients	362(60.3)	93(15.5)	116(19.4)	29(4.8)
Xe3 turn deaf ear to the demands of patient	357(59.5)	98(16.4)	123(20.4)	22(3.7)
Xe4 not give patients the chance to talk with	471(78.5)	53(8.8)	56(9.3)	20(3.4)

Stress frequency of positive recognition showed us care patient, enjoy care of patient, glad to see the patients were confirmative and positively in

elderly asocial activity participated elderly.

Otherwise, for the non-participated elderly, the greatest correlation with well-being aging was mental health.

in Table5, two groups differ. In case of the verbal offence, influence of 'never done and thought were more than thought but and never done. Otherwise, neglect of abuse were too. That makes two of us.

Table5. Verbal offence and neglect of abuse tendency for care n=600, (%)

Unit = people(%)

index of questions	category of response			
	never done and thought	thought but never done	sometimes	often done
verbal offence				
Xf1 use words that death conscious	486(81)	51(8.5)	41(6.8)	22(3.7)
Xf2 rail at the patients	522(87)	41(6.9)	21(3.4)	16(2.7)
Xf3 slander and yell the patients	480(80)	61(10.2)	35(5.8)	24(4.0)
Xf4 denounce patients	492(82)	47(7.8)	39(6.5)	22(3.7)
neglect				
Xg1 take patient to the hospital	487(81.2)	44(7.4)	25(4.2)	43(7.2)
Xg2 let patient without dementia care	494(82.3)	41(6.8)	27(4.5)	38(6.4)
Xg3 left the patient alone	505(84.2)	23(3.9)	21(3.5)	51(8.4)
Xg4 not change diapers or clothes	481(80.2)	41(6.8)	24(4.0)	54(9.0)
Xg5not give the patient bathes	488(81.4)	63(10.5)	30(5.0)	19(3.1)

3. Examination of construct validity and reliability of the method

The fitness for the data in the negative recognition of stress of factor model were GFI=0.954, RMSEA=0.62 and Coefficient of α is 0.834. The fitness to the data in the positive recognition of stress of factor model were GFI=0.905, CFI=0.915 RMSEA=0.078 and Coefficient of α is 0.944.

4. The relationship between stress for main caree worker and the elderly

Supposed that the negative recognition of stress with care worker and positive recognition of care worker to the stress were independent variables, in which 3 type of abuse to the elderly were depending variable. The degree of fitness to the data were GFI=0.841. CFI=0.868. RMSEA=0.066. Among the pass coefficient noted previous model, negative recognition of stress and 3 factor of elderly abuse were significant. In addition, path coefficient heading from positive recognition of stress to negative recognition of stress was statistically significant. Only sex is related among the controlled variables.

Ⅴ. Conclusion

Major results of this study was as follow. First of all, higher, the score of negative recognition of stress of the main care worker have, the possibility of practice of physical status the more the possibility physical, psychological and neglect to frail and dementia elderly they do. In previous study, We clarified that negative recognition of stress is related closely to occurrence of psychological abuse. This study was given suggestion by the study of Lawton. In addition, this study could make clear negative recognition of stress not effect only psychological abuse but wider range of elder abuse such as physical abuse and neglect. This fact mean Lazarus and Folkman that negative recognition of stress cause negative coping would be applicable to the frail and dementia elderly care scene.[12] Secondly, in the result of strength of relationship between negative stress and abuse is relationship of psychological abuse is highest, next is one of neglect and physical abuse. This findings suggest negative recognition of stress would effect each factor not equally , but the degree of effect has systematic order. This systematic order would be important for material to development of method for early direction of elder abuse. Thirdly, in this study it would be clarified that positive recognition of stress, family care-worker would contribute to restrain the occurrence of abuse through decreasing negative cognition of stress, not function directly to decrease the occurrence of abuse. Referring to two factor theory of happiness model raised by Lawton is proposed that is applied in caring practice. The result of this study would support their model while positive

recognition of stress would be resource that reduce the negative recognition of stress for care.

However this hypothesis should be investigated by verifying it prudently. The result of the study showed the character of main care-worker, especially sexual discrimination would effect positive recognition of stress accompanied by care. Concretely female care worker would related to their action of physical abuse comparing to make worker. Therefore, it is necessary to consider the resources that would heighten the positive recognition taking into consider the fact, too. To develop the adequate early finding and intervention for elderly abuse, the extension and refinement of model are required for not only limited to explore the factors of occurrence of abuse, but specifying the casual relationship among the factors and to grasp the mechanism until occurrence of abuse.

These efforts will produce various social distrust community. The findings of this study will provide useful information for social workers who develop programs to help the old people increase successful aging through perception of psychological and physical positive assessment of self, improvement of mental health.

Finally, if you aren't in a position to help an elder personally, you can volunteer or donate money to the cause of educating people about elder abuse, and you can lobby to strengthen laws and policing so that elder abuse can be investigated and prosecuted more readily. The life you save down the line may be your own.

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