

**An evaluation of social work
support groups with informal
caregivers to prevent elder abuse
and neglect: A Namibian
perspective**

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An evaluation of social work support groups with informal caregivers to prevent elder abuse and neglect: A Namibian perspective

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Promoter: Prof H Strydom

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DECLARATION

I, **Janetta Agnes Ananias**, declare herewith that the thesis entitled “**An evaluation of social work support groups with informal caregivers to prevent elder abuse and neglect: A Namibian perspective**” which I herewith submit to the North-West University, Potchefstroom campus in compliance with the requirements set for the PhD in Social Work Degree, is my own original work, has been language edited and has not already been submitted to any other university. All the sources cited in this thesis have been acknowledged and referenced.

.....
Signature

.....
Date

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DEDICATION

This thesis is dedicated to my parents, Basilius and Angelika Lukas, for believing in me, supporting and encouraging me all my life.

FOREWORD

The thesis is presented according to the article format, in accordance with Rules A.11.5.3 and A.11.5.4 that are set out in the Calendar (2013) of the North-West University. Each article will comply with requirements specified in a particular journal in social work. Accredited journals selected are *Social Work/Maatskaplike werk*, *the social work practitioner-researcher/Die Maatskaplike Werk Praktisynnavorser*, *the Journal of family violence* and *the Journal on age and mental health*.

Even though the title of this thesis refers to an 'evaluation', a needs assessment and development of a programme by implication forms part of an evaluation and was also carried out in this research study.

SUMMARY

An evaluation of social work support groups with informal caregivers to prevent elder abuse and neglect: A Namibian perspective

Keywords: support group, informal caregivers, elder abuse, neglect, older persons.

The general objectives of the study were to evaluate a social work support group programme with informal caregivers that aimed to enhance the quality of care provided to older persons in an urban and rural community setting in Namibia. In order to achieve the general objectives of the study, the following specific objectives were formulated:

- To explore how informal caregiving situations in urban and rural communities lead to elder abuse and neglect.
- To describe existing literature on the various factors that contribute to elder abuse and neglect within community settings.
- To develop a support group programme for informal caregivers of older persons in urban and rural community settings that aimed at preventing elder abuse and neglect.
- To implement and evaluate the effectiveness of the support group programme for informal caregivers that aimed at preventing elder abuse and neglect.

The thesis consists of 5 sections:

Section A consists of the problem statement, research objectives, central theoretical argument and the theoretical approaches that underpin the study. Furthermore, the research methodology, the definition of key concepts and the limitation of the study are presented.

Section B contains four articles that together formed part of the research outcomes. Each article can function independently with its own objectives and distinctive content. However, each article is also a sub-project of the umbrella research study. Therefore, some of the data have to be repeated in different sections. The four articles are:

Article 1: Informal caregiving, elder abuse and neglect in urban and rural areas of the Khomas region in Namibia: A needs assessment

A needs assessment on informal caregiving situations and how it may lead to elder abuse and neglect of older persons from an urban and rural constituency in the Khomas region was explored. Data was collected through in-depth interviews with professional and community leaders. In addition, focus group discussions were held with older persons and informal caregivers in the urban and rural constituency.

Article 2: Factors contributing to elder abuse and neglect in community settings

In this article, a comprehensive review of the literature pertaining to the risk and protective factors to elder abuse and neglect was done. The ecological theory was worthwhile to describe the risk factors to elder abuse and neglect.

Article 3: Designing a social work support group programme with informal caregivers of older people in Namibia

A social work support group programme was developed for informal caregivers of older persons in community settings. The eight-week support group programme was developed based on a needs assessment and a comprehensive literature review, and included the following topics; the normal processes of aging, handling of difficult caregiving situations, caregiver stress, self-care of the caregiver, elder abuse and neglect and caregiver grief and loss. The planning model for group work was also utilised to design the group.

Article 4: Evaluation of the effectiveness of a support group programme with informal caregivers to prevent elder abuse and neglect

An eight-week support group programme with ten female informal caregivers from an urban group and twelve informal caregivers from a rural group setting was implemented and evaluated. Standardized measuring instruments that assessed the outcome of the group at pre-test, post-test and postponed post-test were the Zarit Burden Interview (ZBI), Potentially Harmful Behaviour (PHB) scale and the Caregiver Abuse Screen (CASE). The Group Engagement Measure (GEM) assessed the group processes at the fourth, sixth and eight group sessions. In

addition, open-ended questions were used to collect qualitative data. The quantitative and qualitative evaluations indicated that both the urban and rural groups gained knowledge on aging and caregiving, and caregivers acquired vital qualities such as patience, compassion and communication skills. The process evaluation showed that caregivers from the urban group were more engaged in the group process than the rural group. Elder abuse was underreported in the study, while personal stress of caregivers reduced significantly because of the intervention.

Section C consists of the summary of the most important findings and conclusions to the research study. In addition recommendations are provided.

Section D consists of the annexures to the research report, such as the measuring instruments and interview schedules used for data collection.

Section E contains a consolidated list of references.

OPSOMMING

Evaluering van 'n maatskaplikewerk ondersteuningsgroep vir informele versorgers om mishandeling en verwaarlosing van bejaardes te voorkom: 'n Namibiese perspektief

Sleutelwoorde: ondersteuningsgroep, informele versorger, mishandeling, verwaarlosing, bejaarde

Die doel van hierdie studie was om 'n ondersteuningsprogram vir informele versorgers te ontwikkel en te evalueer, wat daarop gemik is om mishandeling en verwaarlosing van bejaardes in 'n stedelike en plattelandse gebied te voorkom. Om die algemene doelstellings te bereik, is die spesifieke doelwitte vir hierdie studie geformuleer:

- Om vas te stel hoe informele versorgingsituasies in 'n stedelike en plattelandse gemeenskap aanleiding gee tot mishandeling en verwaarlosing van bejaardes.
- Om bestaande literatuur oor die verskeie faktore wat aanleiding gee tot mishandeling en verwaarlosing van bejaardes in die gemeenskap te bespreek.
- Om 'n ondersteuningsprogram vir informele versorgers van bejaardes te ontwikkel, wat gemik is op die voorkoming van mishandeling en verwaarlosing van bejaardes in 'n stedelike en plattelandse gemeenskap.
- Om 'n ondersteuningsprogram met informele versorgers te implementeer en te evalueer wat gemik is om mishandeling en verwaarlosing te voorkom.

Die proefskrif bestaan uit 5 afdelings:

Afdeling A bevat onder meer die probleemstelling, navorsingsdoel en doelstellings, sentrale teoretiese stelling en die teoretiese benadering tot die studie. Verder word die navorsingsmetodologie, die definisies van sleutelwoorde en die beperkings van die studie bespreek.

Afdeling B bestaan uit vier artikels wat gesamentlik die navorsings uitkomst beoog. Elke artikel kan onafhanklik staan met sy eie navorsingsdoelwitte, metode en verslag, alhoewel elke artikel ook 'n sub-projek is van die oorhoofse navorsingsprojek. Die vier artikels is:

Artikel 1: Informele versorging, mishandeling en verwaarlosing van bejaardes in stedelike en landelike gebiede van die Khomas streek in Namibia: 'n behoeftebepaling

In 'n behoeftebepaling, informele versorgings situasies en hoe dit kan aanleiding gee tot mishandeling en verwaarlosing in 'n stedelike en plattelandse area was ondersoek. Data was ingesamel deur individuele onderhoude met professionele en gemeenskapsleiers te voer. Verder was fokus groep besprekings met bejaardes en informele versorgers in 'n stedelike en landelike gebied gedoen.

Artikel 2: Faktore wat bydra tot mishandeling en verwaarlosing van bejaardes in die gemeenskap

In hierdie artikel is 'n literatuurstudie gedoen oor die risiko en beskermende faktore van mishandeling en verwaarlosing van bejaardes wat gebaseer is op die ekologiese teorie.

Artikel 3: 'n Maatskaplikewerk ondersteuningsgroep met informele versorgers van bejaardes in Namibia

'n Maatskaplikewerk ondersteuningsprogram is ontwikkel vir informele versorgers van bejaardes in die gemeenskap. Die agt weke ondersteuningsgroep is ontwikkel na aanleiding van 'n behoeftebepaling en literatuurstudie, en het die volgende onderwerpe ingesluit naamlik, die normale prosesse van veroudering, hantering van moeilike versorgingsituasies, versorgingstres, selfversorging van die versorger, en versorger rou en verlies. Die beplanningsmodel vir groepwerk was verder gebruik om die program te ontwikkel.

Artikel 4: Evaluering van 'n maatskaplikewerk ondersteuningsprogram met informele versorgers om mishandeling en verwaarlosing van bejaardes te voorkom

'n Agt weke maatskaplikewerk ondersteuningsgroep met tien informele versorgers van 'n stedelike groep en twaalf informele versorgers van 'n plattelandse groep was geïmplementeer en geëvalueer. Gestandaardiseerde meetinstrumente wat gebruik is gedurende die voortoets, natoets en uitgestelde natoets was die Zarit Burden Interview (ZBI), Potentially Harmful Behaviour (PHB) skaal en die Caregiver Abuse

Screen (CASE). Die Group Engagement Measure (GEM) het die groep proses gemeet tydens die vierde, sesde en agtste groepsessies. Verder was oop vrae gebruik om kwalitatiewe data te versamel. Die kwantitatiewe en kwalitatiewe evaluasies het bevind dat beide die stedelike en plattelandse groepe kennis opgedoen het oor veroudering en versorging, en dat versorgers kwaliteite ontwikkel het soos geduld, meelewing en kommunikasie vaardighede. Die proses evaluasie het bevind dat versorgers in die stedelike groep meer betrokke was by die groep proses as die landelike groep. Mishandeling van bejaardes is onder gerapporteer, terwyl persoonlike stres van versorgers verminder het as gevolg van die ondersteuningsprogram.

Afdeling C bestaan uit die opsomming van die belangrikste bevindinge en gevolgtrekkings van die ondersoek. Verder word aanbevelings in afdeling C gedoen.

Afdeling D bestaan uit bylaes tot die navorsingsverslag, byvoorbeeld die meetinstrumente en riglyne vir die onderhoud wat gebruik was vir data-insameling.

Afdeling E bestaan uit 'n saamgestelde bronnelys

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SECTION A:

GENERAL INTRODUCTION

1 STATEMENT OF THE PROBLEM

The population of people older than 60 years has increased drastically worldwide. In 1950, there were an estimated 205 million older people in the world. The number increased to 606 million in the year 2000. The United Nations predicts that the global population aged 60 years and above will be 1.2 billion in the year 2025. By the year 2050, the number of older people is projected to increase to 2 billion (World Health Organization, 2002; World Health Organization, 2008). Accurate demographic data of older people in Sub Saharan Africa are scarce, however, compared to developed countries, the number of older people in Africa is projected to increase at an even faster rate. According to Velkoff and Kowal (2007:1-4), in the year 2006, 35 million people were aged 60 years and above in Sub-Saharan Africa. This number is projected to increase to 69 million in 2030. Between 2030 and 2050, the number of older people in Sub Saharan Africa is projected to further increase to over 139 million.

Elder abuse was recognized as a serious problem in the United Nations report of the Second World Assembly on Aging (2003), and occurs in both developing and developed countries. According to Anetzberger (2008:15), and Diachman (2005:324), national prevalence and incidence studies on elder abuse were only carried out in selected developed countries. In a large-scale random sample survey on the prevalence of elder abuse and neglect in the USA, Pillemer and Finkelhor (1988:51-57) found that 3.2% of people above 65 years experiences physical abuse, verbal abuse or neglect. Physical abuse was the most common form of abuse, and surprisingly, spouses were most often the abusers. The survey also found that both men and women were victims of abuse, but women would suffer more serious forms of abuse. Ten years later, a National Elder Abuse Incident Study (NEAIS), conducted in the USA in 1998, discovered that about 450 000 cases of elder abuse in domestic settings were reported to the relevant authorities (National

Center on Elder Abuse, 1998:18). The study further reported the characteristics of the victims of elder abuse to be mostly female, the frail older person, above the age of 80 years, while the alleged perpetrator of elder abuse is often a male, younger than 60 years and an adult child or family member of the older person (Lowenstein, 2010:217; National Center on Elder Abuse, 1998:18).

In a systematic review of 49 studies on elder abuse, Cooper *et al.* (2008:151), found that 6% of older people reported that they had experienced abuse in the previous month, 5.6 % had been physically abused by their spouses in the previous year, and a quarter of older people had experienced psychological abuse. In the same report, the nursing staff of old age homes admitted that they were psychologically abusive towards older people while family caregivers also admitted being physically abusive towards older persons.

Although very few prevalence and incidence studies have been carried out in developing nations, small-scale studies show that elder abuse is common. Diachman (2005:324) assessed the perceptions of older people on elder abuse in a random sample study of South American towns and found that 45% of older people admitted that they were mistreated at some point in their lives.

Very little research has been undertaken on elder abuse in Namibia. However, in a 2006 report, the Ministry of Health and Social Services reported that an alarming 21% of older people had experienced physical abuse, 7% experienced sexual abuse and 18% of the elderly had been emotionally abused. In an unpublished study, Klie and Ananias (2010) explored the perceptions of university students on elder abuse and found that both women and men from urban and rural settings were victims of financial abuse, neglect and abandonment, emotional abuse, physical abuse, sexual abuse as well as partner violence. The study also found that the perpetrators of elder abuse were either male or female family members, community members or even strangers.

Timonen (2008:110) is of the opinion that the majority of older people are well functioning individuals not in need of any care. However, the researcher is in agreement with Hooyman and Kiyak (2011:394) that some older people above the age of 65 may need informal care from family, friends or neighbours. Many

countries in both developed and the developing world rely heavily on families as informal caregivers of older persons. However, as Timonen (2008:11) notes, there is little knowledge about the basic aspects of informal care. Hooyman and Kiyak (2011: 394) mention that informal caregiving of older people take place on a daily basis, and an average of 25 hours per week is spent on caregiving. In fact, it has been found that the more the older person is advancing in age and their chronic conditions progress, the higher the hours of caregiving provided.

The mean age of informal caregivers is 47 years, but the ages of caregivers may vary between young and old. Hooyman and Kiyak (2011:394) pointed out that children between the ages of 8-18 years could be caregivers of their parents and grandparents, while people above the ages of 60 and 70 years may care for their surviving parents, spouses, children or grandchildren. Caregivers are typically female, not engaged in paid work and live under impoverished circumstances due to lost chances to engage in paid work.

According to Kart and Kinney (2001:262), one family member normally assumes the role of primary caregiver, and is primarily responsible on a day-to-day basis to care for the older person. In some instances, the primary caregiver may be assisted by a secondary caregiver who offers supplementary support. The researcher is of the opinion that a primary caregiver without any additional help may find the caregiving responsibility very stressful, which has implications for elder abuse.

Reasons for elder abuse and neglect by informal caregivers, according to Hooyman and Kiyak (2011:419), are caregiver stress, other emotional and behavioural problems experienced by caregivers, and power inequalities between the caregiver and older persons. MacNeil *et al.* (2010:83-84) added that some caregivers may have strong emotions of anger produced by anxiety, depression and resentment because of care giving responsibilities, which may lead to potential harmful behaviours displayed towards the older person.

Support groups with caregivers can be regarded as one of the social work interventions to address the challenges caregivers are experiencing as well as reducing the occurrence of elder abuse and neglect. Lee (2008:707-712) assessed the risk and mediating factors that lead to elder abuse amongst 1000 Korean family

caregivers; and confirmed that psychosocial support services and programmes offered to family caregivers can prevent elder abuse, and that support groups for caregivers could be an effective intervention programme. Bergeron and Gray (2003: 96-105) suggest that topics such as caregiver stress, and linking caregivers with community resources, be discussed in support groups with caregivers of older people.

Compared to the social problems of child abuse and domestic violence, very few high quality intervention studies have been carried out in the field of elder abuse (Ploeg *et al.*, 2009:187-210). Penhale (2010:249) also agrees that elder abuse interventions are still at an early stage and developing slowly, as more intervention studies on elder abuse and neglect need to take place to find answers to the best techniques for interventions.

Very little evidence exists on successful elder abuse intervention research. It is worth noting, however, amongst the few intervention studies that have been conducted, educational support group interventions indeed led to a reduction of caregiver psychological abusive behaviour towards older people as well as increased knowledge in caregiving amongst the experimental group (Hsieh *et al.*, 2009:377-386). In a systematic review to evaluate the quality of elder abuse interventions studies, only one rigorous intervention study in 1989 by Scogin *et al.* (cited by Ploeg *et al.*, 2009:187-210) found both positive and negative outcomes as a result of elder abuse interventions with family caregivers of older people.

It is evident from the preliminary literature sources consulted so far that there is a gap in elder abuse intervention studies worldwide, including Namibia. This study intends to fill the gaps in the literature.

The research questions for this study were:

- How does informal caregiving situations in urban and rural communities lead to elder abuse and neglect?
- What are the factors contributing to elder abuse and neglect within community settings?
- What does a social work support group programme for informal caregivers to prevent elder abuse and neglect entail?

- How does a social work support group programme with informal caregivers impact on the prevention of elder abuse and neglect?

2 AIM AND OBJECTIVES OF THE RESEARCH

The aim of the study was to ascertain how a developed and evaluated social work support group for informal caregivers of older persons in rural and urban community settings can prevent elder abuse and neglect.

Objectives

The objectives of the study were:

- To explore how informal caregiving situations in urban and rural communities lead to elder abuse and neglect.
- To describe existing literature on the various factors that contributes to elder abuse and neglect within community settings.
- To develop a social work support group programme for informal caregivers of older persons in urban and rural community settings that aimed at preventing elder abuse and neglect.
- To implement and evaluate the effectiveness of a social work support group programme for informal caregivers that aimed at preventing elder abuse and neglect.

3 CENTRAL THEORETICAL ARGUMENT

Caregiver support groups can offer a platform to express both positive and negative experiences about informal care giving. Social work support groups can be useful for informal caregivers to prevent, reduce or address potential situations that may lead to elder abuse.

4 THEORETICAL APPROACHES TO THE STUDY

Three theories were regarded as relevant to gain a thorough understanding of the key concepts in this study; the ecological theory was useful to gain a better understanding on the risk and protective factors on elder abuse and neglect, the

intergenerational solidarity theory brought more insight into the interactions of different generations in the caregiving context, while the solution-focused theory was useful for concentration on the solutions for the support group programme with informal caregivers.

4.1 Ecological theory

According to Shields (2010:22-23), the ecological theory is one of the most researched theories to explain elder abuse. Payne (cited by Pierson & Thomas, 2010:190) claims that the ecological theory focuses on the adaptive and mutual relationship between people and their environment. In the context of elder abuse, the ecological theorist has a keen interest in the interactions between the older person and the caregiver as well as within the caregiving and broader societal contexts (Penhale, 2010:239; Podnieks *et al.*, 2010:161; Schiamberg *et al.*, 2011:195). The ecological theory suggests that elder abuse and neglect may occur at four systems, namely, the micro, meso, exo and macro systems Gans and Schiamberg (cited by Shields, 2010:22-23). The micro system refers to the relationship between the older person and his or her caregiver. The meso-system refers to the relationship between the older person and church or community services, the exo-system focuses on the impact of a caregiver's workplace on caregiving while the macro system refers to the interactions of the older person with health and government services. In later works by Schiamberg *et al.* (2011:207) the chrono-system is added as a fifth level that focuses on the timeframe an older person has been staying in a potential abusive environment. These systems may overlap, since risk factors found in the one system may also appear in another system (Schiamberg & Gans, 1999:93-94).

4.2 Intergenerational solidarity theory

The intergenerational solidarity theory is of relevance to this study as it provides an understanding of the associations between informal caregivers and older care recipients. The theory further describes the relations between and amongst people in multigenerational family networks and amongst different age groups (Kim, 2010:2). According to Lüscher (2011:193), the intergenerational solidarity theory was developed in the United States in response to the concept of the isolated

nuclear family, and became popular through research on aging and intergenerational solidarity relations. Moreover, the intergenerational bonds amongst family members are regarded as more important because older persons live longer these days (Katz & Lowenstein, 2012:6); therefore, the needs and wellbeing of older persons can be better understood within the family caregiving context. Many older people in Namibia live in community settings in multigenerational households that consist of people from different age groups.

4.3 Solution-focused theory

The solution-focused approach is a relatively new theory, which originates from family therapy and systematic practices, and developed by de Shazer and associates at the brief family therapy centre in the USA (Sharry, 2007:7). Different from pathology-centred therapists who concentrate on the problem, its causes and development; solution-focused therapists are directed towards the solution, preferred futures and goals (Saadatzaade & Khalili, 2012:780; Sharry, 2007:7). The goal of group work from the perspective of solution-focused therapy is to create a culture of positive, supportive interpersonal communication among group members (Sharry, 2007:12). Practitioners who follow the solution-focused approach concentrate on the skills and solutions rather than shortfalls and problems (Saadatzaade & Khalili, 2012:780). Types of structured exercises used in solution-focused groups are, amongst others, the miracle question using creative visualization, group brainstorm for solutions, role plays and mind mapping (Sharry, 2007:166). This support group with informal caregivers used in this study is based on the solution-focused approach because of its strength-based emphasis on the positives instead of deficits.

5 METHODS OF INVESTIGATION

In this investigation, a literature study and an empirical research project were undertaken.

5.1 Analysis of the literature

A number of primary and secondary sources were consulted such as books, journals and websites to gain an understanding on elder abuse as a social problem,

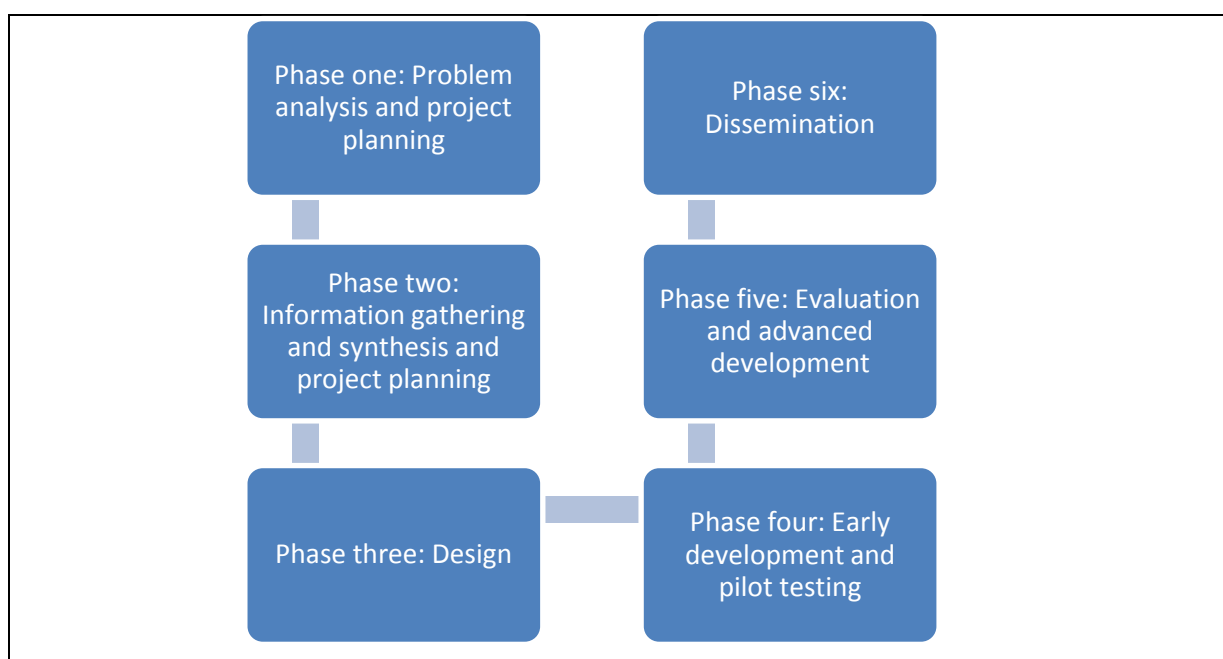
as well as useful interventions for informal caregivers as a response to elder abuse. Databases consulted included: EBSCOHOST, Academic Search Premier, Cinahl, Psych Articles, SocIndex and other online peer reviewed journals.

Themes that were used to analyse, integrate and synthesize the literature were amongst others, elder abuse, violence, neglect, mistreatment, maltreatment, informal caregiver, family member, care recipient, care provider, older person, caregiver support and support groups.

5.2 Empirical investigation

The intervention research approach was the most appropriate to evaluate this innovative applied study with informal caregivers from urban and rural communities that aimed at preventing elder abuse and neglect (De Vos & Strydom, 2011:475). Intervention research is often used in large-scale studies, where quantitative and qualitative studies are combined in a mixed method research (Babbie, 2010:363; Neuman, 2011:27-28). The exploratory mixed method design was applied in this study (Delpont & Fouche, 2011:441); which started off with a qualitative exploration, that eventually led to the development and quantitative evaluation of the support group programme. All the six phases of the intervention research were applied in this study (De Vos & Strydom, 2011:476), (See Diagram 1).

DIAGRAM 1: PHASES OF THE INTERVENTION RESEARCH PROCESS



Phase one: Problem analysis and project planning

Six critical actions are highlighted by De Vos and Strydom (2011:477) during problem analysis and project planning phase. The informal caregivers of older persons were identified as the population with whom the researcher would collaborate. In order to gain access and cooperation from the population, the researcher engaged in conversations about the intended programme and its benefits with key informants such as political leaders, community leaders, church leaders, and professionals. To provide a sense of ownership, key informants were also involved in identifying the problem, planning and implementation of the intervention. The researcher did not impose her own views about the problem under study, but gathered various perceptions from community leaders, professionals, older people themselves and from informal caregivers about informal caregiving situations in urban and rural communities and vulnerabilities to elder abuse and neglect. The identified problem was analysed as follows: The majority of the older people in Namibia lives in community settings, are caregivers themselves or are being cared for by informal caregivers. Although informal caregiving can be a rewarding fulfilling experience, it may at times also be highly stressful, a situation which may result into elder abuse. Gender-based violence is a concern that receives some attention in Namibia, however, elder abuse is not sufficiently acknowledged in Namibia. In fact, interventions to address elder abuse and neglect, and in particular, the situation of informal caregivers is lacking in Namibia. Therefore, the need to develop, implement and evaluate a support group programme with informal caregivers from urban and rural communities to prevent elder abuse and neglect was identified.

Phase two: Information gathering and synthesis

The researcher conducted an in-depth literature review from a variety of sources to gain an understanding of the various factors that contribute to elder abuse and neglect within informal caregiving community situations. A review of literature on successful and unsuccessful models or programmes on elder abuse interventions was also done. The researcher conducted key informant interviews with various service providers, as well as community and political leaders who were most knowledgeable on informal caregiving, and elder abuse and neglect. In addition,

focus group discussions were conducted with older persons and informal caregivers. Insight gained from the literature review on successful support group programmes as well as results from the needs assessment were used to develop a support group programme with informal caregivers to prevent or reduce elder abuse.

Phase three: Design

According to De Vos and Strydom (2011: 482) two important tasks are carried out in the design phase namely, the design of an observational system and specifying procedural elements of the intervention. Standardized measuring instruments chosen as an observational system during the pre, post and postponed post-test were the Zarit Burden Interview (ZBI) (Annexure 11), the Potentially Harmful Behaviour (PHB) scale (Annexure 12) and the Caregiver Abuse Screen (CASE) (Annexure 13) were used to measure burden and caregiver behavioural outcomes. The process of social work groups, as outlined by Toseland and Rivas (2005:85-89), can be useful to assess effectiveness of a group intervention. Therefore, the Group Engagement Measure (GEM) (Annexure 14) appraised process outcomes of the intervention at the 4th, 6th and 8th group session. Furthermore, qualitative data in the form of open-ended questions (Annexure 15) were also collected to evaluate the support group programme. Finally, procedural elements in terms of a step-by-step planning of the group work intervention were also carried out to ensure that the support group programme with informal caregivers can be replicated by any other practitioner.

Phase four: Early development and pilot testing

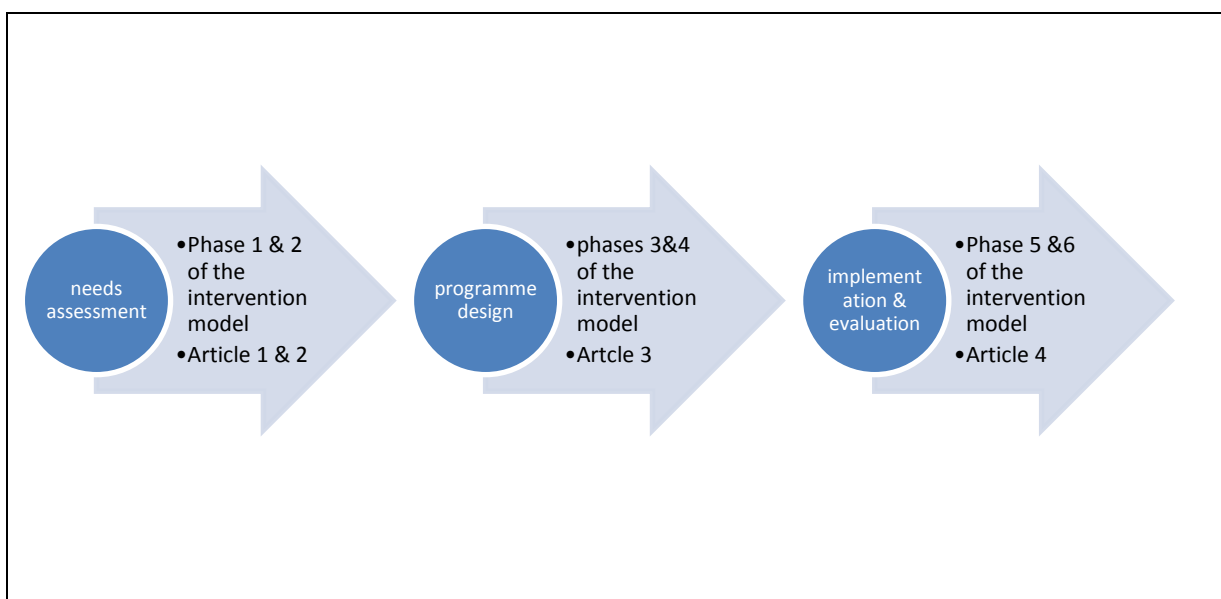
In this phase of the intervention model, the support group programme was tested for its adequacy. The prototype support group programme was completed before any attempt was made to announce the group or to screen group participants (De Vos & Strydom, 2011:484). To collaborate with other researchers and social work practitioners, inputs on their comments concerning the draft support group programme was sought and the necessary amendments were made to the programme.

Phase five: Evaluation and advanced development

A single system design was chosen as an appropriate design to evaluate the effectiveness of the support group intervention. According to Strydom (2011:160), a single system can be a group, family or community. Support groups with informal caregivers in an urban and rural area were two single systems on which the intervention was applied. During the intervention, quantitative and qualitative data was collected and analysed at different stages while the comments and evaluations of the group participants were used for the further refinement of the intervention programme (De Vos & Strydom, 2011:485).

Phase six: Dissemination

De Vos and Strydom (2011:487) assert that intervention research results must be disseminated with community organisations, scholars, and other stakeholders. The programme will be disseminated to the Ministry of Health and Social Services, as the government agency responsible for policy and programmes on older people. This support group programme can be replicated by social workers from other regions throughout the country as an intervention programme on community care of older persons. To reach out to a broader scholarship, articles will also be submitted to accredited journals for possible publication, and findings will be presented at national, regional and international conferences. The process of dissemination and adaptation would be effective if the following actions are considered, namely preparing the product for dissemination, identifying potential markets for the intervention, creating a demand for the intervention, appropriate adaptation and providing technical support for adopters (De Vos & Strydom, 2011:487). For a more practical application of the intervention model, the six phases of the intervention research model were compressed into three phases, as outlined in (Diagram 2), namely the needs assessment phase, the programme design phase and the programme implementation and evaluation phase.

DIAGRAM 2: PHASES OF THE RESEARCH STUDY

5.2.1 Needs assessment phase

Needs assessment, as part of the intervention research model, is often conducted before an intervention programme is compiled and evaluated (De Vos & Strydom, 2011:475). In the needs assessment phase, key informant interviews and focus group discussions were conducted to gain an understanding of informal caregiving situations that could lead to potential risks of elder abuse and neglect. The purpose of this qualitative phase was to assess the situation of informal community based care of older people, and to identify solutions which were eventually addressed in the intervention phase of the research project.

– Research design

The evaluation design was appropriate in this needs assessment phase, to explore how informal care giving situations in urban and rural communities could lead to elder abuse and neglect (Fouche, 2011:465), whilst the evaluation of the intervention programme was carried out in phase three. Based on the themes identified in the exploration phase, the researcher designed a support group programme for informal caregivers aimed at preventing elder abuse and neglect.

– Participants

The study was undertaken in the Khomas region, which is one of the fourteen political regions in Namibia. The Khomas region is centrally located, and a practical choice for the feasibility of this intervention study. The Khomas region consists of ten constituencies (Annexure 3); the Katutura central constituency has a high concentration of older people while Windhoek rural constituency offers the only rural representation. Qualitative data collection was conducted by means of in-depth interviews with key informants from the Katutura Central and Windhoek Rural constituencies in the Khomas region. In-depth interviews were carried out in offices or other private settings until saturation. The key informant sampling was used as a non-probability sampling method (Strydom & Delpont, 2011:394), to interview identified experts and community leaders who were most knowledgeable on the research question.

Qualitative data was also collected from focus group discussions with older people and informal caregivers who were residing in Katutura Central and Windhoek Rural constituencies in the Khomas region. The population of the older people consisted of all pensioners who are recipients of cash, bank and post office pension payments. The older persons acted as gatekeepers to provide contact details of informal caregivers as potential candidates for the focus group discussions. Focus group discussions were done with older persons and informal caregivers from Katutura central and Windhoek rural constituencies at a convenient time and place until saturation was reached. The purposive sampling method, as a non-probability sampling method was used to select the older people and the informal caregivers as participants of the focus group discussions (Bryman, 2008: 458; Strydom & Delpont, 2011: 392). The inclusion criteria for the older persons as participants of the focus group discussions were the following; they must (i) be above the age of 60 years, (ii) reside in Katutura central or Windhoek rural constituency, (iii) not suffer from any cognitive or mental disability and (iv) have a caregiver.

– Measuring instruments

Interview schedules (Annexure 5-7) were developed for both the focus group discussions and the key informant interviews. The interview schedules consisted of

open-ended questions (Bryman, 2008:442; Greeff, 2011:352; Rubin & Babbie, 2011:233), and further offered an outline of all the issues and themes to be discussed, including, but not limited to caregiving situations that may lead to elder abuse and neglect. A pilot test of the interview schedule was conducted with participants who did not form part of the sampling and the necessary amendments to correct errors were made. Due to the diverse number of languages spoken in Namibia, and to ensure optimal participation, interviews took place in the language of choice of the participants. During the focus group discussions research assistants were used to make translations into the languages the researcher could not speak.

– Research procedures

The following procedures were followed in the needs assessment phase:

- Permission was obtained from the Ministry of Health and Social Services (Annexure 2) and the local Councillors of the respective constituencies.
- Semi-structured interview schedules (Annexure 5 -7) were developed for the key informant interviews and the focus group discussions.
- Informed consent forms (Annexure 4) were prepared and signed by all the research participants.
- Key informant sampling and purposive sampling were used to select the participants.
- All the focus group discussions and the interviews were tape-recorded and then transcribed verbatim (Annexure 8).
- Data were analysed and themes to be incorporated in the intervention programme were identified.
- Based on the literature review and the qualitative data the social work support group programme for informal caregivers to prevent elder abuse and neglect was designed.

- Ethical aspects

Many scholars discuss ethical consideration in research (Babbie, 2010:64-70; Creswell, 2009:87-98; Strydom, 2011:115-126). The following ethical aspects were considered in this study.

- Avoidance of harm

Rubin and Babbie (2011:78-79) and Strydom (2011:115) argue that many respondents of social science research may be exposed to emotional harm because of the nature of some studies. In this study, the researcher took precautions to ensure that participants were not exposed to either physical or psychological harm. Debriefing sessions with participants in qualitative studies can minimize potential harm (Strydom, 2011:122). Therefore, debriefing sessions were conducted by the researcher with especially the participants of the focus group discussions immediately after data gathering. The debriefing sessions were intended to help participants work through their experiences. The key informants and all the participants of the focus group discussions were not forced to take part in the study; they did so voluntarily.

- Informed consent

According to Strydom (2011:118), proper informed consent procedures must be followed for every research project. Thus, in this research, every participant received a thorough explanation about the research project before they consented to the study. The researcher prepared an informed consent form (Annexure 4), that explained the purpose of the study, aspects around voluntary participation and freedom to withdraw as well as privacy and confidentiality. A copy of the signed informed consent form was issued to every participant. Illiterate older persons and informal caregivers from the focus group discussions could verbally consent to participate in the study. Permission to use tape recorders was also sought from the participants.

– Data analysis

According to Creswell (2009:183), qualitative data analysis is a process whereby the researcher prepares the data for analysis. Different analyses can be conducted to find themes and patterns in order to gain deeper understanding of the data, with a final interpretation of the larger meaning of the data. In this study, all the audio-recorded data, collected from the focus groups discussions and key informant interviews were transcribed verbatim (Annexure 8). The ATLAS-ti version 7 data analysis software was utilised to analyse the qualitative data according to themes and categories.

5.2.2 Programme design phase

Based on the needs assessment conducted in phase one as well as the literature review, the programme design was carried out. This phase basically involved a desk review that entailed the development of a comprehensive support group programme for informal caregivers of older persons. The programme design was carried out over a period of two months from March to April 2013, after which the support group programme was implemented and evaluated in the subsequent phase.

5.2.3 Programme implementation and evaluation phase

The actual social work support group programme with informal caregivers was implemented and evaluated in this phase. The intervention aimed at offering a platform for informal caregivers to share both positive and negative experiences about caregiving, and to find effective ways to better respond to older persons that could reduce chances of abusive or neglectful behaviour towards older care recipients.

The support group programme consisted of eight group sessions as well as a follow up session. The follow-up session was conducted, six weeks after the support group was terminated. Each group session lasted between 60 and 90 minutes. All the group sessions were conducted in the church Hall. Common concerns that informal caregivers had that could influence abusive or neglectful behaviour towards older persons, were amongst others, difficult caregiving situations, aging, stress, self-care as well as grief and loss.

– Design

A single system design was used in this study (Strydom, 2011:160), to evaluate the effectiveness of the support group intervention with informal caregivers of older persons. Support groups with informal caregivers from urban and rural communities were two single systems on which the intervention was applied. Quantitative data was collected repeatedly from both the urban and rural groups at pre-test before the intervention commenced, post-test at the termination of the support group programme, and again at postponed post-test six weeks after the intervention had ended to measure the outcome of the group. The effect of the intervention was therefore assessed by comparing the changes from observations of the urban and rural groups at different pre-test, post-test and postponed post-tests intervals (Toseland & Rivas, 2005:403). Furthermore, process evaluations of the group dynamics was conducted at the fourth, sixth and eight group session. Qualitative data was also collected through open-ended questions to evaluate perceptions of informal caregivers on the outcome of the support group programme.

– Participants

A total of 22 female informal caregivers of older persons took part in two support groups, with ten caregivers from the urban area in one group and twelve caregivers from the rural area in another group. Caregivers were eligible for the study if they met the following criteria:

- A child, spouse, sibling or extended family member in the role of primary caregiver;
- Who assist an older person with one or more Activities of Daily Living (ADL);
- Willing and available to participate voluntarily for the duration of the programme; and
- Residing in the urban or rural constituency in the Khomas region.

– Measuring instruments

In order to evaluate the outcome of the intervention, the researcher used the Zarit Burden Interview (ZBI) (Annexure 11), the Potentially Harmful Behaviour (PHB) scale (Annexure 12) and the Caregiver Abuse Screen (CASE) (Annexure 13). A

pilot testing of the questionnaire was done to correct any ambiguity or other errors. The same questionnaire was administered to both the urban and rural groups at pre-test, post-test and postponed post-test intervals. It was not only the outcome of the group intervention, but also the group process that needed to be evaluated. Therefore, the researcher used the Group Engagement Measure (GEM) (Annexure 14) to evaluate the level of engagement and participation of the group members, at the 4th, 6th and 8th group session. Quantitative measures are normally employed in intervention research. However with small group participants (Fouche, 2011:449) claims that open-ended questions often offer limitless options for participants to share their experiences concerning the support group. Therefore, a qualitative open-ended schedule (Annexure 15) was also used in the study.

– Procedures

The following procedures were carried out in the intervention phase of the research project:

- Recruitment and random selection of research participants for both the groups in the Katutura Central and Windhoek Rural constituencies;
- Implementation and evaluation of the support group programme; and
- Analysis of the data.

– Ethical aspects

Many scholars discuss ethical consideration in research (Babbie, 2010:64-70; Creswell, 2009:87-98; Strydom, 2011:115-126). The ethical aspects that were considered in this study were avoidance of harm, voluntary participation of both urban and rural groups, informed consent, and confidentiality.

Permission for the study was also obtained from the Ethics Research Committee of the North-West University (Annexure 1), as well as from the research committee of the Ministry of Health and Social Services of the Republic of Namibia (Annexure 2).

– Data analysis

The quantitative data was processed with the assistance from the Statistical Consultation Services of the North-West University (Potchefstroom Campus).

Tesch's approach was used to analyse the qualitative data manually (Poggenpoel, 1998:343-344).

6 LIMITATIONS OF THE STUDY

The study had limitations in a number of ways:

Firstly, the study was only carried out in the geographical area of the Khomas region, and thus cannot be generalized to the rest of the Namibian population. In any case, qualitative studies, which were part of the needs assessment, do not need generalization. Intervention studies are practically also not possible to be carried out with big sample sizes.

Secondly, a non-controlled pre-test, post-test and postponed post-test was done with the informal caregivers from the rural and the group as two single systems. However, a comparison group for both the rural and urban group was lacking because caregivers as a target population were not easily accessible.

Thirdly, the Potentially Harmful Behaviour (scale) and the Caregiver Abuse Screen (CASE), among the few existing standardized measuring instruments for elder abuse and neglect behaviour outcomes, only focused on psychological and physical abuse, thus other forms of elder abuse and neglect could not be measured.

Fourthly, it is generally difficult to obtain access to informal caregivers of older people. Caregivers at risk of displaying abusive or neglectful behavior towards the older person are even more difficult to access. The intervention study could have yielded different results if informal caregivers at risk of displaying abusive behaviours towards the older person could take part in the study.

7 DEFINITION OF KEY CONCEPTS

For the purpose of this research, the following key concepts will be clarified.

7.1 Older person

There is no universal definition on an older person. In Namibia, all citizens above the age of 60 years qualify to receive a state old age pension. Therefore, for the

purpose of this study, any person 60 years and above will be referred to as an older person.

7.2 Elder abuse

There is no universal definition of elder abuse, and perceptions about what constitute elder abuse differs amongst professionals, caregivers, older persons and even the perpetrators of elder abuse (Barnett *et al.*, 2005:346; Diachman, 2005:326; Ferreira, 2004:19; Hempton *et al.*, 2011:472; Penhale, 2010:236; Schiamberg *et al.*, 2011:192). Differences about the forms and extent of elder abuse further exist between African and Western communities (Donatelli, 2010:672-676; Ferreira, 2004:17; Ferreira & Lindgren, 2008:97-107).

A global definition on elder abuse initially developed by the Action on Elder abuse in the United Kingdom, but adopted by the World Health Organization (WHO) and the International Network on the Prevention of Elder Abuse (INPEA) states that “elder abuse is 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), 2002:126). From a Namibian perspective, elder abuse is defined in the draft Bill on the rights, protection and care of Older People (2002) as ‘the maltreatment of an older person or the infliction of any physical, mental or financial power on an older person which adversely affects that person.’

7.3 Informal caregiver

An informal caregiver can be a family member, neighbour, friend or acquaintance who offers unpaid care in the house of an older person (Hooyman & Kiyak, 2011:394; Timonen, 2008:111). According to Wilson *et al.* (2008:433), informal caregivers offer help to an older relative or friend in the form of active support, social interaction or supervision. For the purpose of this study, an informal caregiver refers to an adult person above the age of 18 years, who can be a family member or not related to the older care-recipient and assisting an older person in the house with some activities of daily living without receiving any remuneration.

7.4 Caregiver support groups

A support group of caregivers consists of a small group of people who share the same interests as providers in the needs of other people who are unable to take care of themselves because of age or frailty. Caregivers often find relief from their stress as caregivers through the mutual support members offer one another (Barker, 2003:51). Toseland and Rivas (2005:21) assert that supportive intervention strategies applied help group members cope with stressful life events, and enhance the coping abilities of group members to be able to adapt and even cope with future stressful life events. Support groups can be facilitated by a social worker or other professional, or be led by the group members themselves as a self-help group. For the purpose of this study a caregiver support group will refer to a small group of informal caregivers with a closed membership, that meet once a week and is co-facilitated by the researcher and practicing social worker.

8 PRESENTATION OF THE RESEARCH REPORT

The research report is presented in article format with the following sections:

SECTION A: GENERAL INTRODUCTION

This section provides an overview to the research study and focuses on the problem statement, aim and objectives, central theoretical argument and well as the theories that underpins the study. Furthermore the research methodology, definition of key concepts and the limitation of the study are also included.

SECTION B: ARTICLES

This section consists of four articles which will be outlined in a schematic presentation below:

FIGURE 1: SYNOPSIS OF SECTION B

TITLE OF ARTICLE	OBJECTIVE OF ARTICLE
1. Informal caregiving, elder abuse and neglect in urban and rural areas of the Khomas region in Namibia: A needs assessment.	To explore how informal caregiving situations in urban and rural communities lead to elder abuse and neglect.
2. Factors contributing to elder abuse and neglect in community settings.	To describe existing literature on the various factors that contributes to elder abuse and neglect within community settings.
3. Designing a social work support group programme with informal caregivers of older persons in Namibia.	To develop a support group programme for informal caregivers of older people from urban and rural community settings that aimed at preventing elder abuse and neglect.
4. Evaluation of the effectiveness of a social work support group programme with informal caregivers to prevent elder abuse and neglect.	To implement and evaluate the effectiveness of the support group programme for informal caregivers that aimed at preventing elder abuse and neglect.

SECTION C: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Section C presents the summary, conclusions and recommendations to this research.

SECTION D: ANNEXURES

This section comprised of the annexures that were utilised in the various articles of this research study.

SECTION E: CONSOLIDATED LIST OF REFERENCES

The final section consists of a consolidated list of references.

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SECTION B: THE JOURNAL ARTICLES

ARTICLE 1

J. A. Ananias & H. Strydom

Informal caregiving, elder abuse and neglect in urban and rural areas of the Khomas region in Namibia: A needs assessment

ABSTRACT

Not much research has been carried out on the state of informal caregiving of older people, elder abuse and neglect in Namibia. Since very few old age homes can be found in Namibia, the vast majority of older people lives in the community and are taken care of by informal caregivers. The objective of this article was to report the findings from a needs assessment on the informal caregiving situations that may lead to potential risk of elder abuse and neglect in urban and rural areas in the Khomas region. Key informant interviews were conducted with professionals and community leaders, while focus group discussions were held with older people as well as with informal caregivers. On the part of the caregivers, findings suggest that informal caregivers are in dire need of information and support to enable them to cope better with the challenges of caregiving. On the part of the care recipients, findings suggest that due to urbanization and westernization, older people, especially in the rural areas, may find themselves without any informal caregiver, which may lead to neglect. Emotional abuse and financial exploitation were found to be the most common types of elder abuse. Very few incidences of physical abuse were reported, and sexual abuse is rare. The discovery that many older people, especially in the rural areas, are staying without an informal caregiver whilst they are in need of such help, as well as the fact that caregivers are in need of information and support are major issues for policy development and practice.

1 INTRODUCTION

Even though most of the older people in Africa live with and are being taken care of by extended family members (Cattell, 1997:38; Ferreira, 2004:6; Oluwabamide & Eghafona, 2012:62); the contributions made by family caregivers are not recognized sufficiently (Hooyman & Kiyak, 2011:395). Family solidarity and care towards older relatives is under threat because women are entering the labour market and the youth are migrating for better job opportunities (Sibai & Yamout, 2012:73; Oluwabamide & Eghafona, 2012:62).

While the family setting should provide safety to older persons, Habjanic and Lahe (2012:261) argue that older people in the family setting are more at risk of abuse. Hooyman and Kiyak (2011:419) confirm that an estimated 2-10 % of older adults are abused by someone who lives with them.

According to Strydom (2003:76) elder abuse is a hidden phenomenon and also underreported. In addition, Hooyman and Kiyak (2011:420) claim that one in four older people is at risk of elder abuse, but only one in five cases of elder abuse is reported.

The aim of this article is to report on a needs assessment with key informants, older people and informal caregivers in urban and rural settings in Namibia.

2 PROBLEM STATEMENT

While there has been much attention given to gender-based violence against women and children in Africa and a number of studies has focused on such abuse (Kalache & Blewitt, 2012:89; Splinter, 2009:6); limited attention has been paid to elder abuse in southern Africa. In Namibia, there have only been a few small-scale studies on the forms of elder abuse and neglect (Klie & Ananias, 2010; Ministry of Health and Social Services, 2006). No reliable data exist on the prevalence and incidences of elder abuse and neglect. Most research related to caregiving of older people in Namibia has focused on institutional care of older people (Dima, 2003; Kloppers, 2011).

In the past twenty years, there has been increased research attention internationally on the phenomenon of elder abuse. Hooyman and Kiyak (2011:393) explain that the majority of older adults above the age of 65 years does not live in institutional facilities but rather informally within family or other community-based settings and receives care from family, friends and neighbours. In fact, the vulnerability of older people to elder abuse and neglect in family and community settings is one of the unexplored facets that has only lately attracted research attention (Lee, 2008; Lowenstein, 2010; Nadien, 2006). Some of these unexplored aspects concerning elder abuse in family and community settings appear to be important and worthy of investigation in the Namibian context.

An investigation is necessary to gain a proper understanding of elder abuse in community settings as well as to make recommendations for the development of policy and programmes that strengthens informal caregiver support systems. Furthermore, previous research has focused primarily on caregiving situations and elder abuse in developed countries. Very little research has been done in urban and rural under-resourced African communities. This needs assessment on informal caregiving, elder abuse and neglect is a direct response to the knowledge gap in Namibia. The article is structured as follows; Firstly, the aim of the research is presented, followed by a discussion on the research methodology. The findings of the needs assessment concerning informal caregiving, elder abuse and neglect are then discussed. Finally, the article is concluded with recommendations and a summary. The research question for this article is *“How does informal caregiving situations in urban and rural communities lead to elder abuse and neglect?”*

3 AIM OF THE ARTICLE

The aim of this article was to explore how informal caregiving situations may lead to neglect and abuse of older people living in urban and rural community settings in the Khomas region in Namibia.

4 METHODOLOGY

4.1 Research design

This part of the study was of a qualitative nature, that explored, through in-depth interviews with community leaders and professionals their perceptions on informal caregiving of older people, as well as to ascertain what informal caregiving situations in rural and urban communities lead to elder abuse and neglect. In addition, focus group discussions were held with older people and informal caregivers to gather data on positive and negative aspects of caregiving, and in particular, perceptions of older people as care recipients and informal caregivers as care providers.

4.2 Research context

The research context for this study is the Khomas region, one of the fourteen regions in Namibia (Annexure 3), situated in the central area of Namibia, with an estimated population of 250 262. The 2001 Population and Housing Census reveals the four predominant languages spoken in the Khomas region are Oshiwambo, Afrikaans, OtjiHerero and Damara/Nama (National Planning Commission, 2003:28). After Namibia's independence in 1990, the Khomas region was divided into ten constituencies (National Planning Commission, 2007:1). This study only focused on two of these constituencies, namely Katutura Central and Windhoek Rural constituency.

The Katutura Central constituency has an estimated population of 21 243. The Katutura residential area was established in 1959 after the forced eviction of black residents from the Old Location. According to Nangombe and Ackermann (2013:185) the residents of Katutura were relocated in accordance with the principle of ethnicity. As a result, a high concentration of specific ethnic groups is still predominantly found in certain locations in Katutura.

The Windhoek Rural constituency has an estimated population of 20 212 and consists of nine settlements. The study was done in Groot Aub, one of nine rural settlements in the Windhoek Rural constituencies, located approximately 60 km

south of Windhoek, where residents mainly consist of farmers and pensioners (National Planning Commission, 2003:9).

4.3 Sampling

The target population for this study consisted of people above the age of 60 years and informal caregivers residing in the Katutura Central and Windhoek Rural constituencies in the Khomas region. The sample of identified experts and community leaders from the urban and rural setting for the key informant interviews (Annexure 5) was selected by means of the key informant sampling method until data saturation was reached (Strydom & Delport, 2011:394). Table 1 below provides a breakdown of the key informant participants.

TABLE 1: PROFILE OF THE KEY INFORMANT PARTICIPANTS:

Urban constituency	Rural constituency
1. Pastor of Lutheran church (F)	1. Pastor Lutheran church (M)
2. Manager, Life Change Centre (M)	2. Chairperson, Rehoboth community Trust (M)
3. Registered Nurse (F)	3. Registered Nurse (F)
4. Medical Officer (M)	4. Namibian Police, Community Police (F)
5. Social Worker (Women & Child Protection Unit) (F)	5. Member of committee on older people (M)
6. Inspector (Women & Child Protection Unit) (F)	6. Member SWAPO Elders Council (M)
7. Constituency officer (M)	7. Elder of the church (F)
8. Community development leader (Herero location) (F)	8. Member of the traditional authority (M)
9. Community Development leader (Single Quarters) (F)	
10. Catholic Aids Action, Regional Manager: Home based care (M)	
11. Social Worker (Ministry of Health and Social Services) (F)	
12. Post master, Katutura Post office (F)	

13. Pension officer, Ministry of Labour and Social Welfare (M)	
14. Namibian Police, community police (M)	

Twenty-two key informant interviews were held, of which eleven were with males and eleven with females. Fewer key informant interviews were conducted in the rural area because fewer governmental or community structures were available. Some of the key informants found in the urban area, such as the postmaster, the pension officer, the Women and Child Protection Unit and Catholic AIDS action are rather representing the views on the entire Khomas region.

The purposive sampling method as a non-probability sampling method was used to select the older people and the informal caregivers as participants of the focus group discussions (Bryman, 2008:458; Strydom & Delport, 2011:392). Community leaders acted as gatekeepers announcing separate meetings for older people and informal caregivers residing in a particular area. At the day of the meeting, the researcher screened the participants, checking if they complied with the selection criteria before the focus group discussion started. The inclusion criteria for the older people were as follows: (i) they must have been above the age of 60 years, (ii) they must have been residing in the specific urban or rural constituency, (iii) they must not have been suffering from any cognitive or mental disability and (iv) must have had a caregiver. The researcher discovered that many older people had no informal caregiver, although it was quite obvious that a caregiver was needed. Therefore, an adjustment was made to the selection criteria, so that they included those older people without caregivers into the study. The inclusion criteria for the informal caregivers were as follows; (i) they must have been a primary caregiver, (ii) they could be an adult child, a spouse, sibling or extended family member, (iii) they had to have regular contacts with the older person, and (iv) they must have been residing in the specific constituency in the Khomas region. Six focus group discussions were held with 53 older people from both the urban and rural constituencies, while four focus group discussions were conducted with 23 informal caregivers. Tables 2 and 3 below provide a breakdown of the informal caregivers and older persons as participants of the focus group discussions.

TABLE 2: PROFILE OF THE INFORMAL CAREGIVERS AS PARTICIPANTS OF THE FOCUS GROUP DISCUSSIONS

Focus group type	Area	Number & gender of participants	Age of participants
Caregivers: Eiland	Rural	5 female	36-40 years: 3 Above 60 years: 2
Caregivers: Rooirand	Rural	5 female	Younger than 20: 1 26-30 years: 2 36-40 years: 2
Caregivers: Damara location	Urban	7 (1 male; 6 female)	21-25 years: 1 31-35 years: 2 36-40 years: 1 41-45 years: 2 46-50 years: 1
Caregivers: Herero location	Urban	6 (1 male; 5 female)	21-25 years: 4 46-50 years: 1 Above 60 years: 1

TABLE 3: PROFILE THE OLDER PEOPLE AS PARTICIPANTS OF THE FOCUS GROUP DISCUSSIONS

Focus group type	Area	Number & gender of participants	Age of participants
Older people: Verdruk	Rural	9 (4 male; 5 female)	60-65 years: 6 66-70 years: 1 71-75 years: 1 Above 80 years: 1
Older people: Laeveld	Rural	7 female	60 – 65 years: 3 66-70 years: 3 Above 80 years: 1
Older people: Platkop Hill	Rural	11 (6 male; 5 female)	60-65 years: 4 66-70 years: 2 71-75 years: 3 76-80 years: 2

Older people: Single Quarters	Urban	9 (3 male; 6 female)	60-65 years: 3 66-70 years: 4 70-75 years: 1 76-80 years: 1
Older people: Herero location	Urban	7 (3 male; 4 female)	60-65 years: 4 66-70 years: 1 Above 80 years: 2
Older people: Damara location	Urban	10 female	60-65 years: 3 66-70 years: 3 71-75 years: 2 76-80 years: 2

4.4 Data collection

Data was collected over a two-month period during April and May 2012 with 22 key informant interviews (Annexure 5) as well as six focus group discussions with older respondents and four focus groups with informal caregivers (Annexure 6 & 7). The perceptions of older people, informal caregivers and key informants from the Katutura Central and Windhoek Rural constituencies in the Khomas region around informal caregiving situations that could lead to elder abuse and neglect were explored. No incentives were provided, except for refreshments at the end of the focus group discussions. All interviews were conducted by the researcher, with the assistance of trained and experienced fieldworkers who also assisted with translations in Oshiwambo, Damara/Nama, and OtjiHerero. All focus group discussions in Groot Aub were carried out at the house of an identified community leader, in a specific location, in a private setting. Focus group discussions in urban settings took place at known community structures such as Council offices or the church. Interviews were audiotaped and lasted between 60 and 90 minutes.

4.5 Research procedures

Permission was obtained from the Councillors of the Katutura Central constituency and the Windhoek Rural constituency, the two constituencies where the field work was carried out. Interview schedules were developed for the key informant interviews and the focus group discussions (Annexure 5-7). The interview schedules

were pre-tested with three older people and amendments were made with regard to the order of the questions and the rephrasing of the questions. The interview schedules were further pretested by requesting inputs from two experts in gerontology. Informed consent forms (Annexure 4) were developed and explained to all the participants verbally, the participants who could read and write signed the consent forms, while those who were illiterate gave verbal consent.

4.6 Ethical aspects

Many scholars discuss ethical considerations in research (Babbie, 2010:64-70; Creswell, 2009: 87-98; Strydom, 2011: 115-126). In this study, the researcher guaranteed the safety of respondents from exposure to either physical or psychological harm. Therefore, debriefing sessions were conducted by the researcher with respondents of the focus group discussions immediately after data gathering to assist the respondents to work through their experiences (Strydom, 2011:122). The research respondents were not forced to take part in the study, they did so voluntarily. Respondents were assured that information would be treated with confidentiality, while the interviews and focus group discussions were held in private settings. Permission was granted from the North-West University, Potchefstroom campus, Ethics Committee for this research project (Annexure 1), with ethical clearance number NWU-00012-12-S1. Permission was also granted by the Research Ethics Committee of the Ministry of Health and Social Services in Namibia (Annexure 2).

4.7 Data analysis

All the audio-recorded data, collected from the focus groups discussions and key informant interviews were transcribed verbatim (Annexure 8). The transcripts were downloaded into the Atlas-ti version 7 software programme. After reading through the transcripts several times, coding of the data took place in three stages, namely, open coding, axial coding, and finally, selective coding (Saldanha, 2009:10-12; Schurink et al., 2011:412-413). The constant comparison analysis was used as a qualitative analysis technique, to generate a set of themes (Leech & Onwuegbuzie, 2008:590). Eventually six major themes were generated from the data, namely, (i) challenges of caregiving, (ii) coping with conflict, (iii) benefits of caregiving, (iv) risk

factors of elder abuse and neglect in informal caregiving settings, (v) forms of elder abuse and neglect and (vi) support systems. Each of these interrelated themes, accompanied by subthemes with supporting quotes, will be reported in the subsequent section. The themes and subthemes are presented in the table 4, below:

TABLE 4: OUTLINE OF THE THEMES AND SUBTHEMES

THEME	SUBTHEME
Theme 1: Challenges of caregiving	Subtheme 1: No source of income for caregivers Subtheme 2: High costs of caregiving Subtheme 3: Uncooperative behaviour of older people Subtheme 4: Unmet nutritional needs of older people Subtheme 5: Lack of support from other family Subtheme 6: Transport expenses
Theme 2: Coping with challenges	Subtheme 1: Avoidance of conflict situations Subtheme 2: Emotional reactions Subtheme 3: Paid caregiver
Theme 3: Benefits of caregiving	Subtheme 1: Strengthened interpersonal relationships Subtheme 2: Develop sense of responsibility Subtheme 3: Spiritual upliftment Subtheme 4: Caregiving is a privilege
Theme 4: Risk factors of elder abuse in community setting	Subtheme 1: Poor interpersonal relationships Subtheme 2: Substance abuse Subtheme 3: Caregiver stress Subtheme 4: Social isolation of caregivers
Theme 5: Forms of elder abuse and neglect	Subtheme 1: Financial abuse Subtheme 2: Emotional abuse Subtheme 3: Physical abuse Subtheme 4: Sexual abuse

	Subtheme 5: Neglect
Theme 6: Support systems	Subtheme 1: Health care Subtheme 2: Social services Subtheme 3: Law enforcement Subtheme 4: Diaconic services from church Subtheme 5: Institutional care Subtheme 6: Food security

5 FINDINGS

When the inductive approach is followed in qualitative research, the literature review is only conducted after data collection and data analysis (Botma et al., 2010:196; Delport & De Vos, 2011:49). In this article, the researcher therefore started with the empirical observations with its' findings reported below, while the literature control and theoretical observations will be reported in article two.

5.1 Theme 1: Challenges of caregiving

All the respondents were asked about the challenges they believed caregivers were experiencing because of their caregiving role. The challenges mentioned were, amongst others, no source of income for caregivers, high costs of caregiving, uncooperative behaviour of older people, nutritional needs of older people, lack of support from other family members and transport expenses.

5.1.1 Subtheme 1: No source of income for caregivers

Many respondents indicated that informal caregivers have no source of income because either they declined employment offers or had resigned from their jobs to fulfil caregiving responsibilities. The poor socio-economic position of informal caregivers made it difficult to provide for the basic needs of older care recipients. One key informant said, *“they won’t be able to buy healthy food or correct food that can contribute to a balanced diet of an elderly. Or even just money to take the elderly to the nearest health facility to get medication or go get other medical assistants to health facilities. And also just to make sure that the elderly is well taken care of to buy groceries for them, for cleaning purposes and stuff, I think soap, and*

other things.” Present and future needs of unemployed caregivers and their dependents also remain unattended to. One caregiver explained, “yeah, it is actually a very big challenge....you also have your own children....and you also need to plan for the future of your children....so it is a bit difficult.” Some respondents mentioned that informal caregivers who experience difficulties to find employment may suffer from depression and low self-esteem. Similarly, those informal caregivers who devalue their caregiving role may also experience feelings of unworthiness. One key informant said, “but when you are unemployed your self-esteem suffers, you are constantly in a state of depression....You will be seen as someone who is not worthy, or in your mind you will feel worthless.....because you are struggling with your own self-worth, you are struggling to give care, you are also in need of care.....now you go and care for someone else.”

5.1.2 Subtheme 2: High costs of caregiving

Only a few of the older people who participated in the focus group discussions had a physical disability, but many caregivers were looking after an older family member with some form of disability. Caregivers from urban areas accentuated their need for adult nappies and bed linen when caring for frail care recipients, but expressed concern about the expensive costs of purchasing adult nappies. Wearing adult nappies can also cause discomfort to the older person, especially if it is not changed regularly. One key informant said, *“You also need bed linen and nappies for the elderly. For example, my mother is also bedridden, and the nappies are 400 rand a pack, per month, and their pension is only 500 rand.”*

Instead of spending money purchasing adult nappies, the State Health facilities offer bed linen to bedridden older people free of charge. However, only a few caregivers reported that they were aware of this resource. Some caregivers of frail older people also regard home visits from the state health professionals as another helpful resource. However, caregivers were uncertain about the correct procedures to follow requesting for resources such as bed linen and home visits for frail older persons from State health care workers. One caregiver explained, *“Usually I am using the bed linens, I have to collect 30 bed linen every month at the clinic.”*

Caregivers in rural areas were silent about adult nappies and bed linen as resources for bedridden older people. Consequently, they carried a greater burden because of repeatedly cleaning after frail older care recipients. One caregiver explained, *"the last time when my grandmother had a running stomach and she was like doing it in the bed and we had to clean up, every minute we had to clean up, so it really has become a challenge."*

5.1.3 Subtheme 3: Uncooperative behaviour of older people

Many respondents reported that some older people display resistant behavioural patterns, refusing take a bath, eat or to take medication. One caregiver explained, *"grandfather is someone who does not want to cooperate and does not want to agree.....he gets angry....he does not want to drink the pills, and does not want to be bathed. He does not want to understand.... sometimes they don't even want to go to the clinic.....you have to force them."* Some respondents explained that some older people associated bathing with smelling bad and may felt insulted whenever requested to take a bath. Negative perceptions that older people smell also exist amongst caregivers, and as a result, they may neglect the hygienic care of an older person. One respondent said, *"if someone come visit at the house, and ask, 'what smells?' I do not feel alright because the person ought to know that an elderly person is in the house"*.

Requesting older people to take a bath sometimes ends in conflict between the caregiver and care recipient. One caregiver said, *"we are always telling her, grandma you need to bath now, then we have to argue about it, for the whole day, she won't even talk with us just because you were telling her to bath. She would give excuses such as, 'we don't have soap', but we will tell her that there is soap. Sometimes we will even try to beg her."*

Some respondents mentioned that cultural norms exist that hinder younger caregivers as well as caregivers from the opposite sex from assisting an older person with bathing. Young caregivers especially find it very uncomfortable to view the naked body of their elder relative. Furthermore, there are also cultural inclinations with regards to age- gender and caregiving, as explained by one caregiver, *"when my mother's elder brother, which is my uncle, needed help....*

there was a split (division) in the family because my mom cannot bath her older brother. My mother would also not bath her oldest sister either. We grew up like that; another older woman must bath my mother's older sister".

5.1.4 Subtheme 4: Unmet nutritional needs of older people

Key informants expressed concern over the inadequate nutritional care older people receives, as caregivers lack knowledge about the nutritional needs of older care recipients. Furthermore, some informal caregivers who act as procurators, managing the pensions of older persons unwisely as they purchase junk food, which is not only unhealthy but also expensive. Once the pension money has finished, only one type of food is served to the older person. One key informant said, *"Only giving your mother porridge and porridge everyday. You do not buy fruits and vegetables on pension payday but instead buy Kentucky (take away food)"* Older people who suffer from chronic conditions have to adhere to specified dietary restrictions. Key informants indicated that the health conditions of older persons are deteriorating because informal caregivers do not have financial resources to respond to these dietary requirements. One key informant explained, *"Care have to start from home right, you see for example hypertension patient, every time they come here, their blood pressure is high, sometimes circumstances at home can contribute to this, maybe the elderly is stressed at home, or the diet at home, nobody care, and some hypertension patient they are not supposed to eat food that are having a lot of salt, and must also not drink alcohol."*

Respondents reported that impoverished households of older people lack adequate food supplies, a situation which causes starvation and hunger. One key informant explained, *"Even if you go there in the morning to feed that bedridden patient. You can see that this Tate did not even take a cup of coffee or tea or bread, nothing. And uhm, he gets his social grants, but there is just nothing in the house."*

When the food supply is depleted in some households, respondents reported that older people, especially those in the rural areas, would buy food on credit, which is paid off with the pension payment. Respondents reported that these credit purchases were more expensive because prices for credit purchases were inflated by shop owners. Consequently, families ended up in a never ending cycle of debt.

One caregiver explained, *“but if the shop owner decided to add a 50 cent to every item that was bought on credit...no matter if it is a pensioner... he will do it. If the sugar costs 15 rand, the shop owner will add a 50 cent or one rand merely because it was bought on credit.”*

5.1.5 Subtheme 5: Lack of support from other family members

Most respondents indicated that only one person acted as primary caregiver, whilst the rest of the family members were less involved in the caregiving of their older relative. One key informant said, *“Whether I am an own child, or a grandchild, it is telling me that I have a responsibility towards my parents..... but some of us children withdraw and we think that only one child is responsible for our parents.”* An interesting phrase repeated by several respondents emphasised the contributions made by parents who raised many children, but in old age find very few children willing to care to aging parents was as follows, *“You can raise ten children, but ten children cannot take care of one parent.”*

Respondents explained that older people’s criticism of other family members as well as preferences to receive help from one particular family member were among the reasons why other family members eventually withdraw from providing care to an older relative. One caregiver explained, *“If someone else should bring the water, then the water is too cold....if I do not prepare the food, then the food is not nice. All the people have withdrawn now; I am the only one left. If I do not cook, and someone else is cooking, my grandma reply the food is not tasty, and then she will refuse to eat”.*

5.1.6 Subtheme 6: Transport expenses

Many respondents indicated their reliance on public transport in the form of taxis and minibuses in both urban and rural areas. The costs of public transport have been reported to be expensive by all respondents. To save on transport costs, respondents reported that some family members would send an older person unaccompanied to the health centres. One older person said, *“the transport is too expensive, because you are paying for your body, and your bag and food that you have bought, and then you are also just dropped off next to the road, and when you are asking to be dropped off at the house then you must pay an extra 10 rand.”*

Older people with a disability find it even harder to access public transport as they may be discriminated against. One caregiver said, *“Transport is a problem, people do not want to lift the elderly to put them in their cars...Taxi’s refuse to transport bedridden elderly people.”*

5.2 Theme 2: Coping with challenges

Respondents were asked how caregivers cope with the challenges of caregiving, and it was indicated that caregivers cope with challenging conflicting situations by avoidance, and also through release of strong emotions of anger and sadness.

5.2.1 Subtheme 1: Avoidance of conflict situation

Some of the challenges caregivers experience may lead to interpersonal conflict between older people and caregivers. Some caregivers reported that they would walk away from a conflict scene in an attempt to avoid conflict with an older care recipient, but would return at a later stage to proceed with their caregiving role. Caregivers have also indicated that their spiritual connectedness helped them cope during difficult caregiving situations. One caregiver said, *“the grandfathers are more stubborn.....sometimes when he is getting angry, I will leave him.....then I will walk out and come back.....and I will ask him ‘are you oraait now?’ or ‘Can I do you something?’.....and if he agree, and I will know everything is okay.”*

Respondents revealed that some older persons had a strong attachment to a particular family member, whose presence had a calming effect on the older person in times of conflicts. One caregiver said, *“I actually stay with my 16 years old daughter, my mom likes her a lot, and calls her very often. So when I feel like that, then I will ask my daughter to enter my mom’s bedroom. And as my mom is talking to my daughter she forgets everything, and as I come back later there is no more conflict.”*

5.2.2 Subtheme 2: Emotional reactions

Respondents pointed out that caregiving for an older family member may elicit a range of emotions amongst caregivers. Some caregivers find it hard to control their emotions and may burst out into tears after argumentative interactions with the older person. One caregiver said, *“sometimes I will also say some things neh...there are*

also times that I cry because she (older person) really doesn't...sometimes appreciate what we are doing for her (older person)." Caregivers reported that they may also have feelings of anger and helplessness, which they may never express in the presence of the older care recipient. One caregiver explained, *"I get really angry quickly I am made like that..... I am a short tempered person ... but I do not want my grandmother to notice that I am angry. If things are not going well or the face cloth is falling... then I go wash my face in the bathroom or I would scream at a child that is nearby.*

5.2.3 Subtheme 3: Paid caregiver

Respondents reported that the recruitment of a paid caregiver as a new concept has been introduced by a few families where there was no one in the family to provide care to an older relative. Respondents indicated that paid caregivers that were employed had little knowledge and/or training on caring for an older person. One key informant said, *"They (family members) don't have the time to do it (caregiving)..... and employ the paid caregiver, the so-called paid caregiver are not trained. It is just someone picked up who know how to iron, and washing the clothes. There is a difference in taking care of an elderly person and ironing and washing, it is just to take care holistically of the elderly."* The payment of paid caregivers also became a problem for poor households, as somebody had to make the payments from his or her income. It was suggested by older respondents that unemployed young people be offered training in care for older people and recruited as an alternative where no informal caregivers are available. One older person said, *"I think if there are younger people at the house of every elderly person who is visiting them at least twice a week to care for them...to look at what is lacking, are there food, blankets, toiletries, something like that...then I will appreciate it... and on that manner it will be easier to prevent problems... caregivers that are paid and is doing the caregiving in the houses."*

5.3 Theme 3: Benefits of caregiving

Despite the challenges of caregiving, respondents mentioned a number of benefits. Among others, it was mentioned by respondents that caregiving enhances relationships, and leads to the development of maturity and spiritual growth.

5.3.1 Subtheme 1: Strengthened interpersonal relationships

Compared to non-caregiving family members, the results indicated that informal caregivers have developed a stronger bond with the older person since there is regular and open communication. One caregiver said, *“there are times when they (older people), can be very interesting, one can even enjoy it. Sometimes they (older people) are just chatting with you, (all speak together in agreement). Grandmother and I may also do some gossiping,...we speak about everything. They (older people) give us blessings, which the other family members do not receive.”* Respondents added that older people are full of wisdom and offer advice to caregivers. One caregiver said, *“They also bless you, they speak things to you that will guide you and then you will know, one day I will also get old”*.

5.3.2 Subtheme 2: Development of a sense of responsibility

Respondents indicated that caregivers developed a sense of responsibility and learned to persevere because of the multiple caregiving tasks they fulfilled. One young caregiver said, *“to come and look at it, you also learn responsibility...its like you need to do this and you need to finish up.....so its actually responsibility that one also gets to learn.”* The sense of responsibility to care for older relatives is passed on to younger children who may become helpful caregivers in the future. One caregiver said, *“you actually teach the children in the house also... they see from your example, and can take care of you in the future. But if you are not taking proper care of the elderly, what do you expect from your children one day?”*

5.3.3 Subtheme 3: Spiritual upliftment

Respondents reported that caregiving results in spiritual satisfaction, since caregiving is regarded as a favour to God. Caregivers also consider the prayers that older people make as a benefit. One caregiver said, *“at night, I always hear how my grandmother is praying for me. We are arguing some days, but when she is going to bed, I can hear her praying for me.”* Respondents also reported that caregivers would not suffer from feelings of guilt after the death of an older care recipient, because they would feel at peace as they did their part as caregivers while the older person was still alive.

5.3.4 Subtheme 4: Caregiving is a privilege

Many respondents indicated that they were privileged to be caregivers of older persons. This is because, according to the respondents, caregivers care for the older person out of appreciation for what they have received in the past from the older person. One caregiver said, *“I shall say it is a privilege to look after your grandmother who gave you the best for so many years, and now return in giving her your best.”*

5.4 Theme 4: Risk factors of elder abuse in community settings

Respondents were asked what the risk factors were for elder abuse and neglect in community settings; poor interpersonal relationships, substance abuse, caregiver stress and the social isolation of caregivers were identified as key risk factors.

5.4.1 Subtheme 1: Poor interpersonal relationships

Respondents indicated that poor communication patterns between older people and family members were even observable in public places, as caregivers reportedly shout at the older people and communicate with them in a harsh manner. Surprisingly, some respondents reported that disrespectful communication patterns are an acceptable norm among both young and old people in some communities. One key informant explained, *“Whether the person is drunk or sober, in the morning seven’ o’ clock, the way she is talking to the mother or whoever neh... you don’t talk to people like that. To them it is normal. And even the way the person who is spoken to. She just saw it maybe as normal, but it is unacceptable. Maybe to them it is okay.”*

Respondents attributed the poor interpersonal relationships between parents and their caregiving children to the fact that some parents have a favourite child who is treated differently from the other children. Consequently, the caregiving responsibility of the older parent is shifted onto the favourite child, while the rest of the children of the older parent are less involved in caregiving. One key informant said, *“when you (parent) are supporting your children...they did not treat children equally, and now when you are growing older, the adult children respond differently towards an elderly parent as they were treated as children... so what I’m trying to*

say,... is, us as parents we should play our cards really well, because what goes around, it will come back. Yeah, that's how I see it."

Some parent-child relationships have deteriorated to such an extent that there is no communication between older parent and their caregiving child. In certain instances, this has been found to last for considerable periods. Such situations have been reported to cause a great deal of emotional pain to the older person. One older person explained, *"The problem with my grandchild. We stay in one house, but since August, we are not talking to each other... My grandchild who does not talk to me, I do not even have the feeling to say that this is my child's child (grandchild). I wish people can talk to the child. I am unhappy, that the child does not have respect."*

5.4.2 Subtheme 2: Substance abuse

Another risk factor that also occurs in combination with other factors is substance abuse by older people, informal caregivers and other family and community members. Some respondents regard older people, who abuse alcohol as undesirable role models to the youth and therefore not fit to reprimand children for displaying unacceptable behaviour. One key informant said, *"Elders are also drinking, now that you speak, about elders ...Satan cannot rebuke Satan... you are the parents. You are telling them (children), don't drink, yet you are also drinking."* Respondents reported that family conflict erupted because of alcohol abuse by the older person. Respondents reported that older people became verbally abusive when intoxicated, thus unwittingly opening themselves to physical abuse. One older person explained, *"You, who are an older person, you are drinking, and when intoxicated you swear at the children, and so the child will get up and beat you. Elderly people are also drinking as man and wife, and they are beating each other (all laughing). The one wants to hear the truth while the other one does not want to hear the truth, and they are beating each other."*

Many respondents mentioned that substance abuse by family members and caregivers affects their ability to be reliable and consistent with their caregiving responsibilities. One key informant explained, *"if I'm an abuser of substances, do I really find time to look after my granny? Their pension, and probably give me 50*

rand to go and use alcohol and drugs. Will I come back on time to care for them (granny)? So as a result you cannot rely on those people to say that they are caregivers. If I'm a caregiver then it means that I've got a responsibility to look after someone that cannot take care of themselves."

Many respondents linked the excessive abuse of alcohol to the availability of alcohol at shebeens. Respondents complained about the mushrooming of shebeens and other liquor outlets in the community that are ignoring operating hours as prescribed by law. Those highly intoxicated people who leave the shebeens resort to abusive behaviour towards their older loved ones. One older person explained, *"But the surrounding is full of shebeens, who do not respect us. And one thing that makes me feel bad, these people with the shebeens, they only notice the money, they do not take notice of the elderly people, and they do not consider the time of operations as is stated by the law. They (shebeen owners) just do as they please. Look if they are told they must close at 22:00 during the week, but they are open until the next day, then they are deliberate."*

5.4.3 Subtheme 3: Caregiver stress

Respondents indicated that caregivers under severe stress may engage in arguments with older care recipients, which leads to verbal abuse. One key informant said, *"A caregiver can also become stressed, because you become rebellious ... eventually scolding each other and may use abusive words ... you may hurt the elderly in the process it brings unhappiness in the house...and the elderly is to be blamed."* One of the reasons mentioned for caregiver stress is when the unemployed caregiver compares themselves with their peers who earn an income. Another source of stress is ascribed to the behaviour of older care recipients. One caregiver explained that some older care recipients displayed unpredictable behaviour because of their poor mental functioning. Caregivers reported observing minor signs of dementia, since some care recipients are forgetful and repeatedly call or asks caregivers for trivial issues. One caregiver said, *"Because of being called every now and then, and when you respond to the call, then the elderly does not know why she called you. And then if she calls you, you cannot ignore her, because she might want to ask you for something, but once you turned up she only asks whether she had eaten for the day."*

5.4.4 Subtheme 4: Social isolation of caregivers

Having few social contacts with people other than the care recipient was reported to be a source of stress for caregivers. Caregivers reported that the only social contact they had on a daily basis was with the older care recipient and other members of the household. One caregiver said, *“And if I’m just at home all day long then I feel trapped (everybody laughs). You do not relax, and eventually you are stressed, very stressed”*.

Caregivers reported that they were engaged all day and could only spend small breaks away from their older care recipient. One caregiver said, *“so I do everything alone...I only relax for 10-15 minutes watching soccer.”* Another caregiver added that her presence at the focus group discussion was her only chance to find relief from the caregiving situation. The caregiver explained, *“As I am not at home at this moment and sitting with you (at group discussion), this is the only time that I relax.”* It is really only at night, when the older care recipient is asleep, that caregivers can find some time for relaxation. One caregiver said, *“I do get the time to relax....like when they are asleep at night....I may go out for the night...and I must just make sure to see them early in the morning to check if they have slept well.”*

5.5 Theme 5: Forms of elder abuse and neglect

The forms of elder abuse reported (in no particular order) were financial abuse, emotional abuse, physical abuse, sexual abuse and neglect. Due to the sensitivity of the topic, respondents were initially hesitant to share their perceptions on elder abuse and neglect but as the discussions progressed, participants warmed up and become more open in their disclosures during the discussions. Generally, key informants were more forthcoming in sharing their observations and perceptions on elder abuse and neglect than were the older people and informal caregivers.

5.5.1 Subtheme 1: Financial abuse

One of the forms of financial abuse that older people experience is property grabbing. Respondents reported how older people who own houses had lost their properties because of fraudulent actions by their own children, grandchildren and even neighbours. Under false pretenses, respondents reported that children would propose to renovate the houses of the older person or offer to assist with payment

of municipality rates. After losing their property, older people ended up living in substandard housing in shacks. One key informant explained, *“the child will tell the grandmother that he/she would want to expand or renovate the house, and will ask the grandmother to sign a form for the expansion of the house, in this way the grandmother signed the papers for the selling of the property; after grandmother has signed the form, there is nothing that can be done.”*

Another form of financial abuse experienced by older people is the misuse of their pension money. Key informants reported that procurators and caregivers misuse the old age pensions for their own personal benefits while the needs of the pensioner were ignored. Respondents reported that procurators and caregivers were around only for as long as there was some pension money, but disappeared when the pension has been depleted. One key informant said, *“children are only interested in the pension...on the first week of pension payday it is okay and from the second week, the elderly are again on their own.”*

Older people reported that their pension money was being stolen and that they were being robbed by their own children as well as other youngsters in the community. Pensioners receiving cash pension pay-outs were more at risk than those pensioners who receive their pension payment through the bank or post office. Respondents reported that older people would handover their pension money out of fear for their lives. One older person said, *“We have children, you see the child came to visit, but this child came to kill you. Because whenever the child comes here things are just disappearing in the house. It is the only help they bring.... Sometimes they (children) are coming home but are looking for money from you or they are bringing problems for you.”* Another caregiver disclosed that her brother, who is also a pensioner, has been a victim of financial abuse. The caregiver said, *“to tell you straight, my brother also has that abuse of money... he is telling me ‘I will die, not because of illness but my child will kill me’....because he must give that money.... now he (abusive child) have became used to it...if he (abusive child) is not given money then it is a problem.....so the dad must give (money) to have peace at home.”*

5.5.2 Subtheme 2: Emotional abuse

Respondents indicated that older people were emotionally abused by family members, who often insult and swear at them. One key informant revealed that older people are insulted when they reprimand their children for improper behaviour. The emotional abuse is not one-directional, some respondents reported that older people are also verbally abusive towards family members, which results in abusive replies from family members and conflict amongst family members. One caregiver said, *“children will report that their grandfather have been swearing at them....and I will reply to the grandfather that this is not good for the child...If I’m not at home the children may be swearing back at him, and he will not be happy about it.”* Respondents reported that older people who drink alcohol with young people are at particular risk of losing respect and experience verbal abuse. One key informant said, *“those elderly who are drinking with the young people can be insulted which leads to unhappiness between people.”*

Another form of emotional abuse that older people experience is loneliness and isolation. Respondents reported that older people miss their children when they are not visiting them regularly. During the festive season especially, the absence of an older person’s own children is felt even more strongly. One older person said, *“At least you must see your children on Christmas, but they are not coming.”* Respondents reported that some older people were threatened and manipulated by their children and caregivers, who claim certain entitlements in exchange for providing care. One key informant said, *“children are emotionally abusing the elderly. They are doing it through threats; they can blackmail them (older person) because they (caregivers) are the only ones who will help the elderly... ‘if you don’t do this for me, than I will not do that for you’. You know this kind of things.”*

5.5.3 Subtheme 3: Physical abuse

Many respondents indicated that physical abuse of older people is not a common phenomenon. Respondents also reported that it was hard to recognize physical abuse of older people, since there could be many explanations for the physical injuries of older people. One key informant said, *“you can see a person is maybe swollen maybe he is having a wound... that he was beaten up..... Then he won’t talk in front of people that he was beaten up..... It is difficult to come up with the*

conclusion that this person was beaten by somebody.” Respondents indicated that older people who abuse alcohol might provoke young people verbally and end up being physically abused. Respondents also mentioned that a culture of violence was more prevalent among family members who abused alcohol. One older person said, “The elderly people are drinking and telling things to the children that they are not supposed to say, they are drinking together with children. And we are fighting with each other, young and old, husbands and wives also. “Respondents reported that older people could also resort to violence to deal with conflict, which, in turn, could lead to potential elder abuse. Respondents revealed that misbehaving adult children who abused alcohol had been beaten up by the older person. One older person reported, “I have beaten my child, and my husband has also helped to beat him. Afterwards we called the police who arrested my daughter also. It all happened while my child was still intoxicated. Since that day, my daughter stopped with her troubling behaviour.”

5.5.4 Subtheme 4: Sexual Abuse

Most respondents indicated that sexual abuse of older persons rarely happens. When it does happen, however, it is never reported to the relevant authorities. The one incident of sexual abuse reported occurred in the house of the older woman, and was committed by a male family member. Once again, substance abuse plays a role in sexual abuse. One key informant said, *“I heard a case where the son of the older woman was smoking dagga... the older woman was not a frail elderly person,....But when this son had smoked dagga... he would lift up his mother and carry her from her bedroom and had sexual intercourse with her. And the mother was hiding this from people, because it looked so shameful to talk about it ...whenever the old woman was asked to report the matter, she would reply ...‘no, there are things that you must talk, and there are things that you should not talk about’.”*

5.5.5 Subtheme 5: Neglect

Respondents indicated that neglect of older people is common. Older people are in a state of neglect because caregivers fail to provide assistance in daily activities of living to older people such as preparing meals, assistance with medication and personal hygiene. The transition of older people from independence to dependence

on a caregiver happens abruptly, without any warning or preparation to caregivers. One key informant said, *“Because they were independent and self sufficient older adults but suddenly became dependent on their children. I do not think the children realize that mom should take soup or porridge before they have their tablets in the morning. And then grandmother must be bathed to be clean for the day, neh... and I experience that as one is visiting the houses of the elderly, that grandmother have bathed weeks ago.”*

Respondents indicated that older people who lived alone and those whose pensions were collected by a procurator were more at risk of neglect. Most of the reports made about neglect were of older men, rather than neglect of older women. One older person said, *“generally there is neglect, you can see it everywhere also in Windhoek and Groot Aub, especially those elderly people who stays alone or those pensioner whose pay is collected by other people. You can see that they are dirty, they are clothed with torn dirty clothes.”* However, respondents also cautioned that conclusions about neglect of older people based on a person’s physical appearance could be deceiving. Some older people dressed up for special occasions only, but prefer to wear old clothes under normal circumstances, for example, when there is no special occasions, thus looking neglected and uncared for to outsiders. One key informant said, *“Sometimes the elderly do not want to wear the new clothes or shoes, they rather prefer to wear the very old clothes... and so other people will be gossiping that the children are not buying proper clothes to the grandfather.”*

5.6 Theme 6: Support systems

Respondents were asked about formal and informal systems of care for older people and informal caregivers. Respondents expressed their views on the various government systems of care, the diaconic services offered by the church and feeding projects as community initiatives.

5.6.1 Subtheme 1: Health care

Respondents reported that the State health services are offered free of charge to older patients. Older people are supposed to receive state medical assistance promptly but many respondents mentioned that older people were subjected to long waiting periods before they received medical help. One older person said, *“There*

was a time when a bench was allocated to the elderly (to reduce their waiting time). But these days, the situation has worsened at the Katutura clinic. That speedy health treatment has ended. We are suffering these days, and things must be improved for us at the clinic." Respondents further reported that the language barrier was also a factor contributing to older people not accessing state health services because many health professionals could not speak the local languages. One key informant said, *"While we as elderly already experiences problems at the clinic, the English language used at the clinics is also chasing elderly people away."* Many respondents complained about the poor quality of health care for older people, and that some health concerns of older people are not treated. An older person explained, *"the clinic nurse is telling me that chronic illnesses are apparently old age, and she is not giving us any medication. Any kind of pain is apparently old age,....elderly people are seldom regarded as emergency cases."*

5.6.2 Subtheme 2: Social services

Some respondents raised concerns about the scattered nature of social welfare services, pointing out that as many as three Government Ministries were providing a variety of welfare services to older persons. This was reported to be causing confusion among clients, including the older people. One key informant explained, *"a challenge for the clients is the setup of the different ministries, they are a bit confusing. Because you know, all of them are social workers, but now it's a matter of, the elderly will be referred. You may think that the complaint is abuse and report it at the Women and Child Protection Unit. But when you came to the unit, you may be referred to the Ministry of Health and Social Services or to the Ministry of Labour and Social Welfare. But it is not only the elderly, it's the entire community that is affected."*

Respondents from the rural area reported they had no social welfare services, adding that they had to travel long distances to the city when in need of social services. Because of this difficulty, social problems are never reported anywhere. Respondents in the rural area also have little understanding of what social work is all about, as they referred to the community police officer as the social worker. One key informant explained, *"There is no psychological caregiver (social worker).....there is no place to talk about problems."*

5.6.3 Subtheme 3: Law enforcement

Respondents complained that police services are supposed to offer protection to all the citizens but are generally unhelpful in the rural areas. As with the case of social services, this lack of responsiveness becomes a factor in older persons not reporting abuse to the police. One older person said, *“There is no place where we go and report, except for the police. But they are telling us to go to bed and go sleep and come back tomorrow.”* Many respondents confirmed that few complaints about abuse and violence are made to the police by older people. Compounding the matter is the fact that when older persons do report abuse and violence, their only desire is to see the perpetrator reprimanded, rather than seeing them face the full ‘wrath’ of the law. This is because, although older people did want relief from abusive situations, they were reluctant to request for a protection order against an abusive family member. The reasons for older people’s reluctance to report abuse are varied and complex, but mainly they can be reduced to older people’s emotional attachment as well as dependence on the perpetrator or feelings of pity towards the perpetrator. One key informant said, *“where the elderly are the victims, it is even much more silent..... If the elderly come to report then they do not want to see a case was opened.... But that the perpetrator must just be warned.”*

Family relations can, to quite a large extent, unintentionally contribute towards the cyclical nature of abuse and violence. Applying for a protection order against an abusive child who is a caregiver is a case in point. For example, although older persons may know that a protection order is a legal remedy against abusive relationships and environments, they seldom resort to this action. This is because, as a key informant explained, *“these children can emotionally and even physically abuse the elderly you know. For some elderly it becomes so difficult to apply for a protection order and stuff, because they (elderly) will reason ‘if I kick my child out of my house, where will this child go?’*

It is because of these complex family relationships that respondents expressed doubts about the effectiveness of protection orders in cases of elder abuse, since many older victims of abuse may allow an abusive family member back in the house because of strong parent-child relationships. One key informant said, *“If the parent can apply for a protection order and if they would want to, because you have to*

explain to them 'what is protection order' if they want to, we assist them....But the difficulty is that they allow the child (perpetrator) to come back in the house, and you will not know about it... The next day when you see the elderly woman again and enquires about the protection order that was issued, she may reply ... 'no it's my child,'...

5.6.4 Subtheme 4: Diaconic services from churches

Respondents indicated that churches play an important role towards the informal care of older people through what they referred to as 'diaconic services'. One key informant explained that diaconic services involve a variety of activities such as spiritual care, feeding programmes, cleaning and conducting home visits to the older church members. One key informant said, *"the church has a soup kitchen for the elderly on Mondays, Wednesday and Fridays. It is very little (that is given), but we feel that it has an impact on the elderly people. And we do not only give them food, but also the Word of God which I feel plays a very important role."* Respondents reported that these diaconic services are only provided to members of a specific church group in the urban areas. One older person said, *"If there is help from the church, then you must be a member of that church. There are many churches that help people here, but you must be from that church. If you want to get food, then you must go to church, then you get food."* There was a general feeling amongst respondents in rural areas that diaconic services are not operating as they used to in the past. One older person said, *"we hear in Windhoek about the help churches are giving to the elderly people in the form of soup kitchens, food parcels and blankets. But here in Groot Aub is not such kind of help."*

5.6.5 Subtheme 5: Institutional care

Despite the many challenges caregivers encounter, all caregivers reported that they prefer to live with an older relative rather than consign such relative to old age home care. Most respondents indicated that old age homes, as a form of institutional care, are against indigenous Namibian cultures. One caregiver said, *"in our culture...it's very rare to find a Herero person in an old age home, because of whatever reasons they might have, yeah."* Sampled older persons themselves expressed a great sense of dislike about old age home care. One older person said, *"I am not yet Old Age Home. Yes and I refuse to go the old age home man. I have more suffering*

here, but in the old age home it is even much more suffering. It does not help man. I rather die just here at my house." Many respondents saw old age homes as places for rejected older people. This, they argued, could have a negative emotional effect on the older person. One key informant said, *"Emotionally the elderly is affected, he will feel like – 'nobody wants to be with me, I'm a burden to them, that's why they send me away. They (older person) will end up not eating, neglecting themselves, yeah."* Respondents reported that old age homes are perceived as places of passivity, where older people do nothing but sit all day.

5.6.6 Subtheme 6: Food security

Many respondents indicated that soup kitchen projects as community initiatives attempt to supplement the food security needs of older people. Many respondents however expressed a lack of trust in some of the individuals who have initiated these feeding projects. The main reason for the lack of trust was that the individuals leading these feeding project initiatives were perceived to be using the names of the older people but collect food for their own personal gain. One older person explained, *"people receive donations in the form of food, but divide it amongst their family members, and the little that remains is distributed to the people that were apparently on the list...We see it everyday in our country... people are forming organisations for their own benefit."*

Respondents spoke positively about the drought relief food programme as a Government initiative of distributing food parcels to needy people. Many respondents stated that the drought relief food was helpful, and expressed a desire for the re-distribution of the drought relief food programme. One older person said, *"There used to be the drought relief food, it is only given in the North. In Groot Aub there is no such help... If we could at least get the drought relief, then the pension can last until the next pay day."*

6 DISCUSSION

The study aimed at exploring how informal caregiving situations may lead to neglect and abuse of older people in an urban and rural constituency in the Khomas region in Namibia. To my knowledge, this is the first study in Namibia that has explored

informal caregiving situations that may lead to elder abuse and neglect.

The findings of this qualitative study indicate that informal caregivers are unable to provide for their own needs as well as the needs of older care recipients. This is because these caregivers have made the sacrifice of not participating in the formal labour market. Instead, they have chosen to be informal caregivers for their older relatives. The basic needs of older people, such as food, clothing shelter and transport, but also the particular needs of frail older persons, such as disposable nappies, heighten the financial pressures felt by informal caregivers. Because they are unemployed, caregivers suffer emotionally from low self-esteem and depression because of financial inadequacy or dependence. These findings are consistent with recent research which suggests that caregiving situations with insufficient resources can lead to negative caregiving outcomes (Fajemilehin *et al.*, 2007:162; Lowenstein, 2010:223; Rahman & Gaafary, 2012:536).

Maintaining the personal hygiene of older people is a challenge for caregivers since some older people dislike bathing as it is negatively associated with smelling bad. Furthermore, cultural beliefs and practices related to the gender and age of the informal caregiver are also important determinants to caregiving activities that involve the personal care of older people. Thus, a young caregiver, or a caregiver from the opposite sex who offers personal care may encounter resistance from an older care recipient.

Although the extended family still exists in many Namibian families, only one family member engages in primary caregiving activities with an older relative. Preferences of older people to accept help from one family member is used as a justification for other family members' non-involvement in caregiving. The results have also indicated that parents who treated their children unequally by, for example, demonstrating less affection for some of their children, end to receive less care from those children. A very painful experience for some older parents is the poor interpersonal relationship with a specific child or grandchild to such an extent that there is no communication between the two parties for some period. The results indicate that disrespectful communication is the norm in some communities, and this contributes to the way older people are treated in those communities.

Many of the challenges of caregiving lead to conflict between the older person and the caregiver. The results indicate that caregivers have poor coping mechanisms to deal with challenging caregiving situations, and would avoid challenging caregiving situations or even have emotional outbursts.

Despite the many challenges in caregiving of older people, the results indicate that the caregiver/care recipient relationship is not without some benefits. One of those benefits is that closer bonds develop between the informal caregiver and care recipient. Another benefit is the strength of character that derives from spiritual growth and learning to take responsibility. These findings are consistent with previous research by (Ackermann & Matebesi, 1998:24; Sibai & Yamout, 2012:66).

An unexpected finding from this study is the need for paid and trained informal caregivers, in situations where older people are without any informal caregiver. Impoverished families would not have the necessary means to sustain payment of informal caregivers. Government and involvement from the civic society are needed to strengthen community care for older people. The huge unemployment rate in Namibia, especially among the youth is also an under-utilised resource of potential caregivers.

The results indicate that substance abuse by young and older people contributes to a general culture of violence in Namibian communities. The excessive availability of alcohol and drugs because of the mushrooming of liquor outlets such as shebeens leads to especially verbal and physical abuse of older people. A surprising finding from the research indicates that norms of physical violence, which have existed for years, are still practised to discipline a disobedient adult child through corporal punishment.

The findings support previous research evidence that caregiving stress is a risk factor to elder abuse and neglect (Lee, 2008:708; Lowenstein, 2010:218). Caregivers are under severe stress because of family conflict, financial difficulties and the unpredictable behaviour of older people because of poor mental functioning.

The results indicate that caregivers who have little social contact with their outside world, or only brief opportunities for relaxation during day time can suffer severe stress. These findings are consistent with previous findings on the lack of leisure

time, recreation and lack of independence as inner caregiver stressors that can lead to elder abuse and neglect (Ackermann & Matebesi, 1998:22; Nadien, 2006:165).

This study also found that older people were losing their rights to home ownership because family members were robbing their older relatives of their houses through fraudulent actions. The socio-economic climate in Namibia and the lack of housing among the general population can make people desperate, the end result of which can be financial abuse or exploitation of older persons. The poor socio-economic climate in society also leads to the misuse of the pension money of older people. People in positions of trust, such as procurators and caregivers, were amongst the perpetrators of financial abuse.

The results indicated that older people are emotionally abused through many forms such as manipulation by spiteful caregivers who demand entitlements in exchange for caregiving. Loneliness and isolation is a reality for older people whose children has migrated to towns for better job opportunities, but fail to visit their parents regularly.

Contrary to the findings by Splinter (2009:1) who advocated for the inclusion of older people in national gender-based violence programmes, this study has revealed older women are rarely victims of sexual abuse.

The results indicate that neglect of older people is very common especially amongst impoverished families. Physical appearances of neglect can however be deceiving as some older people may create an impression of proper care only when in public but are actually living in conditions of neglect. Similarly older people may prefer dressing up in old torn clothes which may give the impression of neglect while their family members are actively involved in caregiving.

The results indicate that health care, social welfare and law enforcement as support systems from the State are inaccessible to the older population. Protection orders issued by the courts as a remedy for elder abuse and neglect are reported to be unsuitable for older complainants although relief of abuse and neglect is needed. The results acknowledge how churches can contribute to informal caregiving within communities through the provision of diaconic services. The role of the church

towards older people in community settings is an area that can still be explored with further research.

The harsh climatic conditions, unique to the Namibian context are a threat to the food security of older people. The results indicate that there is a need for an equal re-distribution of the food from the drought relief programme, as part of the government food security programme, to ensure that older persons especially in the rural areas are benefiting as well. Community initiatives of soup kitchen feeding projects are viewed with distrust as they are seen as self-enrichment schemes.

The study did not shed much difference between informal caregiving situations in urban and rural settings, except that rural communities have fewer resources, and caregivers and care recipients have to travel longer distances to access systems of care.

7 RECOMMENDATIONS

In view of the findings, this study would like to make the following recommendations:

- The social work support groups serve as a platform where informal caregivers of older persons receive support from one another and find ways to cope with the challenges of caregiving. Therefore, the development and implementation of a social work support group programme for informal caregivers of the older people is necessary.
- One of the critical issues affecting informal caregivers is that they lack knowledge on aging, caregiving and elder abuse. This situation can be mitigated by exposing informal caregivers to educational programmes that especially address matters related to caregiving of older people within community settings.
- Both informal caregivers and multidisciplinary professionals need exposure to the unique needs of older victims of abuse and neglect. There already exist in Namibia a host of national gender-based violence intervention programmes. These should be tapped into for the benefit of older persons.
- Substance abuse is a general concern in Namibian society. Awareness campaigns on responsible drinking, with specific messages designed for the older person who abuses alcohol and drugs would be helpful for both caregivers and care recipients.

- In tandem with the awareness campaigns on responsible drinking should be the strict enforcement of existing legislation on the excessive availability of alcohol by controlling and regulating licensed and illegal liquor outlets in the community. This will go a long way towards mitigating alcohol consumption and/or abuse among caregivers and care recipients.
- Informal caregivers live under poor socioeconomic circumstances. Incentives for informal caregivers could enable them to provide in their own needs, and prevent financial abuse of the older person. Incentives could be in the form of further development, income generation or grants.

8 SUMMARY

The article has provided new information in the Namibian context about caregiving situations of older people in community settings that could lead to elder abuse and neglect, however some limitations must be addressed. The study only focused in the Khomas region in Namibia, therefore the findings cannot be generalized to the entire Namibian population. Secondly, researcher relied on the assistance from community leaders to recruit respondents from focus group discussions which could have resulted in selection bias of the sample. A third potential limitation is related to the fact that few bedridden or frail older people could participate in the focus group discussions because it was practically impossible to involve them in the study. The results of this study emphasized the importance of further investigation on interventions with informal caregivers that can relieve their emotional burdens and ultimately reduce chances of potentially harmful behaviour being displayed towards the older care recipient. Future research should also examine the vulnerability of frail and bedridden older people to elder abuse and neglect within the community settings.

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ARTICLE 2

J. A. Ananias & H. Strydom

Factors contributing to elder abuse and neglect in community settings

ABSTRACT

This article provides an overview of elder abuse and neglect within the community setting from the perspective of the ecological theory. The ecological theory offers a deeper understanding of the complexity of elder abuse by considering the interactions that take place across a number of interrelated systems as well as the multiple risk factors that contribute to elder abuse and neglect. Researchers, policy makers and practitioners need to develop awareness of the risk factors regarding elder abuse and neglect and to develop appropriate interventions in response to elder abuse and neglect.

1 INTRODUCTION

Elder abuse is a relatively new phenomenon which was initially referred to as 'granny battering' in the 1970's (Ayres & Woodtli, 2001:328; Brook, 2008:46; Richardson *et al.*, 2002:335; Selwood *et al.*, 2007:1009). Ground-breaking work on elder abuse was initiated in the UK and the USA, but with different perceptions of the settings of elder abuse. In the UK, the focus of elder abuse was within the medical and institutional settings, while in the USA elder abuse was observed as a family and domestic violence problem (Habjanic & Lahe, 2012:261). The researcher agree to the notion of elder abuse in the family and domestic violence milieu.

According to Lowenstein (2010:283), initial surveys on elder abuse conducted in the 1970's as first generation studies; could not be generalized because of vital sampling and methodological limitations. Subsequent studies conducted in the 1980's, referred to as second generation studies, made improvements in their methodology, which also led to the advancement of national studies on elder abuse. Eventually, elder abuse was recognized as a global concern (Kalache & Blewitt, 2012:89), but the problem of elder abuse remains an under-researched topic.

2 PROBLEM STATEMENT

Many older people live in extended, multigenerational households and receive informal care from their adult children, partners as well as other family members (Sibai & Yamout, 2012:65). In fact, Lowenstein (2010: 218) considers informal caregiving as a family and an intergenerational issue, which can be fulfilled by many people as a life course role at some point in life.

Even though family members are the main providers of informal care to older persons, Decalmer and Glendenning (cited by Strydom, 2003:77) claim that almost 10% of older people who are cared for by family caregivers are at risk of elder abuse. There are many explanations for the weakening of the family as an important safety net for older people. Ferreira (2004:6) explains that some children have lost their sense of obligation to care for older relatives. Family structures are also undergoing major changes since adult children no longer live in the same towns as their elderly parents because of the current socio-economic climate, high costs of

living and pressures to find employment. Consequently a lesser number of family caregivers are available to care for older people (Lowenstein, 2010: 219; Peri *et al.*, 2009:168). Older people are also at risk of abuse by family caregivers who experience difficulties in finding a balance between caregiving and other life activities. Similarly, conflicting intergenerational relations and stress in caregiving may also lead to potential elder abuse and neglect (Lowenstein, 2010:223). Furthermore, Lowenstein *et al.*(2009:255) comment that switching into the caregiving role can be stressful, as some conditions of the aging populations can be chronic and progressive, which may lead to elder abuse and neglect in families.

Within the Namibian context, family relations have also broken down because of urbanization and migration (Dima, 2003:10). Furthermore, the draft green paper from the Ministry of Health and Social Services (1997:P7-1) maintains that Namibian families are no longer able to care for their older relatives due to poverty and modernization, as traditional norms to care for older people are fading. The research question for this study is *“What are the factors contributing to elder abuse and neglect within community settings?”*

3 AIM

The aim of this article is to provide an overview of elder abuse and neglect in community settings. The article is based on the ecological perspective, which is used to discuss risk factors and protective factors of elder abuse. In order to develop appropriate responses to elder abuse, all the risk factors of elder abuse need to be taken into consideration.

4 DEFINITION OF CONCEPTS

4.1 Informal caregiver

A caregiver can be a family member or any other person who is looking after another person who is unable to look after him or herself in some or all respects. Informal caregiving takes place in the domestic setting and does not receive any payment (Pierson & Thomas, 2010:65). The typical caregiver is a spouse or an adult child. Both men and women could be informal caregivers. However, women often

perform longer hours of caregiving and provide higher levels of care, and have ended up as caregivers because of lesser options in life (Lowenstein, 2010:218).

4.2 Elder abuse

There is a lack of commonly accepted definitions of elder abuse (Ayres & Woodtli, 2001:328; Ferreira, 2004:27; Walsh & Yon, 2012:105). The notion of elder abuse is defined differently by various professionals to fit discipline-specific purposes such as legal, law enforcement, medical or protection (Ayres & Woodtli, 2001:328). The concept of elder abuse is further understood differently by older people and caregivers (Ayalon, 2011:499-520; Hempton *et al.*, 2011:466-472; Selwood *et al.*, 2007:1009). A widely accepted definition on elder abuse by The International Network for Prevention of Elder Abuse (INPEA) and the World Health Organization (WHO) (cited by De Donder *et al.*, 2011:303), will be applied in this article. Elder abuse is 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.” The definition implies that an abusive act towards an older person could be either an act of commission or omission by any person in a position of trust such as family, friend, or neighbour.

4.3 Types of elder abuse

Many types or categories of elder abuse can be found. Ayres and Woodtli (2001:328) mention the struggle to fit abusive acts into a specific category of elder abuse since some abusive acts may not fit one single category or may be appropriate for several categories. In addition, elder abuse situations are complex and these categories do not always reflect those complexities. International scholars have agreed upon five types of elder abuse, namely physical abuse, psychological abuse, financial abuse, sexual abuse and neglect (Habjanic & Lahe, 2012: 262). A brief description of each type of elder abuse will be discussed below.

4.3.1 Physical abuse

The National Centre on Elder Abuse (cited by Mouton *et al.*, 2005:23) defines physical abuse as “the infliction of physical pain, injury, or physical coercion, and

involving at least one act of violence including beating, slapping, hitting, burning, cutting, or physical restraint use, or intentional over-medication”.

4.3.2 Psychological abuse

The National Centre on Elder Abuse (cited by Conrad *et al.*, 2011:149) defines emotional or psychological abuse as “the infliction of anguish, pain, or distress through verbal or nonverbal acts. Emotional or psychological abuse includes, but is not limited to, verbal assaults, insults, threats, intimidation, humiliation, and harassment.” Some examples of emotional or psychological abuse may also consists of actions such as treating an older person like a child; isolating the older person from his or her family, friends, or regular activities; giving an older person the “silent treatment;” and enforced social isolation.

4.3.3 Financial abuse

According to Sev'er (2009:280) financial abuse involves exploitative actions such as theft, fraud, forgery as well as charging older people inflated fees for cheaper goods. Severe forms of economic exploitation includes selling the property of older people without informed consent, stealing the pension money of older people, or forcing older people to change their will. Other forms of elder abuse also includes forcing older people to take care of grandchildren, refusing to vacate the home of the older person or staying with the older person without making any financial contribution towards the household.

4.3.4 Sexual abuse

The World Health Organization (WHO) (cited by De Donder *et al.*, 2011: 303) refers to sexual abuse as “non-consensual sexual contact of any kind”. Examples of sexual abuse are unwanted intimacy, touching in a sexual way, rape, undressing in front of the victim.

4.3.5 Neglect

Neglect of older people is the most common type of elder abuse, but it is not easy to prove neglect. Examples of neglect are failure to provide proper nutrition, clothing

and hygiene care to bedridden older people, and leaving an injured older person unsupervised (Sev'er, 2009:280-281).

5 THEORETICAL PERSPECTIVE

The complexity of the problem of elder abuse remains a challenge, because there is no theoretical framework that properly explains the causes of elder abuse (Anetzberger, 2005:10). Only a few theoretical approaches are supported from empirical research. However, more than one theoretical perspective is needed to fully understand the problem of elder abuse (Penhale, 2010:239-241). Some well-known theories on elder abuse are, amongst others, the learning theory, the dependence theory, the psychopathology theory, the caregiver stress theory, the family systems theory, the social exchange theory and the ecological theory. Because the ecological theory considers the interactions that take place across a number of interrelated systems, it offers a better explanation to the complexity of the problem of elder abuse and neglect.

5.1 Ecological theory

According to Shields (2010:22-23), the ecological theory is one of the most researched theories for explaining elder abuse. Payne (cited by Pierson & Thomas, 2010:190) claims that the ecological theory focuses on the adaptive and mutual relationship between people and their environment. In the context of elder abuse, the ecological theorist has a keen interest in the interactions between the older person and the caregiver, as well as within the caregiving and broader societal context, (Penhale, 2010:239; Podnieks *et al.*, 2010:161; Schiamberg *et al.*, 2011:195). The ecological theory suggests that elder abuse and neglect may occur at four systems, namely the micro, meso, exo and macro systems Gans and Schiamberg (cited by Shields, 2010:22-23). The micro system refers to the relationship between the older person and his or her caregiver. The meso-system refers to the relationship between the older person and church or community services, the exo-system focuses on the impact of a caregiver's workplace on caregiving while the macro system refers to the interactions of the older person with health and government services. In later works by Schiamberg *et al.* (2011: 207) the chrono-system is added as a fifth level that focuses on the timeframe an older

person has been staying in a potentially abusive environment. These systems may overlap, since risk factors found in the one system may also appear in another system (Schiamberg & Gans, 1999:93-94). The micro and macro systems are of special interest in this article; therefore the risk factors found in these systems will be further discussed in the next section.

6 RISK FACTORS FOR ELDER ABUSE AND NEGLECT

Knowledge of risk factors to elder abuse is under-researched (Peri, *et al.*, 2009:14; Post *et al.*, 2010:325). Furthermore, no consensus has been reached amongst the few scholars who have worked on risk factors of elder abuse (Kalache & Blewitt, 2012:89). The ecological theory is useful for understanding the risk factors of elder abuse and neglect. This is because the ecological theory offers a broader understanding of risk factors to elder abuse, as it applies to the older victim, the perpetrator, the context of caregiving and the broader societal context (Jayawardena & Liao, 2006:129; Pe'rez-Rojo *et al.*, 2009:17). Moreover, Schiamberg *et al.* (2011:207), suggest that not only one but several risk factors need to be considered when the ecological theory is applied.

6.1 Individual characteristics: the older victim of abuse and neglect

There are a number of risk factors related to the older victim of elder abuse. Each of these characteristics will be discussed.

6.1.1 Gender

A great deal of controversy still reigns regarding the gender that is most at risk of elder abuse and neglect (Kravitz, 2006:36; Pe'rez-Rojo, 2009:17; Schiamberg & Gans, 1999:90; Von Heydrich, 2009:48). Substantial evidence exists that older women are more vulnerable to elder abuse and neglect (Ferreira, 2004:19; Lowenstein *et al.*, 2009:271; Peri *et al.*, 2009:164; Rahman & Gaafary, 2012:534; Von Heydrich, 2009:47; Weeks *et al.*, 2005:10). However, in a community based prevalence study the World Health Organization (2002:130) found that older men were equally at risk of being abused by spouses, adult children or other family members. In fact, in a needs assessment in Namibia, Ananias and Strydom (2012) found that older men rather than older women often tend to be victims of neglect.

6.1.2 Chronological age

The more a person advances in age, the more the physical, psychological and cognitive functioning of the older person deteriorates. These factors may increase the elderly person's chances for being abused and neglected (Horsford *et al.*, 2010:80; Kravitz, 2006:35; Schiamberg & Gans, 1999:90; Von Heydrich, 2009:48).

6.1.3 Marital status

There are contradictory findings on marital status as a risk factor. Married women are more at risk of elder abuse than widowed or divorced older women. However, it is not the marital status but rather the living arrangements that places older people at risk of elder abuse and neglect. Therefore, it is more accurate to state that older people who live with someone are at greater risk of abuse, than older people who live alone (Kravitz, 2006:36-37; Schiamberg & Gans, 1999:90; Von Heydrich, 2009:48-49). It is, however, not commonly accepted that this is a general 'rule', as shown by Weeks *et al.* (2005:11) who argue that older people are abused, irrespective of whether they live with a spouse, a family member or alone.

6.1.4 Chronic serious physical health problems

Older people with serious, chronic physical health problems are more dependent on their caregiver. This dependence can lead to caregiver stress, which causes vulnerability to elder abuse (Ayalon, 2011:503; Kravitz, 2006:37; Nadien, 2006:166; Schiamberg & Gans, 1999:90; Von Heydrich, 2009: 49). In contrast, Jayawardena and Liao (2006:129) claim that there is no direct link between elder abuse and the physical health condition of the older person. They view the increased frailty of the older person as a more precise risk factor for elder abuse than chronic health problems.

6.1.5 Presence of cognitive disorders

Older people suffering from a cognitive disorder such as Alzheimer's disease and dementia, may behave violently towards the caregiver, especially when the disease is progressing. It is important to note that the violent behavior, and not the diagnosis of the cognitive disease, increases the chances of elder abuse (Jayawardena & Liao, 2006:129; Lee & Kolomer, 2005:69; Schiamberg & Gans, 1999:90-91; Von

Heydrich, 2009:50). In addition, a vulnerability to elder abuse also exists amongst older people with a memory impairment, which leads to their dependence on the perpetrator (Selwood *et al.*, 2007:1009).

6.1.6 Presence of mental or emotional illness

Von Heydrich (2009:51) confirms that there is a strong cause-effect relationship between the emotional or psychological problem of the older person and elder abuse. According to Coyne *et al.* (cited by Kravitz, 2006:40), older people with mental and emotional illnesses may display violent and aggressive behaviour or may just be completely dependent on their caregiver, which leads to caregiver stress and burden that could result in elder abuse.

6.1.7 Substance abuse

Some people believe that they might enjoy good health if they use alcohol moderately, but excessive drinking may trigger psychiatric illnesses (Von Heydrich, 2009:52). According to Ananias and Strydom (2012) older people under the influence of alcohol and drugs may risk physical abuse because they may behave verbally abusive towards others. Schiamberg and Gans (1999:91) assert that older people who misuse alcohol are more vulnerable to elder abuse, since they are unable to care for or fend for themselves. In the same way, the huge amount of over the counter-drugs and chronic medication taken by many older people could also have an addictive effect (Von Heydrich, 2009:52).

6.1.8 Difficult behaviour

Some older people have the tendency of being demanding, ungrateful and just difficult, which may result in aggressive behaviour on the part of the caregiver. Besides, older people with dementia may display aggressive and unpleasant behaviour because of cognitive, psychological or unmet emotional needs (Jayawardena & Liao, 2006:129; Kravitz, 2006:43; Schiamberg & Gans, 1999:91; Von Heydrich, 2009:53).

6.1.9 Social isolation and loneliness

According to Schiamberg and Gans (1999:95), older persons who are isolated from friends and relatives are at a greater risk of elder abuse, since the abusive behaviour remains hidden because there is no one to report the abuse. Some lonely older people may develop relationships with unreliable strangers who may abuse them financially.

The older victim of abuse and neglect is thus a person with the following characteristics; an older male or female, in advanced age, who is abusing alcohol, displays violent or difficult behaviour and suffers from a serious physical, cognitive, or mental disorder.

6.2 Individual characteristics: the perpetrator of elder abuse

According to Bergeron (2001:53), the terms 'caregiver' and 'perpetrator' have become equivalent in elder abuse work, since perpetrators of elder abuse could be an adult child caring for an older relative, or spouse caring for a frail partner. Even though more empirical evidence is needed, it seems that the adult child rather than the spousal caregiver is more likely to display potentially harmful behaviours towards the older parent (Rahman & Gaafary, 2012:534; Sasaki *et al.*, 2007:256). A better understanding of each of these risk factors associated with the caregiver will follow in the next section.

6.2.1 Gender

There are contradictory findings on the gender of the perpetrator and elder abuse, with various researchers having found both men and women could be perpetrators of elder abuse (Kravitz, 2006: 46; Von Heydrich, 2009: 44).

6.2.2 Chronological age

There are contradictory findings on age as a risk factor for elder abuse (Kravitz, 2006:46; Von Heydrich, 2009: 44). In fact, Rahman and Gaafary (2012:536) assert that younger caregivers are more likely to commit acts of elder abuse and neglect than older caregivers.

6.2.3 Psychological and emotional problems of the caregiver

Some caregivers suffer from physical and mental illnesses, have developmental difficulties or are themselves in advanced age with dementia. Such caregivers may have good intentions but are not competent caregivers due to their inability to provide proper care, or to understand the consequences of poor care (Choi & Mayer, 2000:5; Penhale, 2010:241; Schiamberg & Gans, 1999:91).

6.2.4 Substance abuse by the caregiver

Caregivers with substance abuse problems make inappropriate decisions around their caregiving role, and may also misuse the finances of the older person, since buying alcohol will be the priority instead of caring for the older person (Jayawardena & Liao, 2006:129; Schiamberg & Gans, 1999:91).

The perpetrator of elder abuse and neglect could be therefore, a male or female person, who suffers from a psychological or emotional problem and is a substance abuser.

6.3 The caregiving context

The interaction between the older person and the caregiver within the caregiving context also holds specific risk factors. They are discussed below.

6.3.1 Lack of caregiver experience and reluctance

Not all caregivers have experience in caring for an older person, since some people are forced by poor socio-economic circumstances or the need for care of an older family member and became caregivers against their will. Caregivers may have feelings of inadequacy and hostility because they lack experience in caregiving. Furthermore, caregivers might find it difficult to make financial, social, emotional, physical or mental sacrifices because of caregiving (Schiamberg & Gans, 1999:91). Reluctance in the caregiver will also increase the feelings of incompetence regarding caregiving on the part of the caregiver, which may lead to elder abuse (Kravitz, 2006: 50; Schiamberg & Gans, 1999:91).

6.3.2 Lack of support

Caregivers with inadequate formal and informal support systems are at risk. It is thought that if caregivers do not receive any emotional support from family or broader society they may feel overwhelmed and become abusive (Kravitz, 2006:54; Schiamberg & Gans, 1999:91). If the relationship between the caregiver and older person is tense because of violence, other family and friends may be discouraged to visit such a family, which leads to further isolation and increased risk of elder abuse (Schiamberg & Gans, 1999:95). Contrary to findings of Kravitz (2006) and Schiamberg and Gans (1999) about the importance of support systems for informal caregivers, Lee (2008:711) found that informal support to family caregivers was no safeguard against elder abuse. According to Lee (2008), those family caregivers with high levels of informal social support were just as likely to abuse the older disabled person as caregivers without any support system, formal or informal.

6.3.3 Past relationships between older person and caregiver

There is some evidence that unhealthy past relationships between the adult child caregiver and older parent, characterized by actions of child abuse, domestic violence, inappropriate discipline, physical punishment and domestic violence could lead to elder abuse (Schiamberg & Gans, 1999:94; Von Heydrich, 2009:41-42). Further empirical evidence about how past relationships can be a risk factor for elder abuse was found by Hughes (1997:53-60), who, in a study of 43 caregivers of older people, assessed how past abuse or violence before caregiving had commenced can impact the older person-caregiver relationship. Hughes (1997) identifies two risk factors to elder abuse namely, the mental health status of older people as well as a history of violence before caregiving had commenced. The study found that the mental health problems of the older person did not lead to elder abuse. However, violence before the commencement of caregiving was confirmed to be a risk factor for elder abuse.

Notwithstanding the findings of the studies cited above, some studies, notably that of Penhale (2010:242), have found intergenerational violence as a risk factor to elder abuse could not be verified. In fact, Penhale (2010) asserts that past relationships is a sensitive research topic and therefore difficult to research.

6.3.4 Dependency

Dependency as a risk factor for elder abuse has been debated at length. Conflicting views exist about dependency as either a risk factor or a protective factor against elder abuse. Current studies tend to regard the interdependency between the caregiver and the older person as a risk factor (Penhale, 2010:242; Schiamberg & Gans, 1999:93). Society does not expect an adult caregiver to be dependent on the older person, but the caregiver may have feelings of discomfort, frustration and anger, which may lead to antisocial abusive behaviour (Horsford *et al.*, 2010:79). An association between dependency and cognitive difficulties of older people was made by Nadien (2006:165), who states that some older people with poor cognitive functioning may display hostile and disturbing behavior, such as constant complaining or asking the same questions repeatedly.

6.3.5 Caregiver stress

Some literature (Lee, 2008:708; Penhale, 2010:241) claims that stress experienced by caregivers is a major risk factor for elder abuse. Fulfilling multiple roles in fulltime employment, raising children as well as taking care of an older care recipient can be extremely stressful to the caregiver (Kravitz, 2006:51). Caregivers who experience stress may have good intentions of providing quality care, but if the expectations of care are higher than which is offered, caregivers may become verbally and physically abusive towards the older care recipient (Kravitz, 2006:51).

In contrast to the above studies though, the World Health Organization (2002:131) merely regards stress as a contributing factor, and not a risk factor for elder abuse. This view seems to suggest that the caregiver's perception of his or her own stress seems to be a more accurate risk factor than the actual burden of caregiving (Jayawardena & Liao, 2006:129; Schiamberg & Gans, 1999:91). Examples of caregiver stress that could lead to depression and elder abuse are, according to Smith *et al.* (2011: 587-589), the poor physical health of the caregiver, manipulative and controlling behaviour of the older person, as well as restricted social contacts because of caregiving. The more stress experienced by the caregiver the higher the chances of the caregiver displaying verbally abusive behaviour such as screaming, yelling or threats towards the older person.

6.3.6 Financial difficulties

Lowenstein (2010:223) explains that providing care over a long period of time, without the necessary resources can affect solidarity and exchange. The conflict and ambivalent feelings may as a result, bring about negative caregiving outcomes such as elder abuse and neglect. Some caregivers may suffer economic difficulties as they had to resign from their jobs to take care of their elderly relatives. These caregivers may then develop feelings of resentment because they have lost their source of income (Schiamberg & Gans, 1999:95). Von Heydrich (2009: 55), points out that unemployed caregivers are financially dependent on the older person's housing and accommodation. While financially well off older people could be vulnerable to financial abuse (Peri *et al.*, 2009:165), frail older people with less financial resources are at risk of neglect (Ayalon, 2011:503).

6.3.7 Living arrangements

Older people and caregivers who live in the same house have little privacy, and older people are vulnerable to physical abuse (Yan & Kwok, 2011:534). Wang *et al.* (2006: 289) reason that conflict and tension is unavoidable between older people and caregivers who share the same household, which can thus lead to more frequent psychologically abusive behaviour. However, Pe'rez-Rojo *et al.* (2009:20) found no relationship between the risk for elder abuse and the fact that the caregiver and older person were sharing the same household. It is possible, though, that overcrowded living spaces may lead to family conflicts (Pe'rez-Roja *et al.*, 2009:18; Schiamberg & Gans, 1999: 93-94). However, the literature seems to be quiet about specific overcrowded situations in which older people share the same room with other members of multigenerational households.

The caregiving context that could place older people at risk of elder abuse and neglect is thus the following, the inexperienced or reluctant caregiver, with an inadequate formal and informal support system, a history of dysfunctional relationships between the caregiver and care recipient, interdependency between the caregiver and care recipient, caregiver stress, financial difficulties, and co-resident living arrangements between the caregiver and care recipient.

6.4 Broader societal risk factors to elder abuse and neglect

Social, economic and political factors make older people vulnerable to elder abuse and neglect. In addition, older people who lack resources, and who live in impoverished conditions, as well as those older people who experience inequalities because of race, gender and ageism are also vulnerable to elder abuse (Ferreira, 2004:20; Podnieks *et al.*, 2010:156). Ferreira (2004:21) adds that widespread unemployment and lack of income have an impact on the intergenerational relations and family harmony. Evidence from a qualitative study with older people, caregivers, and service providers in New Zealand by Podnieks *et al.* (2010:159-172) confirms ageism, older people's rights, gender roles and societal ideas of individuals and families are important themes of elder abuse at the broader societal level.

6.4.1 Ageism

Ageism or negative beliefs about older people and attitudes towards older persons, for example beliefs that older people are weak, frail and dependent, could make them vulnerable to elder abuse (Kalache & Blewitt, 2012:89). In western societies, youth, beauty and health are considered to be of more value than age. Because of this, older people may be perceived to be of a lesser value and could be at risk of elder abuse (Schiamberg & Gans, 1999:96; Von Heydrich, 2009:55). While some older people with negative self-perceptions may believe that they deserve disrespect, caregivers with negative perceptions and attitudes towards older people may also feel entitled to be abusive or neglectful (Nadien, 2006:165).

6.4.2 Historical disadvantages

Based on research in South Africa, violence occurs because of societal factors, such as social disorder, crime, alcohol and drug abuse, poverty, lack of job opportunities, lack of education, and prostitution (World Health Organization, 2002:132). According to Horsford *et al.* (2010:78), contextual factors unique to African-American communities that contribute to elder abuse are historical disadvantages such as racial discrimination, structural segregation or anger and hopelessness associated with economic and health disparities. The broader societal risk factors to elder abuse within the Namibian context have similarities with the South African and African-American communities. According to Dima (2003:1), due

to the historical and political background, indigenous older people were marginalized in terms of equal access to basic social services such as education, health and employment. The draft green paper from the Ministry of Health and Social Services (1997:P1-1) further states that previously marginalized Namibians continue to live under poor socio-economic conditions as they are aging.

7 PROTECTIVE FACTORS TO ELDER ABUSE AND NEGLECT

Whereas literature largely concentrates on the risk factors to elder abuse and neglect, very little attention has been paid to the protective factors to elder abuse and neglect. There are factors within family settings that can reduce the chances for elder abuse. Nadien (2006:158) claims that caregivers who are not suffering from any mental illness or personality disorder, and abstain from alcohol and drugs are less likely to be abusive towards older care recipients. In addition, caregivers who have received some form of training to cope with the stress of caregiving or to cope with provocative or abusive behaviour from the older person can also be seen as a protective factor against elder abuse. Finally, caregivers who receive adequate remuneration and support are less likely to display abusive behaviour towards the older person.

At broader societal level, Horsford et al.(2010:83-85) claim that communities characterized by a strong sense of community, spirituality and resilience, loyalty to family, value of motherhood and the value of the elderly are less likely to abuse older people. A strong sense of community can be created through the extended family, the church community and neighbours who are a source of support during times of distress. Spirituality and resilience can offer strength, support and comfort to both the older person and the caregiver. Peri et al. (2009:166) emphasize that practical suggestions concerning protective factors to elder abuse are, amongst others, the treatment of older people with respect, the education of communities on aging processes, promoting the needs and rights of older people, and improvement in the coordination of policies and services for older people.

8 RESPONSES TO ELDER ABUSE AND NEGLECT FOR CAREGIVERS

Based on the discussions on the risk and protective factors to elder abuse and neglect, appropriate responses to elder abuse must be designed that target the various systems according to the ecological perspective.

Within the informal caregiving context in particular, Nadien (2006:166) proposes that the offering of social support and respite care to caregivers can reduce caregiver stress tremendously. Additionally, Ackermann and Matebesi (1998:24) argue that day care and emotional support services need to be developed to reduce caregivers stress.

Many scholars suggest support group interventions with caregivers as a proper intervention to reduce elder abuse and neglect (Ackermann & Matebesi, 1998:24; Lee, 2008:711; Sasaki *et al.*, 2007:55; Smith *et al.*, 2011:589). These scholars argue that support group interventions with informal caregivers of older people can be of great value. The value lies in the fact that support groups can reduce the caregiving burden by linking caregivers with community resources (Wang *et al.*, 2006:289). Support groups also engage caregivers in social activities that can reduce isolation (Smith *et al.*, 2011:589). Another intrinsic value of support groups is that they provide platforms for caregivers to exchange skills and share coping strategies (Lee, 2008:711). Finally, support groups can offer psychosocial support and problem-solving skills (Ackermann & Matebesi, 1998:24).

In spite of the foregoing arguments, Post *et al.* (2010:339) argue that effective interventions to elder abuse and neglect have not yet been developed. In addition, Ploeg *et al.* (2009:206) maintain that there is a lack of high-quality research on the effectiveness of elder abuse interventions, since most elder abuse intervention studies are descriptive by nature and do not include a comparison group.

9 RECOMMENDATIONS

More literature is needed on elder abuse and neglect from the developing context.

The development of a universal definition on the concept of elder abuse and neglect can lead to better understanding on the problem of elder abuse and neglect.

A proper theoretical framework on elder abuse can also lead to a better explanation on the problem of elder abuse and neglect.

The protective factors to elder abuse and neglect are positive factors in community settings that needs more research and incorporated into practice.

10 CONCLUSION

In this article, an overview on elder abuse and neglect in the community setting was discussed. The ecological theory was used to offer a comprehensive understanding of the various risk factors of elder abuse and neglect. However, there are still many controversies among scholars regarding these risk factors involved in elder abuse and neglect. Elder abuse and neglect may only be addressed properly if combined actions are taken by various role-players to respond to risk factors across all systems as stated in the ecological theory, which ultimately can result in multidisciplinary research and practices.

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ARTICLE 3

J. A. Ananias & H. Strydom

Designing a support group work programme with informal caregivers of older people in Namibia

ABSTRACT

The population of older people is increasing drastically in both developed and developing countries. Older persons from African communities, including Namibia, are often resourceful people serving as a support system for needy family members. However, some older people rely on informal care from family and friends because the harsh realities of aging have affected their physical and cognitive functioning. Informal caregivers, often female family members, work without any remuneration and do not enjoy a high status in society. Besides, stressful caregiving situations may evoke strong emotions of anger, depression and resentment due to the demands of caring for frail and disabled older care recipients. The inability of informal caregivers to properly deal with these strong negative emotions may lead to intentional or unintentional abuse and neglect of older persons. The purpose of this article is to develop a social group work support programme for informal caregivers of older people that enhances their caregiving skills and ultimately prevents elder abuse and neglect.

1 INTRODUCTION

Informal caregiving, primarily carried out by family, friends or neighbours, is an important social resource for the aging population. However, caregiving requires a great deal of time and energy, may last for months or even years, and can be physically, emotionally, socially and financially arduous (Thompson *et al.*, 2007:2). According to Fialho *et al.* (2009:134), many caregivers lack experience and are ill-prepared to deal with the changes that occur within the older care recipient because of the aging process. As a result, committed and dedicated caregivers may unintentionally harm an older care recipient because of lack of knowledge and competence, while caregivers may also display harmful behaviours towards the care recipients, such as screaming and yelling, threats to abandon the care recipient, the use of physical force or withholding food (Reinhard *et al.*, 2008:13). Therefore, caregivers are in dire need of information, resources and services (Lee & Yim, 2013:14). According to Dupuis *et al.* (2004:36), support groups are the most common type of intervention for informal caregivers, however findings on the effectiveness of support groups are inconsistent. The purpose of such support groups is, according to Wayne and Cohen (2001:38), “to help members relieve stress and develop constructive behaviours to deal with difficult situations”. Group work interventions can create a platform for caregivers to share common concerns and issues and improve knowledge and skills of caregivers (Ebenstein, 2006:256). This article will focus on the design of a social group work support programme for informal caregivers of older people which will take place in urban and rural settings in Namibia.

2 PROBLEM STATEMENT

Much has been written on the challenges faced by family caregivers of older people. However, little empirical data is available on the management of these challenges (Zarit & Femia, 2008:5). Most of the intervention research is either directed at older people assessing the programmes that address the problem behaviours displayed by older care recipients (Schulz & Martire, 2004:244). Few intervention studies actually evaluate the effectiveness of programmes that equip informal caregivers with knowledge and skills on caregiving (Reinhard *et al.*, 2008:15; Toseland *et al.*, 2011:79). In addition, there is a lack of knowledge on the type of useful interventions

as well as the effectiveness of intervention programmes with caregivers (Thompson *et al.*, 2007:2; Toseland, 2004:1). According to Chan and O'Connor (2008:118) family support group interventions is a powerful and important strategy to support caregivers provided that pressures which negatively affects their health and wellbeing is being reduced.

A number of factors that may affect the effectiveness of intervention programmes were identified by Cooke *et al.* (2001:121), as amongst others; the type of intervention, the duration and intensity of the intervention, the relationship between the care giver and care recipient, and co-residence and the type of outcome selected. Additional factors suggested by Toseland (2004:2-3) are the characteristics of the informal caregiver and the older care recipient, the range of caregiver needs for information on aging and caregiving, coping skills, problem solving and support, and the extent of the older person's functioning. Zarit and Femia (2008:50) propose that interventions that combine educational and supportive components as more effective.

An educational practice oriented programme with paid caregivers in old age homes was conducted by Kloppers (2011), but no social work intervention has ever been done with informal caregivers of older people who live in non-institutionalized settings in Namibia. In view of the above, this study intends to fill the gap of scientific knowledge on community based caregiving for older people, by focusing on the development of a social group work support intervention with informal caregivers of older people in domestic settings. The research question for this study is *"What should the content of a social group work support intervention programme with informal caregivers of older people be that would enhance caregiving skills and prevent elder abuse and neglect?"*

3 AIM AND OBJECTIVES

The aim of the article is to describe the design of a social group work support programme for informal caregivers of older people that would increase knowledge on caregiving, improve the coping strategies of caregivers, which will ultimately lead to the prevention of elder abuse and neglect.

The objectives of the support group programme for informal caregivers from the urban and rural setting were:

- To increase the knowledge of informal caregivers on the process of aging, caregiving and elder abuse,
- To foster the expression of feelings about caregiving,
- To enhance coping skills and strategies in caregiving, and
- To increase personal and social support for informal caregivers.

4 RESEARCH METHODOLOGY

The article is part of a bigger study, which uses the intervention research model to enhance the functioning and wellbeing of informal caregivers of older people and evaluate the effect of the support group programme aimed at reducing caregiver stress and preventing elder abuse and neglect.

This research study consists of two phases. Needs assessments, vital before intervention programmes are compiled and evaluated (De Vos & Strydom, 2011: 475), was part of phase one of the research study, which explored the state of informal caregiving situations of older people from urban and rural settings in the Khomas region. Based on the needs assessment and a literature review, the support group programme with informal caregivers was designed in preparation for the second phase of the study, namely, implementation and evaluation of the support group programme.

4.1 Research design

A suitable research design to evaluate the effectiveness and impact of the intervention programme is the single system design (Strydom, 2011:160). The single system design is useful to evaluate data that was collected from a group as a single system. In single system designs, baseline data that was collected before an intervention is compared with data that was collected after the intervention occurred (Toseland & Rivas, 2005:403).

Care must be taken with the design of intervention programmes to ensure that the intervention is suitable for the target population. Zarit and Femia (2008:52-53) contend that problems with the research design can lead to negative outcomes with the intervention. Some of the examples of design problems relate, to among others,

the treatment goals and research design does not match the population of caregivers. Another important example is that the risk factors and needs of caregivers are different from the intervention. To compound matters further, the researcher may impose his or her goals in the treatment programme. Sometimes there is also no homogeneity among caregivers in terms of the social role and characteristics of the caregiver.

4.2 Research sample

The participants of the support group programme will be informal caregivers of older people. A closed group is a better option for this specific intervention where group sessions will be building on each other. In addition, cohesion and intimacy has a better chance to develop in a closed group rather than in an open group (Sands & Solomon, 2004:11). The research sample will consist of two support groups with the same focus, one in the urban setting and the other in the rural setting. Purposive sampling method will be used to select informal caregivers for the urban and the rural settings. The selection criteria for the participants of the support group are as follows; (i) an adult child, spouse, sibling or extended family member who is a primary caregiver; (ii) reside in Katutura central or Khomas rural constituency, (iii) is willing to participate, (iv) ability to communicate in the group, and (v) involved in one or more activities of daily living (ADL's) of the older care recipient.

4.3 Measuring instruments

When designing intervention research, proper measurements to assess the outcome of the intervention have to be considered (Zarit & Femia, 2008:6). In this support group programme the following measurements will be used.

- The demographic interview schedule (Annexure 10), developed by the researcher.
- The Zarit Burden Interview (ZBI) (Annexure 11) to assess the level of personal strain and role strain amongst caregivers (Whitlatch *et al.*, 1991; Zarit *et al.*, 1980:649-655).
- The Potentially Harmful Behaviour (PHB) (Annexure 12) scale to assess potentially psychological and physical abusive behaviour displayed by caregivers (Miller *et al.*, 2006:128).

- The Caregiver Abuse Screen (CASE) (Annexure 13) to assess the risk of elder abuse or neglect (Reis & Nahmiash, 1995:45-60).
- The Group Engagement Measure (GEM) (Annexure 14) to assess the dynamics in the group (Macgowen, 2006:35).
- Open-ended questions (Annexure 15) on a qualitative level, developed by the researcher which will be used during the group discussions.

5 SOLUTION-FOCUSSED APPROACH AS THEORETICAL BASE

The solution-focused approach is a relatively new theory, which originates from family therapy and systematic practices, and developed by de Shazer and associates at the brief family therapy centre in the USA (Sharry, 2007:7). Different from pathology-centred therapists who concentrate on the problem, its causes and development; solution-focused therapists are directed towards the solution, preferred futures and goals (Saadatzaade & Khalili, 2012:780; Sharry, 2007:7). The goal of group work from the perspective of solution-focused therapy is to create a culture of positive, supportive interpersonal communication among group members (Sharry, 2007:12). Practitioners who follow the solution-focused approach concentrate on the skills and solutions rather than shortfalls and problems (Saadatzaade & Khalili, 2012:780). Types of structured exercises used in solution-focused groups are, amongst others, the miracle question using creative visualization, group brainstorm for solutions, role plays and mind mapping (Sharry, 2007:166). This support group with informal caregivers used in this study is based on the solution-focused approach because of its strength-based emphasise on the positives instead of deficits.

6 PLANNING MODEL FOR GROUP WORK

Pre-group planning is a vital component of social work practice with groups. However, group work practitioners pay poor attention to planning (Wayne & Cohen, 2001:87). In fact, enough time and consideration should be put into the design of groups, otherwise groups might fail (Sharry, 2007:89). The planning model was used in the design of a support group for informal caregivers. This model, according to Wayne and Cohen (2001:90), consists of the following elements, namely, agency

and social context, needs of potential group participants, group purpose, group composition, group structure, group content, formation strategy and evaluation strategy.

6.1 Agency and social context

The agency and social context consist of factors and influences from the agency and larger environment that may affect the development of a group (Wayne & Cohen, 2001:91). The group is not attached to a specific agency, but does rely on the church or government structures for resources such as venues for meetings. A needs assessment can be useful to uncover the unmet needs of a particular target population from their context (Toseland & Rivas, 2005:158-159). The needs assessment for this support groups revealed that community-based care for older persons is non-existent in Namibia. In addition, informal caregivers of older persons from urban and rural communities are not properly prepared for their role; they are stressed and do not receive the necessary financial, emotional and practical support.

6.2 Needs of potential group participants

Once the target population for a support group has been identified, the needs of group participants that will be addressed in the support group programme must be considered (Sands & Solomon, 2004:8; Wayne & Cohen, 2001:94). The needs assessment that was carried out in phase one clearly showed that services for informal caregivers are non-existent. Moreover, informal caregiver structures that are not strengthened can lead to negative caregiver outcomes, such as elder abuse and neglect. The variety of needs that informal caregivers experience can be summarized as lack of financial and community resources, insufficient family and social support, caregiver stress and lack of information.

6.3 Group purpose

The purpose of the group is one of the most important aspects to consider when designing a group. The purpose can be formulated as a tentative statement that is broad enough to include the goals of all group members, but specific enough to address the common nature of the group and clear enough to enable members to

remain focused (Toseland & Rivas, 2005:156). The statement of purpose of the support group was as follows, “the group will provide a platform for informal caregivers to discuss their experiences and to find better ways to cope with stressful challenging caregiving situations, such that this supportive service can improve caregiving skills and prevent elder abuse and neglect.”

6.4 Group composition

When composing a group, consideration should be given to aspects of the homogeneity and heterogeneity of the group members, as well as the issue of solo or co- facilitation by the group leaders. According to Wayne and Cohen (2001:38), support groups are composed of people who share a similar set of challenging circumstances and who could help each other through exchange of their experiences, ideas and feelings. Indeed, balancing the levels of heterogeneity and homogeneity of group members instills some sense of community and can lead to the development of positive relationships among group members (Toseland & Rivas, 2005:166-167; Wayne & Cohen, 2001:960). The support group for this programme will consist of informal caregivers who are family members, friends or neighbours of older people. Heterogeneity of group members in terms of gender and age will not be a factor when composing the group. However, it will be essential that all informal caregivers have some homogeneity in terms of the extent of their involvement in one or more activities of daily living (ADL's) towards the older care recipient.

The group facilitators also form part of the group composition. The group facilitator could either facilitate the group solo or have a co- facilitator (Wayne & Cohen, 2001: 97). In the group the researcher will be the main group facilitator while a qualified practising social worker will be the co-facilitator. The co-facilitator will be the second set of eyes and ears in the group, and will also pay attention to issues that come up and the reactions of group members. At the end of every group session a debriefing will be done by the group facilitators, discussing the events in the session, concerns and questions, discussions of particular group members and will also review the plan for the next group session (Sands & Solomon, 2004:120).

6.5 Group structure

Formulating the tentative structure of the group can be quite a complicated process that involves a number of issues. Some structural arrangements are made by the group facilitator while other structural issues will be determined through member consultations during the pre-group stage as well as during the group process (Wayne & Cohen, 2001:98-99). The structural issues to consider are, amongst others, the venue of the group, policy around membership, the size of the group, meeting time, frequency and duration.

In the proposed group work project, the following issues around structure are considered:

Venue of the group: According to Toseland and Rivas (2005:178) the venue for the group should not be too big or too small, however it will also depend on the availability of resources. In the proposed group, the group will meet at the church in the urban setting, and will use a classroom at a school in the rural setting.

Membership policy: During the planning phase the group facilitator will have to consider whether the group will be open or closed. In the proposed group, sessions are building on each other and members also need time to develop cohesion and cooperation (Sands & Solomon, 2004:11; Toseland & Rivas, 2005:173). Therefore, the proposed group will have closed membership.

Size of the group: The size of the group will be determined by the group's purpose (Sands & Solomon, 2004:11). Some theorists argue that the ideal size of group participants is seven (Sands & Solomon, 2004:11; Toseland & Rivas, 2005:170). However, groups with a closed membership should rather accept slightly more participants while emphasising the importance to attend all sessions, to ensure that a sufficient number of participants attend every session.

Meeting time, frequency and duration of the group: Group facilitators have to think about the duration and frequency of the proposed meetings of each session. The intensity of an intervention also influences its outcome. According to Brodaty *et al.* (2003:2) the intensity of an intervention is determined by the total number of group sessions. A minimal intervention lasts one to two sessions only, a moderate

intervention between three to five sessions, a medium high intervention between six to ten sessions while a high intensive intervention will last ten or more sessions. Schulz and Martire (2004:244) added that the more intense an intervention is in terms of frequency and duration, the bigger will be its impact than is the case with low intensity interventions. Weekly group contacts will help participants integrate the knowledge presented and to practise skills acquired (Sands & Solomon, 2004:9-10). The intensity of the proposed group will be a medium high intervention which is appropriate for a solution-focused approach.

6.6 Group content

The group content refers to whatever is done in the group, based on the inputs of both the group facilitators and the members, in order to accomplish the purpose of the group (Wayne & Cohen, 2001:99-101). The proposed group will have variable group content that involves the following; opening and closing prayer, check-in at the beginning of the group session and check-out at the end of the group session, ice- breakers, exercises, mediation or relaxation exercises, discussions, role plays and homework assignments.

6.7 Formation strategy

Two key areas need to be considered as part of the formation strategy, namely, recruitment and screening of potential group members. Various strategies are available to recruit potential group members such as self-referrals, referrals from other professionals, announcements of the group and direct outreach. Individual telephone or face-to-face contacts with potential group members can be made during the pre-group phase (Wayne & Cohen, 2001:101-103). Since not all people are suitable group members, some people must be excluded from participating in a group. According to Toseland and Rivas (2005:174), factors to consider for excluding potential group members are, problems to schedule transport or other practical consideration, personal qualities that are completely different from other group members and if need be, expectations or goals that are not congruent with the other group members. For an inclusion criteria, Toseland and Rivas (2005:174-175) suggest a pragmatic view that avoids labeling, but rather considers the ability

of members to communicate with each other, motivation to work on the problem, the absence of bizarre behaviour and few personality or cultural differences.

In the proposed group, announcement of the proposed group will be done with the help of community and church leaders, while the recruitment of group participants will be done by the group facilitator through individual contacts that assess whether they meet the group membership criteria. Prospective group members will then be oriented to the group purpose. The intensity of caregiving will further be assessed by means of checking how involved caregivers are assisting older persons with one or more activities of daily living (ADL's). Finally, the group members will be consulted to determine the most suitable day and time for the meetings.

6.8 Evaluation strategy

An evaluation strategy during the group process consists of three components, namely, methods for monitoring the implementation of the plan, documenting the process of the group and assessing the achievement of the group and individual outcomes. Evaluations assist group practitioners to understand what is happening, the lessons learnt from the group and how to adjust interventions. In addition, through evaluations, group facilitators demonstrate that they have a sense of accountability towards the group members (Wayne & Cohen, 2001:104). In the proposed group the administration of the pre-test, post-test and a postponed post-test of the Zarit Burden Interview (ZBI) (Whitlatch *et al.*, 1991; Zarit *et al.*, 1980:649-655), the Potentially Harmful Behaviour (PHB) scale (Miller *et al.*, 2006:128) and the Caregiver Abuse Screen (CASE) (Reis & Nahmiash, 1995:45-60), will be done. In addition, the group facilitators will complete the Group Engagement Measure (GEM) of every group participants to measure their engagement in the group process (Macgowen, 2006:35). Furthermore, open-ended questions will be discussed by the group members on their experiences about the support group.

7 CONTENT OF THE SUPPORT GROUP PROGRAMME

During the design of a support group programme, researchers also have to give thought to what will be done during the implementation of the project (Sands & Solomon, 2004:9). Based on a needs assessment that took place in phase one of

the study, and a literature review, the support group programme was designed. An outline of the social work support group programme with informal caregivers will be presented in the table below.

TABLE 1: OUTLINE OF THE SUPPORT GROUP PROGRAMME

Number of session	Topic	Programme activities
1.	Introduction and orientation	• Pre-test measuring scales • Getting acquainted (icebreaker) • Explore member expectations • Clarify the purpose of the group • Contracting • Evaluation
2.	The normal process of aging	• Aging simulation exercise (icebreaker) • Explore myths of aging • Discussion: Physical, physiological and social processes of aging • Evaluation
3.	Handling problematic aging behaviour	• Define and identify problematic behaviour • Discuss current ways and brainstorm better ways of coping with problematic behaviour • Role play • Evaluation
4.	Caregiver stress	• Define the concepts 'stress' and 'burnout' • Discuss warning signs of stress and burnout • Identify the sources of stress and burnout • Brainstorm: better ways to deal with stress

		• Evaluation
5.	Self care	• Icebreaker (explore the importance of self care) • Rights of caregivers • Identify barriers to self care • Explore self care strategies • Develop an individualized self care plan • Evaluation
6.	Elder abuse & neglect	• Discussion: Rights of older people • Discussion: What is elder abuse, forms, signs of elder abuse • Where to report elder abuse • Brainstorm: Prevention of elder abuse • Evaluation
7.	Grief and loss	• Icebreaker • Define concepts: grief, loss, tangible grief, psychological grief • Discussion: Personal losses experienced because of caregiving • Discussion: Phases of loss according to Kubler-Ross • Brainstorm: Ways to cope with grief and loss • Evaluation
8.	Termination	• Group discussion • Evaluation • Refreshments • Post-test measuring scales
9.	Follow-up session (6-weeks after termination)	• Group discussion • Final evaluation • Postponed post-test measuring scales

A detailed discussion of each session of the support group programme which includes the objectives, content and evaluation of the programme will follow.

7.1 Session No 1: Introduction and orientation

7.1.1 Objectives

- To complete the pre-test measuring scales.
- To facilitate member introductions.
- To explore the members' expectations
- To outline and clarify the purpose of the group.
- To create a relaxed and conducive atmosphere for the support group.
- To conclude contracts with the group members.
- To do a mediation or relaxation exercise.

7.1.2 Content

In order to get the very first impressions, before members will be exposed to the support group programme in any way, the group members will be requested to complete the pre-test measuring scales which will consist of the demographic details (Annexure 10), the Zarit Burden Interview (ZBI) (Annexure 11), the Potentially Harmful Behaviour (PHB) scale (Annexure 12) and the Caregiver Abuse Screen (CASE) (Annexure 13).

The group facilitator and co-facilitator will introduce themselves, and welcome all the members to the group. The group facilitator will facilitate member introductions by means of an ice-breaker which aims to create a relaxed atmosphere. Participants will be requested to arrange themselves in a line that represents the length of time they have been a caregiver to the older care recipient, from the shortest time of caregiving to the longest time. To figure out who has spent more or less time as a caregiver and where in the line they should be located, participants will have to interact with one another. Members will then be asked to form subgroups according to their relationship with the older care recipient (for example spouse, adult child, sibling etc), and will introduce themselves in the subgroup (their name and their relationship with the older care recipient). The members will be asked form a new

subgroup, and again introduce themselves, until each group member made contact with several group members.

The group facilitator will explore the members' expectations about the group, by asking open-ended questions that directs members in their thinking about their personal expectations. The group facilitator will then compare the expectations of participants with the purpose of the group. The outline of the group will also be presented to the members, and their opinion will be sought.

Group rules will be discussed by both the group facilitators and the members. Rules will be written on a flipchart and pasted on the wall as a constant reminder. Each group members will also receive a copy of the rules to take home. The group will be closed with the deep breathing technique as a stress reduction exercise, a verbal evaluation of the group session, followed by a closing prayer.

7.1.3 Evaluation

The evaluation of the group session will be done in the following ways:

- The pre-test measuring scales will be completed on a one on one basis with each individual member before the commencement of the initial group session.
- At the end of the group session, all group members will have the chance to orally evaluate what they found most and least helpful, as well as their level of satisfaction with the group session.

7.2 Session No 2: The normal process of aging

7.2.1 Objectives

- With the aid of an aging simulation exercise, members will be assisted to understand the physiological changes of aging.
- To explore caregivers myths about aging, and to correct misconceptions.
- To educate the caregivers on the physical, psychological and social processes of aging.
- To discuss ways to cope with these processes of aging.
- To link the processes of aging to elder abuse and neglect.
- To do a mediation or relaxation exercise.

7.2.2 Content

After the welcoming, opening prayer and explanation of the purpose of the session, the group will have a check-in, whereby members can share updates from the week, issues of concern or thoughts about feelings they are experiencing. The group members will then be requested to participate in an aging simulation exercise, to help them realize the physiological losses in terms of hearing, sight, touch and smell because of the normal process of aging.

Thereafter, group members will be presented with true/false statements on aging, to test their misconceptions about aging. Stereotypes that caregivers might hold on aging will be cleared.

Caregivers will then be educated on the normal processes of aging, and will be invited to ask questions afterwards. Caregivers will then discuss how to cope with these changes. Finally, a discussion will follow on the link between the normal processes of aging, and vulnerabilities to elder abuse and neglect. The group will be end with a visualization exercise as a relaxation technique. As part of the check-out group members will evaluate the group session. Handouts will be provided to each caregiver for further reading and thinking about the topic. Home work assignments will focus on coping with the normal processes of aging for that week.

Before the group session ends, the group members will be asked to evaluate their level of satisfaction about the group discussion, and any likes or dislikes about the group session. The researcher and the co-facilitator will also evaluate their observations about the group process and outcome after the group session was ended.

7.3 Session No 3: Handling problematic behaviour because of aging

7.3.1 Objectives

- To review the previous group session on the normal processes of aging.
- To explain what is meant by difficult behaviour displayed by older care recipients.
- To identify challenging behaviours displayed by older care recipients because of aging.

- To discuss current ways of dealing with these challenging behaviours.
- To suggest better ways to deal with difficult behaviours, followed by role plays.
- To discuss the link between problematic behaviours displayed by older people and elder abuse.
- To do home work assignments on better ways to deal with problematic behaviours.

7.3.2 Content

The group facilitator will review the previous group session on the normal processes of aging. The group will have a check-in, whereby members can share updates from the week, issues of concern or thoughts about feelings they are experiencing. Group participants are then requested to form pairs, and to identify the challenging behaviours they encounter because of caregiving, as well as current ways how they are dealing with these problem situations, and will report it to the group. The group will also explore the link between difficult behaviour and violence or elder abuse. The group will then brainstorm better ways to deal with problem situations. Some of the solutions for these problem situations will then be practiced in role play exercises. The group will end with the body scan relaxation exercise. Handouts will be provided to each caregiver for further readings and thinking about the topic. Group members will be requested to design individualized home work assignments based on their unique caregiver challenges.

7.3.3 Evaluation

Group members will have to evaluate their level of satisfaction on the group discussion, as well as the helpfulness or unhelpfulness of the group discussions. After the group has ended, the researcher and the co-facilitators will share their observations with one another on the functioning of individual group members as well as the group as a whole.

7.4 Session No 4: Caregiver stress

7.4.1 Objectives

- To review the previous group session on challenging behaviours and homework assignments.

- To explain the concept 'stress' and 'burnout'.
- To request group members to think about a time they have experienced stress, and to share that experience and their feeling with a partner.
- To identify warning signs of stress and burnout.
- To identify the sources of their stress.
- To explore the link between caregiver stress and elder abuse.
- To ask group members to identify what they can change as well as what they cannot change about their stressors.
- To ask group members to develop an individualized action plan, what they will do to reduce their stress.
- To do a mediation or relaxation/stress reduction exercise.

7.4.2 Content

The group will start with a review of the previous group session on challenging behaviour, and members will be requested to report on their homework assignments. The group will have a check-in whereby members can share updates from the week, issues of concern or thoughts about feelings they are experiencing.

Participants will be asked to explain what their understanding is of the concepts 'stress' and 'burnout', and the group facilitators will provide the correct explanations. Based on their understanding, participants will then be asked to think about a time when they were stressed, share the incident and the feelings such as (anger, frustration, guilt, worry helplessness), they had with a partner, and afterwards to discuss it with the group. The group will discuss the warning signs of stress, warning signs may include aspects such as irritability, sleep problems or forgetfulness. Handouts on the warning signs of stress will be distributed afterwards. The participants will be asked to mention what causes stress in their lives, and possible responses could be, amongst others, having too much to do, family conflicts, feeling inadequate, the inability to say no. Explore with the group members the link between caregiver stress and elder abuse. Group participants will then be told to realize that there are things they cannot change, for example, that other people cannot be changed, and they can only change the things they have control over. Group participants will therefore be asked to identify the changes they can make on the things they have control over. A handout with some examples will also be distributed

after the discussion. Finally, group participants will be asked to identify the action steps they will take to reduce their stress. Further thoughts about implementing the action plan would be a homework assignment. After the evaluations, the group session will end with the progressive muscle relaxation (PMR) technique as a stress reduction exercise.

7.4.3 Evaluation

The evaluation of the group session will be done in the following ways:

- In order to assess the group process, the researcher will complete the Group Engagement Measure (GEM) (Annexure 14) that assesses each individual member's engagement in the group process.
- The group facilitator will also ask the informal caregivers to verbally evaluate their perceptions on the group process so far, their level of satisfaction with the group and any suggestions they wish to make to improve the group.
- After the group session ends, the researcher and the co-facilitator will evaluate whether the objectives of the group session were met.

7.5 Session No 5: Self-care of the caregiver

7.5.1 Objectives

- To review the previous group session on caregiver stress and report back on the homework assignments.
- To explore past experiences of self-care by caregivers.
- Through an ice-breaker, to explore the importance of self-care.
- To discuss the 'rights of caregivers'.
- To identify the personal barriers to self-care.
- To link the absence of self-care to elder abuse and neglect.
- To explore self-care strategies in the physical, emotional, social, spiritual and financial domain of caregivers.
- To encourage and help participants as they develop their own self-care plans.

7.5.2 Content

After the welcoming to the group session, the group members will have a check-in, whereby they review the homework from the previous session. As an introduction to

the session, group members will be requested to share what they did during the past week to take care of themselves. The group will then have an ice-breaker to help them realize that only if they have taken good care of themselves will they be able to be efficient as caregivers. The rights of caregivers will then be discussed, once again to highlight the importance of self-care of the caregiver. Caregivers will form dyads or triads to discuss personal barriers to self-care. A discussion on the link between the absence of self-care and elder abuse and neglect will be made. Group members will then explore self-care strategies in the physical, emotional, social, spiritual and financial domain, in smaller groups and will report it back to the big group. As an individual exercise, group members will be encouraged to develop a self-care plan, which they can continue to think about and also try out as a home work assignment. The group will end with a relaxation or mediation exercise, followed by an evaluation.

7.5.3 Evaluation

Group members will have to evaluate their level of satisfaction about the group session, and any likes or dislikes about the group session. The researcher and the co-facilitator will evaluate individual group members as well as the group as a whole, after the group session was ended.

7.6 Session No 6: Elder abuse and neglect

7.6.1 Objectives

- To review the previous group session on self-care and homework assignments.
- To inform participants on the rights of older people.
- To define what elder abuse is, the forms of elder abuse, and signs of elder abuse.
- To brainstorm where elder abuse can be reported.
- To discuss ways to prevent elder abuse and neglect.
- To do a relaxation or mediation exercise.

7.6.2 Content

The group will have a check-in, whereby members will review the previous session and report back on the homework assignments. The group facilitator will educate

group members on the basic rights of older people, group members will then discuss challenges they may experience to support the rights of older people. Group members will be asked their understanding of what elder abuse is. This will be followed by a discussion on the forms of elder abuse and the signs of elder abuse. The group facilitator will pay special emphasis on elder abuse that can unintentionally happen in caregiving situations, such as restraining and over medication of the older person. Handouts will be provided to each caregiver for further reading and thinking about the topic. Group participants will explore the actions caregivers can take if elder abuse or neglect is suspected, where the problem can be reported. The group will brainstorm ways on how elder abuse and neglect can be prevented in domestic settings. The group discussion will end with a relaxation or mediation exercise, which will be followed by an evaluation of the group session.

7.6.3 Evaluation

The evaluation of the group session will be done in the following ways:

- The researcher will complete the Group Engagement Measure (GEM) (Annexure 14) after the group session has ended to assess the group dynamics of sessions five and six of the group process.
- During the group discussions, group members will be asked to orally evaluate what they found most and least helpful, as well as their level of satisfaction with the group session.
- After the group session has ended, the researcher and the co-facilitator will evaluate whether the objectives of the group session were met.

7.7 Sessions No 7: Grief and loss

7.7.1 Objectives

- To review the previous group session on elder abuse and neglect.
- To define the concepts grief and loss, and further differentiate between tangible and psychological loss.
- To discuss losses that caregivers may have experienced personally.
- To explain the stages of loss according to Kubler-Ross.
- To discuss ways for caregivers to cope with loss and grief.

- To do a mediation or relaxation exercise.

7.7.2 Content

The group will have a check-in, whereby members review the lessons learnt from the previous group session and can also share updates from the week, issues of concern or thoughts about feelings they are experiencing.

After the topic on grief and loss has been introduced, the group facilitator will explain the concepts 'grief' and 'loss'. In order to gain an even better understanding a distinction will be made between tangible loss in the form of death or disease, and psychological loss which entails issues such as losing your dreams or income. Group members will then be requested to share in pairs, and eventually to report back to everybody in the group, the losses that they have personally experienced. Information will be provided on the stages of grief and group members will be requested to relate their losses to the stages presented. Afterwards, a discussion will follow on ways to cope with grief and loss. The group facilitator will announce the approaching termination date of the group. The group session will end with a relaxation or mediation exercise, which will be followed by an evaluation.

7.7.3 Evaluation

During the group discussion group members will be requested to evaluate the lessons learnt and their level of satisfaction with the group. The researcher and co-facilitator will also have a discussion whether the objectives of the group session was met after the group has ended.

7.8 Session No 8: Termination

7.8.1 Objectives

- To review the lessons learnt throughout the group process.
- To verbally evaluate the effectiveness of the group.
- To work out future support plans.
- To complete the post-test measuring scales.

7.8.2 Content

The participants will be doing the final check-in. As part of the review of the group, members will be asked to discuss the important aspects they have learnt, what they have gained and what they value about the group. After the review, group participants will then engage in a verbal evaluation of the group programme. As part of future support and plans, group participants will set a date for the follow-up group session, six weeks after the group was terminated. The meeting will be concluded with a meal.

7.8.3 Evaluation

The evaluation of the group session will be done in the following ways:

- The researcher will complete the Group Engagement Measure (GEM) (Annexure 14) to assess the level of engagement of each individual group member in sessions seven and eight of the group process.
- By means of open-ended questions (Annexure 15), group members will be asked to respond to the following questions:
 - What they have learnt from the group session.
 - How the support group programme has impacted on their caregiving skills.
 - Topics they have liked the most and the least in the support group programme.
 - Amendments or suggestions they wish to make to the support group programme.
- Immediately after the group has ended, the group facilitator will interview each group member to complete the post-test measuring scales (Annexures 11-13).
- The researcher and the co-facilitator will evaluate whether the objectives of the group session were met.

7.9 Follow-up session: six weeks after the group came to an end

7.9.1 Objectives

- To do a verbal evaluation about the effectiveness of the group, which will be tape recorded for a complete reporting (Annexure 15).
- To review the progress of group members since termination.

- To complete the postponed post-test measuring scales (Annexures 11 -13).

7.9.2 Content

According to Sharry (2007:125), the aim of the follow up sessions is to “harness the post session change and to provide a future reflective space where this change can be elicited, amplified and reinforced”. At the follow-up meeting, participants once again review the lessons learnt in the group, and evaluate the progress they have made since the group came to an end. The postponed post-test will then be administered. The final closure of the group will then take place.

7.9.3 Evaluation

During the follow-up group discussion, group participants will discuss how the support group programme had an impact on their lives even after the group has ended. Immediately after the follow up session, the researcher will interview each group member to complete the postponed post-test measurements (Annexures 11-13) that assess the outcome of the group.

8 RECOMMENDATIONS

From a solution-focused perspective, Sharry (2007:123) asserts that “the transformation of a facilitated group into a self-help group can be a very important development in empowering clients to take action for themselves.” Sands and Solomon (2004:8) argue that formally developed groups led by a social worker can eventually change into self-help groups after the group have been completed, and are functioning independently without the involvement of a professional group facilitator. Therefore, depending on the interest of the group members, the support group may be continued, whilst co-facilitated by caregivers who have participated in the group under the supervision of a practising social worker. For further strengthening of this community initiative, informal meetings will be held whenever the need arises among the committee members of the caregiver groups in the urban and rural area.

Support groups are not the only service desired by caregivers. A multidisciplinary approach is needed to respond to the complex realities of the caregiving of older

people in non-institutionalized settings, which in the process can lead to improved caregiving conditions for older people.

9 CONCLUSION

The goal of this article was to develop a social work support group programme with informal caregivers of older people; this goal was accomplished. The design of a group is part of the pre-group planning, however, during the implementation and evaluation of the group work project, the planning process will be continued. The planning model applied in this article was useful in considering all the essential factors of designing the group in a systematic manner. Support group interventions with informal caregivers are indispensable services that help to enhance caregiving skills and improve the quality of care of older people living in non-institutionalized settings.

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ARTICLE 4

J. A. Ananias & H. Strydom

Evaluation of the effectiveness of a support group programme with informal caregivers to prevent elder abuse and neglect

ABSTRACT

The aim of the article is to describe the evaluation on the effectiveness of a support group programme with the aim of enhancing the quality of care provided by informal caregivers of older people in an urban and rural community setting in Namibia. The support group programme equipped informal caregivers with knowledge on aging and caregiving. In addition, coping skills and support were offered to the informal caregivers. Standardized measuring instruments that assessed the outcome of the group at pre-test, post-test and postponed post-test were the Zarit Burden Interview (ZBI), Potentially Harmful Behaviour (PHB) scale and the Caregiver Abuse Screen (CASE). The Group Engagement Measure (GEM) assessed the group processes at the fourth, sixth and eighth group sessions. In addition, open-ended questions were used to collect the qualitative data. The SPSS software was used to analyse the quantitative data, while the qualitative data from the open-ended questions were analysed manually by means of the Tesch approach. Support group interventions indeed had a positive impact on the knowledge of, and sense of support amongst informal caregivers.

1 INTRODUCTION

The establishment and strengthening of community care systems for older people is of global interest seeing that most care of older people is still informal in both developed and developing countries (United Nations report on aging, 2003). Informal care systems within community settings can enhance the quality of life of the increasing aging population. The aim of this article is to describe the evaluation of a support group programme with informal caregivers of older people in an urban and rural setting in Namibia. The need for such a support group programme was identified after a needs assessment was conducted that explored the quality of care of older people within informal caregiving situations. The needs assessment revealed that informal caregivers as family, friends and neighbours, experience, amongst others, stress and burden. They also lacked knowledge about the unique needs of older people and were living in social isolation. The exploratory study further found that some older people had no caregiver or received poor quality of care and even elder abuse and neglect. The central theoretical argument of this study is 'A social work support group programme with informal caregivers will enhance the care of older people in urban and rural community settings.' The support group programme will equip informal caregivers with knowledge on caregiving and aging, as well as skills on stress and self-care.

2 PROBLEM STATEMENT

Many older people live in non-institutionalized settings and receive care from the family and community (Choi & Mayer, 2000:6). Informal caregiving, largely done by women, and is often unpaid and undervalued (Bookman & Kimbrel, 2011:119). To point out the actual value of caregiving, some scholars estimate that informal care could cost 257 billion US dollars annually in America alone (National Alliance for Caregiving and AARP, 2004).

Although family members may have good intentions to care for their older relatives in their homes, family members may not understand the basic care needs that may even sometimes last up to 24 hours a day (Splinter, 2009:24). It is further argued by Hsieh et al. (2009:378) that caregivers may lack training or education on aging and caregiving, and as a result, may develop negative attitudes towards older care

recipients. The demands and responsibilities of the day to day care of older people can become stressful to caregivers, may lead to burnout and eventually emotional abuse of older care recipients (Von Heydrich, 2009:40). Therefore, support interventions in the form of respite care and support groups can have a positive impact on caregivers and older care recipients (Choi & Mayer, 2000:22).

According to Wallhagen and Yamamoto-Mitani (2006:66), most intervention research on family caregiving was conducted in Western countries, with fluctuating reports on success. According to Hsieh *et al.* (2009:379) some of the positive outcomes of support groups are, that they provide an opportunity for caregivers to reflect and share personal and emotional stressors that are associated with caregiving. Such group exchanges enable caregivers to cope with the stress and emotional burdens associated with caregiving. Involvement of caregivers in support groups offers chances to socialise and therefore reduce the social isolation of caregivers.

Little literature is available concerning rural-urban differences about informal caregiving provided to older care recipients. In particular, rural informal caregiving of older care recipients from diverse ethnic groups is understudied (Chadiha *et al.*, 2011:2). Therefore, this article is an attempt to fill the gaps in the literature concerning supportive interventions to informal caregivers from urban and rural community settings. The research question that arose was *“How does a support group programme enhance the quality of care provided by informal caregivers of older people from urban and rural community settings in Namibia?”*

3 AIM OF THE RESEARCH

The aim of the research was to assess the effectiveness of a support group programme with informal caregivers which aimed at enhancing the quality of care to older people in urban and rural settings.

One of the objectives of the research and aim of this article was to report on the evaluation of the effectiveness of a support group intervention with informal caregivers of older people in an urban and rural setting.

4 RESEARCH METHODOLOGY

4.1 Research design

The intervention research design was the most appropriate for this applied study (De Vos & Strydom, 2011:475); that aimed at strengthening informal care of older persons in urban and rural communities through the development and evaluation of an innovative support group programme to prevent elder abuse and neglect. The exploratory mixed method approach was utilised in this intervention study (Delpont & Fouche, 2011:441), which involved a qualitative exploration on informal caregiving situations that may lead to elder abuse and neglect. Based on the qualitative information the support group programme for informal caregivers was developed and evaluated (Creswell, 2009:14; Delpont & Fouche, 2011:441). The intervention research model consists of six phases. The last two phases of the intervention model, namely, evaluation and advanced development and dissemination, apply to this article.

Phase 5: Evaluation and advanced development

Four tasks are carried out in the evaluation and advanced development phase, namely selecting an experimental design, collecting and analysing data, replicating the intervention under field conditions and refining the intervention (De Vos & Strydom, 2011:485). A single system design was chosen as an appropriate design to evaluate the effectiveness of the support group intervention. According to Strydom (2011:160), a single system can be a group, family or community. Support groups with informal caregivers in an urban and rural area were two single systems to which the intervention was applied. Standardized measures used for testing the outcome of the group at pre-test, post-test and postponed post-test were the Zarit Burden Interview (ZBI) (Annexure 11), the Potentially Harmful Behaviour scale (PHB) (Annexure 12) and the Caregiver Abuse Screen (CASE) (Annexure 13).

As the process of social work groups outlined by Toseland and Rivas (2005:85-89) was applied in the intervention, and the Group Engagement Measure (GEM) (Annexure 14) was used to measure process outcomes of the support group intervention. The group engagement measure was utilised to assess the engagement of each group member at the 4th, 6th and 8th group sessions. Open-

ended questions (Annexure 15) were also used to gather qualitative data about the support group programme.

Phase 6: Dissemination

De Vos and Strydom (2011:487) assert that intervention research results must be disseminated with community organizations, scholars, and other stakeholders. The support group programme will be replicated in other communities by the Ministry of Health and Social Services, as the government agency responsible for policy and programmes on older people. This support group programme can be replicated by the social workers from other regions throughout the country as an intervention programme on community care of older people. To reach out to a broader scholarship, articles will also be submitted to accredited journals for possible publication, and findings will be presented at national, regional and international conferences. The process of dissemination and adaptation would be effective if the following actions are considered, namely, preparing the product for dissemination, identifying potential markets for the intervention, creating a demand for the intervention, encouraging appropriate adaptation and providing technical support for adopters (De Vos & Strydom, 2011:487).

4.2 Measuring instruments

Four standardized measuring instruments were used to evaluate the effectiveness of the support group program with informal caregivers.

The Zarit Burden Interview (ZBI) (Annexure 11) is a 22-item self-report measure to assess two domains, namely, personal strain and role strain of caregivers (Whitlatch et al., 1991; Zarit *et al.*, 1980:649-655). Each item on the interview was a statement which caregivers were asked to support or reject by using a 5-point Likert scale, ranging from 0 (Never) to 4 (Nearly Always).

The Potentially Harmful Behaviour (PHB) scale (Annexure 12) is a 10-item instrument which was used to assess poor or inadequate care displayed as physical or psychological abuse towards the older care recipient. Employing a 5 point Likert scale ranging from 0 = never to 4 = all the time, caregivers were asked to report how each behaviour occurred during a conflict situation between the caregiver and care

recipient whenever the care recipient displays undesirable behaviour. Because of the sensitive nature of the questions, Miller *et al.* (2006:128) suggest that these questions be placed towards the end of an interview.

The Caregiver Abuse Screen (CASE) (Annexure 13) is an 8- item screening questionnaire used to assess the risk of elder abuse amongst caregivers. After a caregiver completes the entire screen, “yes” responses are added. The more “yes” responses found, the more likely the presence of abuse. More than four ‘yes’ responses can be an indication of a much higher risk for abuse. However, even one ‘yes’ score could be an indication of elder abuse (Reis & Nahmiash, 1995:45-60).

The Group Engagement Measure (GEM) (Annexure 14) is a standardized 27-item measuring instrument that was used to measure the process of the support group program. The researcher completed the measure to assess the engagement of each group member in the group process at the 4th, 6th and 8th group sessions. According to Macgowen (2006:35), engagement of group members in the group process entails seven dimensions, namely, attending, contributing, relating to the group worker, relating with group members, contracting with group service, working on own problems and working with other’s problems. A five point Likert scale ranging from 1= rarely to 5 = most of the time, was used to rate each item on the scale.

To complement the quantitative data, open-ended questions (Annexure 15) were used to evaluate the effectiveness of the support group programme.

4.3 Reliability and validity of the quantitative measuring instruments

The concept reliability refers to consistency or dependability (Neuman, 2011:208).

Validity refers to how well an instrument measures what it is supposed to measure (Delpont & Roestenburg, 2011:173; Neuman, 2011:208).

It is important that before a study is undertaken, the researcher knows the levels of reliability and validity of the measuring instruments to be used in the study (Delpont & Roestenburg, (2011:172). The most commonly used reliability measure is the

Cronbach's Alpha coefficient, which ranges between 0 and 1. A coefficient closer to 1 (.8 -.9), is regarded as highly reliable (Delpont & Roestenburg, 2011:177).

As already mentioned above, the Zarit Burden Interview (ZBI) was used in this study. This instrument is used internationally and has been translated into different languages (Ruiz-Gonzalez, 2012:22). In a Canadian study with 312 caregivers Hérbert et al. (2000:494-507), found that the Zarit Burden Interview (ZBI) had a good internal consistency and construct validity. In this study, the Cronbach alpha test for the Zarit Burden Interview (ZBI) varied between .68 and .83.

The Potentially Harmful Behaviour (PHB) scale has been found to possess good convergent and discriminant validity and internal consistency to measure abusive behaviour displayed by caregivers of older people with dementia (Cooper et al., 2010:481). In this study, the reliability of the Potentially Harmful Behaviour (PHB) according to the Cronbach-alpha test varied between .59 and .81.

The validity of the Caregiver Abuse Screen (CASE) was explored by Reis and Nahmiash (1995:45-60) and found that the tool is valid as an initial screen tool for elder abuse. The Cronbach alpha reliability of the 8-item measure of Caregiver Abuse Screen (CASE) for this study was an adequate .82.

Four research studies that assessed the usefulness of the Group Engagement Measure (GEM) found that this measurement is indeed reliable, valid and useful in social work groups (Macgowan, 2006:33-52). The Group Engagement Measure (GEM) was found to be highly reliable in this study, with a Cronbach alpha reliability that varied between .80 and .97.

4.4 Trustworthiness of the qualitative data

It is essential that researchers assess the authenticity or rigour of the qualitative data of the study. Trustworthiness can be regarded as an alternative concept for assessing the validity and reliability of qualitative data (Botma et al., 2010: 232; Creswell, 2009:191). The trustworthiness of this study evaluated against the criteria of Lincoln and Guba, 1999 (as cited in Schurink et al., 2011: 420) were credibility, transferability, dependability and conformability.

4.4.1 Credibility

The goal of credibility is to prove that the study was conducted in such a manner that ensured that the research participants were accurately identified and described. In addition, the researcher's idea of the research problem must correspond with the perceptions of research participants. (Schurink et al., 2011:419-422). To increase the credibility of this study, participants of the support group programme were engaged in ongoing evaluations about the effectiveness of the programme. Furthermore, during one-on-one data collections of the quantitative measuring instruments, participants could further elaborate on their qualitative assessments of the support group programme. The researcher took detailed notes of each data collection session.

4.4.2 Transferability

Transferability involves the ability of the researcher to transfer the findings of the research from one specific situation or case to another, very difficult to accomplish in qualitative studies (Schurink et al., 2011:420). Although it is not possible to generalize the qualitative data, the researcher applied the triangulation of multiple sources of data as a strategy to gain trustworthiness of the findings. In this study, both quantitative and qualitative data was collected, which corroborated and further elaborated on the research findings.

4.4.3 Dependability

Questions that researchers have to answer about dependability are whether the research process is logical and well documented (Schurink et al., 2011:420-421). For the purpose of this study, the researcher ensured that the criteria of dependability was met, by the detailed recording and notetaking of all the discussions with participants. The researcher used the same open-ended questions to collect the data in both the urban and rural group. Data was transcribed and analysed. Furthermore, the experiences of support group participants were accurately described and interpreted.

4.4.4 Conformability

The question that researchers must answer for conformability is whether the findings can be confirmed by another study (Schurink et al., 2011:422). In other words, the researcher must provide answers that corroborate the findings and interpretations by means of auditing. In this study, the researcher has attained objectivity by ensuring that the intervention programme was conducted with a practicing social worker as co-facilitator. Furthermore, the researcher and practicing social worker had debriefing sessions after every support group programme for the evaluation and planning of the next group session.

4.5 Participants

Twenty-two female informal caregivers of older people took part in two support groups, with ten caregivers from the urban area in one group and twelve caregivers from the rural area in another group. Caregivers were eligible for the study if they met the following criteria:

A child, spouse, sibling or extended family member as primary caregiver;

Who assist an older person with one or more Activities of Daily Living (ADL);

Willingness and availability to participate voluntarily for the duration of the programme, and

Resides in the urban or rural constituency in the Khomas region.

4.6 Procedures

The following procedures were followed:

The recruitment and selection of participants for the rural and the urban support group;

All the selected participants gave oral consent (Annexure 9) to participate in the groups before the groups commenced because of the low literacy levels of some caregivers;

The pre-test measuring scale was completed with both the rural and urban groups before the groups have started, the post-test was completed after the groups ended and the postponed post-test scales were done six weeks after the groups terminated;

The Group Engagement Measure (GEM) (Annexure 14) to assess the group process was completed by the researcher at the fourth, sixth and eighth group sessions, and

The support group programme was implemented and evaluated in the urban and the rural areas by means of open-ended questions (Annexure 15).

4.7 Data Analysis

The quantitative data was analysed with the SPSS version 21.0. The hierarchical linear modelling, often applied in groups where elements of a group are interdependent was chosen as an appropriate approach for this analysis. The researcher chose the hierarchical linear model because it takes into account the dependency of measurements on the same person within and across a group or cluster (McCroach, 2010:123). The Tesch approach was applied to analyse the qualitative data manually (Poggenpoel, 1998:343-344).

4.8 Ethical aspects

Ethical permission was obtained from the Ethical Committee of the North West University, Potchefstroom Campus (Annexure 1), and the number NW-00012-12-S1 was allocated. In addition, ethical permission was also obtained from the research committee of the Ministry of Health and Social Services of the Republic of Namibia (Annexure 2).

The following ethical measures were followed during the intervention research:

Participation in the study was voluntary (Strydom, 2011:116-117);

Informed consent (Annexure 9) was obtained from the participants after all aspects of the research were explained before the intervention started (Bless *et al.*, 2006:142-143; Strydom, 2011:117-118);

Information as to the goals, procedures, advantages and disadvantages were explained to the participants (Neuman, 2011:149);

Participants were protected from physical and psychological harm, with debriefing sessions offered by the group facilitators after every group session (Neuman, 2011:145-146; Strydom, 2011:122);

All participants were assured of confidentiality and anonymity, and were further encouraged to maintain confidentiality of disclosures from other participants (Bless *et al.*, 2006:143; Neuman, 2011:152-153; Strydom, 2011:119-120);

Both the researcher and the co-facilitator are registered with the Social Work and Psychology Council of Namibia and therefore adhere to the code of ethics of the social work profession (Strydom, 2011:123), and

Data was stored on the computer hard drive, USB sticks and a filing cabinet in safekeeping.

5 IMPLEMENTATION AND EVALUATION OF THE SUPPORT GROUP PROGRAMME

A support group programme for informal caregivers of older people was designed and implemented in an urban and rural setting in the Khomas region in Namibia. The implementation and evaluation of the eight week support group programme which aimed at evaluating the effectiveness of the intervention was co-facilitated by the researcher and a practicing social worker employed by the Ministry of Health and Social Services. The opening rituals of the group consisted of a prayer, a check-in whereby every group member would say something, and an ice-breaker; while the closing rituals entailed a relaxation exercise, verbal evaluation of the group session and a closing prayer. Refreshments were served at the end of all the group meetings.

5.1 Session 1: Introduction and orientation

The pre-test questionnaires with the group members were completed during the recruitment phase after members had understood what the group was all about and confirmed their commitment to participate in the group. Group members in both

urban and rural settings had some difficulty in formulating expectations since they tended to concentrate on the problems care recipients experience instead of their own needs, thus the group facilitators gently steered members to start to think about their expectations as participants of the support group. The establishment of a relationship with co-facilitators of the group and with fellow group members was accomplished in both groups in the urban and rural setting, while contracting towards the group rules and completion of the programme took place verbally due to the lower literacy levels of some of the group members. Group members from both urban and rural settings were very enthusiastic about the group and were looking forward to the upcoming group meetings.

5.2 Session 2: The normal process of aging

Group members from the rural area demonstrated their commitment towards the group by their punctual attendance of every group meeting. The group members from both urban and rural areas believed most of the misconceptions about aging but were challenged by the group facilitators to change their perceptions. Simulation exercises carried out by group members to illustrate the problems older people experience with mobility and vision helped to smooth group member's understanding of the physical changes that occur in older people because of aging processes. The group venue in the rural area was bigger and offered greater opportunity to conduct more simulation exercises, while the venue for the group in the urban area offered lesser opportunities for moving exercises because of its smaller size. As a result the group members from the rural area could even share their thoughts and concerns as they were thinking about their own aging. The simulation exercises and group discussions helped both the urban and rural groups understood the biological, psychological and social processes of aging. They also understood, and shared how these aging processes related to their caregiving experiences. Members from both the urban and rural groups setting had a positive experience of the group sessions. One particular group member in the rural setting disclosed how she had acted insensitively towards her care recipient out of lack of knowledge about the normal processes of aging and resolved to change her attitude as a caregiver.

5.3 Session 3: Handling difficult caregiving situations

The solution-focused approach was considered appropriate to facilitate group discussions. In the discussions, the caregivers listed difficult caregiving situations they experienced and eventually solutions were sought for these problems identified.

Common difficult caregiving situations listed by both the urban and rural group included, amongst others, older people's refusal to bath, dependence of older people on one caregiver only, swearing by some older people, mental behaviour displayed by some older people, sleep deprivation due to monitoring older people's behaviour and the difficulty for caregivers to find help. The rural group listed additional difficult caregiving situations. They were; challenges in caring for bedridden older care recipients, gender sensitivity and age sensitivity with regard to the care recipient-caregiver dyad, difficulty on the part of the caregiver to exercise patience, challenges in communicating with an older person with a hearing problem, some older care recipients being demanding, the use of snuff, pipe or smoking by some older people, and the lack of transport for older people with mobility problems.

Both urban and rural group members related how some difficult caregiving situations made them vulnerable to be subjected to potential abuse by the older care recipient.

Based on the solution-focused approach, group members came up with solutions to the problems that they had listed. Group members exchanged existing ways of dealing with difficult caregiving situations, herein lies the strength of support groups.

Some suggestions shared among group members were; delegation of responsibilities amongst family members, doing proper planning, accepting situations that cannot be changed as well as praying. Group members from the urban group further suggested that bathing of the older care recipients can be done by a male caregiver or another person, example an older person's peer acceptable to the older care recipient as a solution. As a solution to the communication problems between caregiver and care recipient, assertive communication using the 'I'- messages was suggested by the group facilitators. The importance to exercise patience was identified by the rural group as an important aspect to consider for caregivers.

5.4 Session 4: Caregiver stress

After the topic caregiver stress was introduced and defined, group members formed smaller groups to share their personal stressors related to caregiving, which was subsequently reported to the bigger group. Group members from the rural group shared a number of stressors which were amongst others, being called frequently by the care recipient, the lack of finances or income, the irritable behaviour displayed by some older care recipients, especially when they do not have tobacco or snuff, lack of appreciation by some older care recipients, the death of loved ones and substance abuse by some care recipients.

With regard to substance abuse, one group member disclosed multiple caregiver stressors caused by the care recipient's substance abuse problem, refusal to bath himself and extreme condition of self-neglect. The caregiver has not received any help despite reporting of the problem to the relevant authorities. Emotional support was granted to the aggrieved caregiver who felt embarrassed and helpless for the neglectful situation of the care recipient, and a referral was made for individual medical and social interventions.

Signs and symptoms of caregiver stress were displayed on a flipchart and all group members from the urban and rural setting were in agreement that caregiver stress affects their health and wellbeing. Four ways to deal with stress were displayed on the flipchart, namely, asking for help, acceptance, taking care of one's health and finding some time off from caregiving were discussed by the group members as ways to deal with stress. One group member from the urban area reported how delegating caregiving tasks amongst family members had lessened her caregiver burden. In response to keeping a healthy lifestyle a number of group members from the urban group disclosed their weaknesses about indulging in sweet foodstuffs. Group members encouraged each other to start eating healthy food as a way of dealing with stress.

A stress relieving exercise in the form of a massage was enjoyed by all the group members and became a part of the group rituals. The researcher completed the Group Engagement Measure (GEM) to assess the engagement of the group members from the start of the group up to the fourth group session.

5.5 Session 5: Self-care

An imaginary exercise was used to introduce the topic on self-care, as group members had to imagine facing a dilemma whereby they had to choose between their own needs or the needs of the care recipient. As part of the exercise, most group members in both the urban and rural setting opted to respond to the needs of the older care recipient instead of their own. After some time debating, group members realized the detrimental consequences on both caregiver and care recipient if the needs of caregivers are ignored. Group members explored the reasons why caregivers were not keen to care for themselves, which were ascribed by group members to socialization and culture.

Group members discussed how the absence of self-care could lead to poor interpersonal relationships, potential verbal abuse towards the older care recipients and to the poor health of caregivers. Group members of the rural group assisted one group member who was faced with a dilemma between either receive medical help and to leave the older care recipient unattended for a short while or to ignore her own health and continue caregiving responsibilities.

To strengthen the importance of self-care, the rights of caregivers was placed on a flipchart and discussed in the group. Group members from both the urban and rural groups found the information on the rights of caregivers very informative and interesting. Group members shared caregiving experiences where these rights were violated, and the support group offered an environment where group members could vent their emotions.

Self-care strategies grouped under the physical, social, emotional and spiritual dimensions were placed on the flipchart. After these self-care strategies were explained, group members assisted one another to develop a balanced self-care plan. As part of the home work assignment, group members continued to work on an individualized self-care plan.

5.6 Session 6: Elder abuse and neglect

The topic of 'elder abuse' was introduced with a brief history on World Elder Abuse Awareness day celebrated on 15 June. Posters on World Elder Abuse Awareness

Day (WEAAD) and the UN Principles on the Rights of Older People were displayed on the walls. After a brief explanation on the rights of older persons, group members were asked to draw a picture of their emotions whenever they hear about elder abuse. Group members managed to draw images about abuse and shared their pictures with the group. Based on the pictures, group members could point out the various forms of elder abuse, such as financial abuse, emotional abuse, sexual abuse, partner violence and neglect. Group members from the rural area pointed out that poor emergency transport services lead to neglect of older persons' to health care. The perceptions of group members on restraint, as a form of elder abuse, gave rise to some discussion on an incident in the rural setting where restraint did occur. The discussion helped group members realize that restraint is also a violation of the right of older persons.

Group members from the rural setting seem to not report elder abuse to the few government institutions available to them, while the group members from the urban setting were able to mention a number of government, private and faith based agencies that could assist with complaints of elder abuse.

The researcher completed the Group Engagement Measure (GEM) for the second time to assess the engagement of group members in the fifth and sixth group session.

5.7 Session 7: Grief and loss

The group session was started with an icebreaker "How do I feel today?" which offered every group member an opportunity to share their feelings. After the topic grief and loss was introduced, the concepts of 'grief' and 'loss' were defined. A further differentiation was made between a 'tangible' loss and 'psychological' loss.

Members were requested to discuss psychological losses they had experienced and their feelings associated with these losses. Group members from the rural setting were resistant and uncomfortable talking about their losses since long silences were observed. In the urban setting, group members rather revealed some tangible losses instead of psychological losses. However, two members from the urban area, who had expressed emotional reactions about psychological losses in previous group sessions, received an opportunity to share their emotions. Group members

were not that emotional as was expected by the co-facilitators but instead shared how their faith in God helped them through those difficult times of grief and loss.

The phases of loss, according to Kubler-Ross, were displayed on a flipchart. Group members from the urban area were more engaged in recognizing feelings of guilt, denial and acceptance they have experienced than the rural group. The four ways to cope with grief listed on the flipchart were discussed, namely, self-care, awareness and expression of emotions, talking to a professional or religious leader and finally to developing a support network. Group members could identify the various people they regarded as their support network for issues on grief and loss but also caregiving in general.

5.8 Session 8: Termination

The termination session was attended by some government officials and representatives from the church as special guests. As group members reviewed their expectation set at the beginning of the group, both members from the urban and rural groups expressed satisfaction that their expectations were met. To consolidate their learning, group members highlighted the lessons learnt throughout the group process. The certificates of attendance were awarded to each group member, who felt happy and proud to receive them. Since members expressed their desire for the continuation of the support group, amongst the caregivers a coordinator who will be responsible to collaborate with the social worker regarding future support group activities was elected and introduced.

The social worker from the Ministry of Health and Social Services who co-facilitated the group will continue to hold monthly meetings with the members of the support group. Furthermore, the Ministry of Health and Social Services intends to repeat this support group programme once a year in these two constituencies, but also to extend the support group programme to other regions in the country.

The researcher completed the Group Engagement Measure (GEM) for the third time to assess the level of engagement of the group members in the seventh and eighth group sessions. Immediately after the group was ended, a home visit was conducted to fill in the post-test questionnaires.

5.9 Follow-up session

The aim of the follow-up session was to once again review the lessons learnt and applied since the group's termination, to discuss the way forward and to complete the postponed post-test questionnaire. All the objectives of the follow-up session were met. The respondents from both urban and rural areas could still clearly recall lessons learnt and that they could apply since the group has ended on caregiver stress and the importance of self-care. The respondents from the rural area were still concerned about the number of older people without any caregiver, as well as hospitalized older people who are neglected, while the respondents from the urban group were concerned about the substance abuse of older people, some bedridden older people who need help as well as the poor care and control to older persons from the old age home. The group members mentioned that these concerns be attended to as part of the way forward. The groups ended after everybody offered final feedback on the value of the programme. Once again, caregivers expressed their appreciation for the programme. The social worker then announced the days when the monthly meetings would be held. The group members finally completed the postponed post-test questionnaire.

6 RESULTS

The quantitative results of the hierarchical linear models over time, effect sizes and reliability will be presented below. The effect size used in this analysis describes the practical significance of differences between two means. The larger the effect size between two means, the more it is of practical significance (Olivier, 2009:14). Guidelines alluded to by Ellis and Steyn (2003:51-53) to interpret effect size were the following: (a) small effect $d = .2$; (b) medium effect $d = .5$ and (c) large effect $d = .8$. Normally the p -value should be smaller than .05, but for the purpose of this study, a small sample size was used, therefore, p -value of smaller than $<.1$ will be regarded as significant. For this study, it was important to establish whether as a result of the support group intervention programme any differences were observed between the rural and urban group, any differences observed over a time period as the group progressed, and whether these differences are of practical significance.

6.1 Results from the Zarit Burden Interview (ZBI)

The Zarit Burden Interview (ZBI) (in Table 1) was measured at pre-test, post-test and postponed post-test. According to Whitlatch et al. (1991) two domains investigated were personal strain and role strain.

TABLE 1: RESULTS OF HIERARCHICAL LINEAR MODELS OVER TIME, EFFECT SIZES AND RELIABILITY FOR THE ZARIT BURDEN INTERVIEW (ZBI)

	Rural –urban differences				Differences over time: pre-test (1), post- test (2), postponed post test (3)			
Domains	Means Rural/ Urban	P-Value Rural/ Urban	Effect size of Rural/ Urban	Residual estimate	Means (time: 1,2,3)	P-Value (time: 1,2,3)	Effect size (time: 1,2,3)	Reliability
Personal	R: .91 U: 1.34	.02	1.02	.43	1: 1.21 2: .70 3: 1.48	.00	1 & 2: 1.20 1 & 3: .60 2 & 3: 1.80	.83
Role	R: .56 U: 1.02	.01	1.16	.41	1: .75 2: .67 3: .96	.46	1 & 2: .20 1 & 3: .52 2 & 3: .72	.68

6.1.1 Personal strain

The Cronbach alpha reliability test indicates that a score of .83 was attained for the 12-items measure on personal strain. The rural group indicated that they encounter personal strain less frequently as a mean response of .91 was attained, than the urban group who also reported that on average they almost never encounters personal strain with a higher mean response of 1.34. The p-value regarding personal strain between the rural and urban group was measured <.02, which was of statistical significance. The effect size for the difference of the means for personal strain between the rural and urban group is 1.02, which indicates a large effect and is of practical significance. The mean response for personal strain at pre-test was 1.21, the mean response decreased slightly at post-test to .70, and at postponed post-test the mean response increased to 1.48. The p-value regarding personal strain tested at different times was measured <.001 which is of statistical significance. The effect size for the difference of the means for personal strain between the pre-test and post-test was 1.20 a large effect of practical significance,

however, the effect size for the difference of the means between the pre-test and postponed post-test for personal strain decreased to a medium effect of .60. The effect size for the difference of the means between the post-test and postponed post-test was significant as it produced a large effect size of 1.80.

6.1.2 Role strain

The Cronbach alpha reliability of the 6-item measure of role strain was .68. The rural group encountered less frequently role strain, with a mean response of .56, than the urban group who almost never encountered any role strain with a mean response of 1.02. The p-value regarding the role strain for the rural and urban group was measured at $<.01$, which is of statistical significance. The effect size for the difference of the means for role strain between the rural and urban group was found to be 1.16 which indicates a large effect of practical significance.

The mean responses for role strain at pre-test, post-test and postponed post-test were all very low. The p-value regarding role strain during different test was measured at $>.46$, and thus of no significance. The effect size for the difference of role strain between the pre and post-test was .20 which indicates a small effect of no significance. The effect size for the difference of the means for role strain between the pre-test and the postponed post-test was .52 which indicates a medium effect and is of significance. The effect size for the difference of the means for role strain between the post-test and the postponed post-test was .72 which indicates a medium effect of significance.

6.2 Results from the Potentially Harmful Behaviour (PHB)

The Potentially Harmful Behavior (PHB) was measured at pre-test, post-test and postponed post-test. Results on psychological abuse and physical abuse as forms of potentially harmful behaviour (Table 2) will be reported in the section below.

TABLE 2: RESULTS OF HIERARCHICAL LINEAR MODELS OVER TIME, EFFECT SIZES AND RELIABILITY FOR THE POTENTIALLY HARMFUL BEHAVIOUR SCALE (PHB)

	Rural –urban differences				Differences over time: pre-test (1), post- test (2), postponed post- test (3)			
Dimension	Means Rural/ Urban	P-Value Rural/ Urban	Effect size of Rural/ Urban	Residual estimate	Means (time: 1, 2, 3)	P-value (time: 1,2,3)	Effect size (time: 1,2,3)	Reliability
Psychological abuse	R: .30 U: .60	.12	.69	.42	1: .59 2: .38 3: .40	.54	1 &2: .50 1 &3: .43 2 &3: .07	.81
Physical abuse	R: .03 U: .05	.75	.54	.03	1: .04 2: .05 3: .03	.96	1 &2: .35 1 &3: .23 2 &3: .58	.59

6.2.1 Psychological abuse

The 5-item measure for psychological abuse was found to be highly reliable and was .81. A lowest mean response to indicate that psychological abuse on average never occurs was reported by both rural and urban groups, although the mean response for the urban group was higher, at .60 while the mean response for the rural group was .30. The p-value regarding the rural and urban differences for psychological abuse was measured at >.12 which indicates that the differences were insignificant. The effect size for the difference of the means for psychological abuse between the rural and urban group was .69 which indicates a medium size effect and is considered important in practice.

Responses for psychological abuse were under-reported amongst the respondents. At the pre-test the mean response for psychological abuse was .59, the mean response decreased to .38 at post-test, and only slightly increased at postponed post-test with a mean score of .40. The p-value regarding psychological abuse was measured at >.54, that was of no significance. The effect size for the difference of the means between the pre-test and the post-test regarding psychological abuse was .50 which indicates a medium significant difference. The effect size for the difference of the means between the pre-test and the postponed post-test regarding psychological abuse was .43 which indicates an insignificant difference. The effect

size for the difference of the means between the post-test and the postponed post-test regarding psychological abuse was .07 which is insignificant.

6.2.2 Physical abuse

The Cronbach alpha reliability of the 5-item measure of physical abuse was .59.

The effect size for the difference of the means for physical abuse in urban and rural areas was .54 which indicates a medium effect. The mean response for physical abuse was scored even less than psychological abuse. Both rural and urban groups indicated that physical abuse never occurs, although the urban group scored higher. The mean response for the rural group was .03 while the mean response for the urban group was .05. These differences are due to the fact that physical abuse may be less likely to be reported than psychological abuse. The p-value regarding physical abuse was measured at $>.75$ which was too high not of significant value.

The measures for physical abuse at pre-test, post-test and postponed post-test were all very low scores. The p-value regarding physical abuse was measured $>.96$ which is not statistical significant. The effect size for the difference of the means on physical abuse between the pre-test and the post-test was .35 which indicates a small effect of no significance. The effect size for the difference of the means between the pre-test and the post-test regarding physical abuse was .23 which also indicates an insignificant difference. The effect size for the difference of the means between the post-test and postponed post-test regarding physical abuse was .58, which indicates a medium effect of significant difference.

6.3 Results from the Caregiver Abuse Screen (CASE)

The Caregiver Abuse Screen (CASE) was measured at pre-test, post-test and postponed post-test (see Table 3).

TABLE 3: RESULTS OF HIERARCHICAL LINEAR MODELS OVER TIME, EFFECT SIZES AND RELIABILITY FOR THE CAREGIVER ABUSE SCREEN (CASE)

	Rural –urban differences				Differences over time: pre-test (1), post- test (2), postponed post- test (3)			
Dimension	Means Rural/ Urban	P-Value Rural/ Urban	Effect size of Rural/ Urban	Residual estimate	Means (time: 1, 2, 3)	P- value (time: 1,2,3)	Effect size (time: 1,2,3)	Relia bility
Caregiver abuse screen	R: 2.89 U 3.89	.18	.15	6.66	1: 3.88 2: 3.13 3: 3.17	.60	1&2: .11 1 &3: .11 2 &3: .01	.82

The mean response for the rural group with regard to the caregiver abuse screen was 2.89, while the mean response for the urban group was 3.89. The p-value regarding the caregiver abuse screen was measured at >.18 which indicates an insignificant value. The effect size for the difference of the means between the rural group and the urban group with regard to the caregiver abuse screen was .15, and of no significance.

The mean ‘yes’ responses for the caregiver abuse screen was 3.88 at pre-test, the mean response decrease at post-test to 3.13, but the mean response slightly increased at the postponed post-test to 3.17. The p-value regarding the caregiver abuse screen over a time period was measured at >.60 which was not of statistical significance. The effect size for the difference of the means between the pre-test and the post-test as well as the difference between the pre-test and postponed post-test indicates a small effect size of .11. The effect size to illustrate the differences over the time period for the Caregiver Abuse Screen was of no statistical significance.

6.4 Results from the Group Engagement Measure (GEM)

The measurements for the Group engagement measure (GEM) was done at 4th, 6th and 8th group session (see Table 4).

TABLE 4: RESULTS OF HIERARCHICAL LINEAR MODELS OVER TIME, EFFECT SIZES AND RELIABILITY FOR THE GROUP ENGAGEMENT MEASURE (GEM)

	Rural –urban differences				Differences over time: 4th session (1), 6th session (2), 8th session (3)			
Dimension	Means Rural/ Urban	P-Value Rural/ Urban	Effect size of Rural/ Urban	Residual estimate	Means (time: 1, 2, 3)	P-Value (time: 1,2,3)	Effect size (time: 1,2,3)	Reliability
1.Contributing	R: 3.29 U: 4.10	.00	1.08	.75	1: 3.55 2: 3.48 3: 4.06	.12	1 &2: .11 1&3: .67 2 &3: .78	.96
2.Relating to worker	R: 3.70 U: 4.17	.03	.88	.53	1: 3.88 2: 3.68 3: 4.25	.09	1&2: .39 1&3: .70 2&3: 1.07	.81
3.Relating with members	R: 3.25 U: 3.85	.03	.70	.87	1: 3.38 2: 3.22 3: 4.04	.03	1&2: .16 1 &3: .78 2 &3: .94	.80
4.Working on own problems	R 2.74 U: 3.13	.07	.69	.57	1: 2.92 2: 2.70 3: 3.20	.19	1 &2: .38 1 &3: .48 2 &3: .86	.80
5.Working with others' problems	R 2.68 U: 3.02	.09	.70	.50	1: 2.80 2: 2.64 3: 3.11	.17	1 &2: .34 1 &3: .60 2 &3: .94	.91

Amongst the seven domains of the Group Engagement Measure (GEM), two dimensions namely 'attending' and 'contracting' will be excluded from further analysis and interpretation as they scored too low on the Cronbach alpha reliability test. In the section below the results on the five dimensions of the Group Engagement Measure (GEM) namely contributing, relating to worker, relating with members, working on own problems and working with other's problems will be reported.

6.4.1 Contributing

The Cronbach alpha reliability of the 5-item measure of contributing was .96. In the rural group the mean responses for contributing sometimes to the group process was 3.29, while with the urban group the mean response for contributing was higher, as their mean response for contributing a good part of the time was 4.10. The effect size for the difference of the means between the rural and urban group

was 1.08, which indicates a large effect size of practical significance. The p-value of $<.001$ was attained between the rural and the urban group with regards to contributing to the group process, which was statistically significant.

Comparing the changes that occurred over a time period with regards to contributing to the group process, the mean responses at the 4th session was 3.55. at the 6th session the group member contributions slightly decreased to 3.48, but again at the 8th session the members contributions increased to 4.06. The p-value regarding the contribution of group members to the group process was measured at $>.12$ and of no statistical significance because of its high value. The level of contribution between the 4th group session and the 6th group session have shown a small effect size of .11 which was not significant. The level of contribution between the 4th group session and the 8th group session have shown a medium effect size of .67 which was of practical significance. Similarly the level of contribution towards the group process between the 6th and the 8th group session has also shown that a medium effect size of .78. This change in the level of contribution of group members can be attributed to the fact that group dynamics does not remain static but changes constantly depending of the level of trust and cohesion in groups.

6.4.2 Relating to worker

The dimension 'relating to worker' (3-items) attained a Cronbach-alpha score of .81. The rural group relate less frequently to the worker as shown by the mean response of 3.70 than the urban group, as their mean response is 4.17. The effect size for the difference between the means of the rural group and urban group is .88, a large effect and of importance for practice. The p-value for the rural and urban group in terms of relating to the worker was $<.03$, and is of statistical significance.

The results shows that members eagerly related to the worker, the mean response of member's relating to the worker at the 4th group session was 3.88, it slightly decreased to 3.68 at the 6th group session but it increased to 4.25 at the 8th group session. With regard to testing over time how members relate to the worker, a low effect size of .39 was attained between the 4th and the 6th group session which was of no significance. Between the 4th and the 8th group session a medium effect size of .70 was attained for relating to workers. However, between the 6th and the 8th group

session, a high effect size of 1.07 was attained which is of practical and statistical significance. The p-value of the changes that occurred over the time was scored at $<.09$, which is of statistical significance.

6.4.3 Relating with members

The dimension 'relating with members' (3-items) were found to be highly reliable .80. The mean response of the rural group in terms of relating with members was 3.25, while the mean response for the urban group to relate with members was 3.85. The effect size for the difference between the two means of the rural and urban group indicates a medium effect size of .70 which is of statistical significance. The p-value scored between the urban and rural group was $<.03$, which is of significance.

The mean responses of group members as they have related to one another was 3.38 at the 4th group session, it slightly decreased to 3.22 at the 6th session but it increased to 4.04 at the 8th group session. The p-value of members relating to one another was $<.03$ and is of statistical significance. The effect size between the 4th and the 6th group session for relating to members has a low effect of .16 and not of any significant value. However, a medium to high effect size of .78 was attained between the 4th and the 8th group session which is of practical significance. Furthermore, the effect size between the 6th and the 8th group session was even higher, .94 again of practical significance.

6.4.4 Working on own problems

The Cronbach alpha reliability of the 5-items measure of working on own problems was .80. The rural group was less likely to work on their own problem than the urban group, with a mean score of 2.74 for the rural group and a mean score of 3.13 for the urban group. An effect size of medium effect of .69 was scored for the difference of the means between rural and urban groups in terms of working on their own problems. The p-value for the rural -urban differences with regard to working on own problems was a small value of $<.07$, which is of statistical significance. The differences are due to the fact that respondents were initially focused on the problems of the care recipients, but the urban group sooner could make the shift to start to work on their own problems.

With regards to working on own problems the mean responses at the 4th group session was 2.92, it slightly dropped at the sixth group session to 2.70, but the mean response increased to 3.20 at the 8th group session. The effect size for the difference of the means between the 4th and the 6th session regarding working on own problems was .38 which indicates an insignificant difference. Similarly, the effect size of the difference between means of the 4th group session and the 8th group session regarding the domain 'working on own problems' also indicates an insignificance difference of .48. However a large effect size of .86 was found between the 6th session and the 8th session regarding 'working on own problems', which indicates a significant difference. The p-value regarding 'working on own problems' over the time period was found to be $>.19$, which indicates that the changes was not of statistical significance.

6.4.5 Working with others' problems

The Cronbach alpha reliability of the 5-items measure of working with others' problems was .91. The mean response of the rural group for working with other's problems was 2.68 while the mean response for the urban group was 3.02, which indicates that the urban groups have scored higher. The difference between the rural group and the urban group is of statistical significance as a low p-value of $<.09$ was attained. The effect size of the difference of the means between the rural group and the urban group regarding working on other's problems was .70 which indicates a medium significance.

The mean responses of the group members with regard to working on other's problems was 2.80 at the 4th group session, it decreased to 2.64 at the 6th group session but it increased to 3.11 at the 8th group session. The p-value regarding the changes over the time with regards to the member's working on other's problem was $>.17$, and was not of significance. The effect size for the difference of the means concerning working on other's problems between the 4th and the 6th group session was .34 which was small and therefore insignificant. The effect size for the difference of the means about working on other's problems between the 4th and the 8th group session was .60 and is considered of a medium effect. The effect size for the difference of the means relating to working on other's problems between the 6th and the 8th group session was .94, and is considered practically significant.

From the various scales on the outcome of the support group programme, it is obvious that more caregivers in the urban group experienced caregiver burden than the caregivers from the rural group. While the personal strain of caregivers have reduced significantly as a result of the support group programme, elder abuse remains an underreported phenomenon. The scales on the process evaluation of the support group have shown that caregivers from the urban group were more engaged in the group process than caregivers from the rural group.

6.5 Results of the qualitative data

Open-ended questions were asked to determine the group members' views on the effectiveness of the support group intervention. The qualitative data are presented below, per question asked:

6.5.1 Lessons learnt from the support group

To the question **What caregivers have learnt from the group?** some of the responses are as follows:

TABLE 5: LESSONS LEARNT FROM THE SUPPORT GROUP

Group in urban area:	Group in rural area
<i>"Yes we have learnt a lot, we have learnt about some ways how to understand the elderly. As I am an elderly person myself, I have come to understand my own aging as well"</i> (76 years) <i>"I have learnt to take care of myself, to care about my own health, and that one can also become stressed"</i> (55 years) <i>"Yes. Most interesting was the one on how to handle the difficult caregiving"</i>	<i>"I have learnt a lot, things I did not know before. Because we were merely looking after the elderly in the past but did not knew much"</i> (34 years) <i>"we have learnt a lot and I have enjoyed the session. What I have learnt I will apply, such as to have patience, to give love to the elderly, and that caregiving is an issue that needs prayer"</i> (60 years) <i>"I have learnt a lot. How to communicate with the elderly, how to handle difficult situations such as refusal to take their"</i>

<i>situations and also how to prioritize responsibilities in the house.” (23 years)</i>	<i>medication” (46 years)</i>
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From the responses above, it was clear that caregiver from the urban and rural support groups acquired more knowledge. Both groups highlighted lessons learnt in handling difficult caregiving situations as well as self-care. The rural group could translate knowledge into qualities such as patience, compassion and the importance of a prayerful life, while growth, in terms of communication skills, also occurred as a result of the programme.

6.5.2 Changes in terms of caregiving responses

To the question, **Would you be able to respond differently in caregiving situations now that the group came to an end?**, some responses were the following:

TABLE 6: CHANGES IN TERMS OF CAREGIVING RESPONSES

Group in urban area	Group in rural area
<i>“yes, ...people have stopped to quarrel with one another” (35 years)</i>	<i>“we used to argue a lot in the past. Now I know how to handle my stress.” (39 years)</i>
<i>“To take care of myself. I never thought about myself before...I’m always doing everything, everything is just you... I started to talk to my two sons, and we are sharing the responsibilities now. I have also asked for help from my sister” (60 years)</i>	<i>” that there is a difference or a change in the handling of the elderly people. That I am now more patience with the elderly person. The importance of self care, however financial pressures are a hindrance. I have learnt to practice patience.” (53 years)</i>
<i>“to be honest with you, after I have developed high blood pressure I have decided to do exercises.” (56 years)</i>	<i>“there is no change, I am still doing things the way I did them before.” (52 years)</i>

The responses above indicate that the support group programme enabled caregivers to handle caregiving situations differently. Both the urban and rural

groups made positive changes, in terms of handling stress and self-care; and arguments between caregivers and older care recipients were reduced. However, one urban caregiver could only make changes with regards to self-care after an illness, this indicates that more than just one group intervention is needed to bring about change for some members. Another caregiver indicated that no change occurred.

6.5.3 Most interesting topics

In response to the question, **Which topics in the support group programme was the most interesting for you?** the following are some of the responses:

TABLE 7: MOST INTERESTING TOPICS

Group in urban area:	Group in rural area:
<i>“everything was good” (55 years)</i> <i>“place yourself first–self care, to catch up (with self care), all those times when we have neglected to care for ourselves.” (52 years)</i> <i>“Stress, I have learn how to cool down when my stress is coming up.” (56 years)</i>	<i>“everything was interesting because I have learnt a lot.” (60 years)</i> <i>“self-care, caring for myself, I must try to do it” (74 years)</i> <i>“Stress, I have enjoyed that topic a lot, because it was something that I had difficulty with” (39 years)</i>

The responses indicate that the support group programme was generally interesting to all the caregivers, however self-care and caregiver stress were topics that had an even greater personal impact on caregivers in both the urban and rural group.

6.5.4 Least interesting topics

The question **Which topic were the least interesting for you?** received some of the following answers:

TABLE 8: LEAST INTERESTING TOPICS

Group in urban area:	Group in rural area:
<i>“elder abuse, because it is not a good thing.” (56 years)</i>	<i>“grief and loss, because you are losing something” (46 years)</i> <i>“the process of aging, because my mom does not have any complications” (39 years)</i>

The results indicated that the urban group did not like the topic on elder abuse that much, while the rural group did not like grief and loss as well as the process of aging.

6.5.5 Suggestions for future support groups

Another question: **Which other topics would you like to suggest in future support group programmes for caregivers?** were responded as follows:

TABLE 9: SUGGESTIONS FOR FUTURE SUPPORT GROUPS

Group in urban area	Group in rural area
<i>“I can write a proposal for funding for the group, but we will need to have a constitution. Then we can teach the other people what we have gained” (52 years)</i> <i>“yes, we need to form a committee, and we must continue to communicate with each other” (56 years)</i>	<i>“Elderly people who are living in poor housing conditions.” (39 years)</i> <i>“we need products such as ointment, soap, first aid kits, pain pills, bandages to give nursing care to the elderly, and we also need to learn how to massage the elderly.” (46 years)</i> <i>“the financial difficulties around caregiving, for example, difficulties to take the elderly people to the clinics because of lack of transport, that is why some sick older people transported to the clinic in a wheelbarrow” (53 years)</i>

The results show that the caregivers from both the urban and rural groups did not suggest topics but rather further actions that must be carried out in their communities with regards to caregiving. The actions that the urban group wants to engage themselves are the formulizing of the support group, in terms of drafting a constitution, selecting a committee and seeking funding to further educate other caregivers. The action that the rural group suggests is related to caregiving, as they wish to receive nursing aid and financial support to enhance their caregiving. This result is a clear indication that the need for further intervention programmes at macro level for informal caregivers in the community.

6.5.6 Changes proposed to the programme

To the question, **if you have to change anything about the programme, what would that be?** the following answers were received.

TABLE 10: CHANGES PROPOSED TO THE PROGRAMME

Group in urban area	Group in rural area
<i>“everything was good” (55 years)</i> <i>“I wish that handouts that we have received at the end of the meetings are compiled in a booklet” (52 years)</i> <i>“the day that the meeting took place could be changed to a Tuesday or a Thursday” (23 years)</i>	<i>“nothing” (60 years)</i> <i>“the time was too short, the programme should have lasted longer” (39 years)</i> <i>“meeting days should be changed to Tuesdays” (46 years)</i>

The results above indicate that a few changes were suggested by the caregivers. There was a desire in both the urban and rural group to change days of the meeting. While the urban group would want a booklet that could enable them to share the information and skills gained with other caregivers, the rural group showed signs of resistance to end as they wished it to last longer.

6.5.7 Benefits of the support group programme

To the question, **Do you think other caregivers can gain from participating in support group programmes?**, the responses were the following:

TABLE 11: BENEFITS OF THE SUPPORT GROUP PROGRAMME

Group in urban area	Group in rural area
<i>"Yes I think so, I intend to share what I have learnt with the prayer group of women from my church." (76 years)</i> <i>"yes...this programme is an advantage to any person in Namibia." (52 years)</i> <i>"yes, I believe so...other young people also need to learn how to handle the elderly people, how to deal with the sick elderly family member or moody elderly, it can help them understand the elderly better." (23 years)</i>	<i>"yes...because as we are also growing old and ill, there will be other people who can give care...at least two or three people from every household must be included in the programme, to help one another and give advice to one another." (46 years)</i> <i>"yes.... because we can also teach other caregivers, there are many people who can help the elderly people in the future." 47 years</i> <i>"I would say that there were people who have not been part of the programme and who really need it." 39 years</i>

The results show that the support group programme was of great value to informal caregivers. They have been motivated to keep on caring for the older recipient, to reach out to other needy older people without care and to share knowledge and skills acquired with caregivers who have not gone through the programme. The informal caregivers have acquired competencies and confidence and felt supported, which could benefit both the caregivers as well as the care recipients. The urban group mentioned how the group can help in understanding the older people better, while the rural group believes that the group the support group programme can built the capacity of caregivers presently and in the future.

7 DISCUSSION

The purpose of the study was to evaluate the effectiveness of support group interventions with informal caregivers of older people from urban and rural settings to prevent elder abuse and neglect. The research contributes towards the body of knowledge on informal care of older people in urban and rural areas, previous research by (Kloppers, 2011) only focused on an educational programme for formal caregivers from old age homes in Namibia.

The Zarit Burden Interview (ZBI) revealed that urban caregivers experience more personal and role strain than rural caregivers; in fact, the differences between the rural and urban caregivers are of practical significance. According to McKenzie *et al.* (2010:140) contradictory findings exist in the literature concerning urban-rural caregiver's perceptions on their strain. In this study the personal strain of caregivers has decreased significantly between the pre-test and post-test as well as between the post-test and the postponed post-test. These changes can be ascribed to a positive outcome of the support group intervention which was covered through topics such as self-care and caregiver stress. With regards to the role change of caregivers at pre-test, post-test and postponed post-test, fewer significant changes have occurred. Informal caregiving in multigenerational households implies that the presence of many people in the household may influence perceptions on the role strain of caregivers.

The Potentially Harmful Behaviour (PHB) scale reveals that psychological abuse and physical abuse were under-reported in this study. However, contrary to (Phakathi, 2011), who claims that older people experience more physical abuse, psychological abuse was reported to be higher in this study. Insignificant changes occurred with regards to the reporting psychological and physical abuse at pre-test, post-test and postponed post-test, although a decline in reporting Potentially Harmful Behaviour (PHB) was evident as the group evolved. During the group intervention, various forms of elder abuse committed by family members in multigenerational households have been admitted to occur in the community. However, caregivers were less likely to self-report elder abuse. The researcher has even reported a case of verbal abuse and accusation of witchcraft committed by a family member to the Women and Child Protection Unit, and the older victim

received the necessary assistance. The Caregiver Abuse Screen indicated that the more 'yes' responses were attained by the urban group, which implies that they will be more likely to display abusive behavior towards older people. The measurements of the Caregiver Abuse Screen (CASE) at pre-test, post-test and postponed post-test have shown a decline in 'yes' responses for abusive behaviours as the group programme progressed. In the qualitative evaluations, the caregivers from the urban and rural group reported that family conflicts decreased at the end of the support group interventions. Both these quantitative and qualitative results indicate the positive outcome of the support group intervention.

The Group Engagement Measure (GEM) indicated that the urban group was more engaged than the rural group in all the domains of the Group Engagement Measure (GEM) than the rural group. The results are consistent with findings from Chadiha *et al.* (2011:2) that informal care needs are different in rural and urban contexts which need further investigation. The differences between the urban and rural group can further be ascribed to an observation that caregivers from the rural communities are from a closer community, may be related to one another which is not the case in urban communities. Therefore, caregivers from the rural group may assume that it is not necessary to share their struggles that are already known in the community in a support group. The Group Engagement Measure (GEM), over a time period, has shown a decrease in the observations of member engagement between the 4th and the 6th group session, while it increased at the 8th group session. These differences are due to changes in the group dynamics that occur as groups evolve (Toseland & Rivas, 2005). The change that occurred between the second test (6th session) and the third test (8th session) clearly indicates that growth have occurred amongst group members with regards to their engagement to the group process and is an indication of the success of the group intervention.

From the qualitative evaluation, it is evident that both the urban and rural groups have gained knowledge on aging and caregiving, but have also acquired vital qualities for caregivers such as patience, compassion and communication skills. A powerful prayer life was shared as a way of coping for caregivers. Previous studies (Jordan, 2012:14; Sistler & Washington, 1999:49-62) have confirmed that caregivers of frail older people strongly rely on prayers as a way of coping. Furthermore,

caregivers have reported how interpersonal conflicts between the older person and caregiver and with other family members have reduced as a result of the support group programme. Positive changes in terms of handling caregiving stress and self-care was also reported by the group participants. The need for continued caregiving activities was realized by both the rural and urban groups, since the urban caregivers want to be more formalized while the rural caregivers face the realities of many older people in need of assistance from caregivers. Generally, the support group was of great value to the informal caregivers, as the support group motivated them to keep on caring for the older care recipient. Caregivers were further inspired to reach out to other older people without a caregiver, and they would want to share the knowledge gained with other caregivers who have not been part of the programme. Support groups can help build the capacity of caregivers at present but also in an investment for the future older people in need of care.

8 RECOMMENDATIONS

Based on the above-mentioned discussion, the following recommendations are made:

The sample size was appropriate for the design chosen, since ten caregivers from the urban area and twelve caregivers from the rural area were involved in the intervention programme. However, an experimental versus comparison design for both urban and rural groups can perhaps yield better results.

The concurrent measuring of quantitative and qualitative data could complement the results which strengthened the study.

The standardized measuring instruments need further adjustments to the research context, because of difficulties experienced with some items, especially with regards to the varying possible responses in the Likert scale.

Participants of the intervention programme were selected based on their role as caregivers of older people. Selecting caregivers at risk of displaying abusive behaviour towards the older care recipient may produce different outcomes.

A multidisciplinary approach to intervention programmes for informal caregivers such as nursing care and the economic strain of caregivers could address some other pressing needs that were not met through this intervention programme.

The support group intervention is a model for strengthening community care of older people that can be replicated in other parts of Namibia and even in other countries in the third world countries.

9 CONCLUSION

This support group programme for informal caregivers was designed after a need assessment was done in the rural and urban community under study as well as a review of literature. In this article, the effectiveness of a support group intervention for informal caregivers of older people was evaluated. The quantitative data has shown that caregiver stress on a personal level has decreased, although it was only of medium significance; potential harmful behaviour has decreased at the postponed post-test. The qualitative data showed that informal caregivers have gained more knowledge on aging and caregiving while the group also served as a support system. The research question on whether a support group programme can enhance the quality of care of for older people from urban and rural settings was answered in both the quantitative and qualitative questions. One can thus conclude that support group interventions are a proper social work practice, as part of community care for older people.

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SECTION C:

SUMMARY, CONCLUSION AND RECOMMENDATIONS

1 INTRODUCTION

In this section, the summary, important findings and conclusions pertaining to the study are presented. In addition, the aim, objectives and the central theoretical argument will also be tested. Based on the findings, recommendations will be made. An outline of this research report is as follows:

SECTION A: GENERAL INTRODUCTION

SECTION B: ARTICLE 1: Informal caregiving, elder abuse and neglect in urban and rural areas of the Khomas region in Namibia: A needs assessment

ARTICLE 2: Factors contributing to elder abuse and neglect in community settings

ARTICLE 3: Designing a support group work programme with informal caregivers of older people in Namibia

ARTICLE 4: Evaluation of the effectiveness of a support group programme with informal caregivers to prevent elder abuse and neglect.

SECTION C: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

SECTION D: ANNEXURES

SECTION E: CONSOLIDATED LIST OF REFERENCES

2 SUMMARY AND CONCLUSIONS

A summary of the most important findings and conclusions described below, are based on the research methodology as well as the articles that were presented in Section B of this research report.

2.1 Research methodology

The purpose of the study was to design and evaluate a support group intervention programme with informal caregivers that aimed at preventing elder abuse and neglect in an urban and rural community setting in the Khomas region in Namibia.

2.1.1 Literature study

A comprehensive literature review was conducted that included a variety of sources, such as books, journals and research reports regarding informal caregiving, elder abuse and neglect, intervention programmes as well as other related topics. The literature review led to the delineation of the study, the development of interview schedule (Annexures 5-7) selections of standardized measuring instruments (Annexure 11-14), comparisons of empirical data to the literature and the development of the support group programme for informal caregivers of older persons.

2.1.2 Research design

The intervention research design was the most appropriate for this applied study that aimed at strengthening the informal care of older persons in urban and rural communities through the development and evaluation of an innovative support group programme to prevent elder abuse and neglect (De Vos & Strydom, 2011: 475). The exploratory mixed method approach was utilised in this intervention study (Delport & Fouche, 2011:441), which involved a qualitative exploration of informal caregiving situations that may lead to elder abuse and neglect. Based on the qualitative information, the support group programme for informal caregivers was developed and evaluated (Creswell, 2009: 14; Delport & Fouche, 2011:441). In order to achieve the six phases of the intervention research model (De Vos & Strydom, 2011:476), the study was carried out in three phases namely, the needs assessment, designing of the support group programme and the evaluation of the support group program.

Phase one: Needs assessment

Needs assessments are often carried out before an intervention programme is compiled and evaluated (De Vos & Strydom, 2011: 475). In this phase, an assessment was conducted that explored informal caregiving situations that may lead to elder abuse and neglect in an urban and rural community in the Khomas region. Key informant interviews (Annexure 5) and focus group discussions (Annexure 6 & 7) were held to gain an understanding of informal caregiving situations that could lead to potential risks of elder abuse and neglect.

Phase two: Design of the support group programme

Based on the needs assessment as well as a literature review, the support group programme was designed as an intervention for informal caregivers that aimed at improving the care of older persons and preventing elder abuse and neglect. No empirical work was carried out during this phase, which basically involved a desk review of literature on support group interventions, informal caregiving and elder abuse and neglect. The literature consulted was used for the development of the support group intervention programme for informal caregivers of older persons.

Phase three: Evaluation of the support group intervention

In phase three of this intervention study, a support group for informal caregivers that aimed at preventing inadequate informal care of older persons in urban and rural communities was evaluated (De Vos & Strydom, 2011:475). A single system design was chosen as an appropriate design to evaluate the effectiveness of the support group programme. According to Strydom (2011:160), a single system can be a group, family or community. Support groups with informal caregivers of older persons from an urban and rural community were two single systems on which the intervention was applied.

2.1.3 Measuring instruments

Needs assessment phase:

An interview schedule was developed for both the focus group discussions (Annexure 6 & 7) and the key informant interviews (Annexure 5). The interview schedule consisted of open-ended questions, and further offered an outline of all the issues and themes to be discussed surrounding caregiving situations that may lead to elder abuse and neglect (Bryman, 2008: 442; Greeff, 2011:352; Rubin & Babbie, 2011:233). A pilot test of the interview schedule was conducted with participants who did not form part of the sampling and the necessary amendments were made. Due to diverse languages spoken in Namibia, and to ensure optimal participation, interviews took place in the language of choice of the participants.

Intervention phase:

Standardized measures were used to evaluate the effectiveness of the support group programme with informal caregivers from an urban and rural community. Standardized measuring instruments to measure the outcome of the group at pre-test, post-test and postponed post-test were the following: the Zarit Burden interview (ZBI) (Annexure 11), the Potentially Harmful Behaviour (PHB) scale (Annexure 12), and the Caregiver Abuse Screen (CASE) (Annexure 13).

The Group Engagement Measure (GEM) (Annexure 14) was used to measure the process of the support group intervention at the 4th, 6th and 8th sessions in the group process. To complement the quantitative data, open-ended questions (Annexure 15) on a qualitative level were also used to evaluate the success of the support group programme.

2.1.4 Participants

Needs assessment phase:

The key informant sampling method was used to select a diverse group of professionals and community leaders from the rural and urban communities who were most knowledgeable on informal caregiving and abuse of older people, until data saturation was reached (Strydom & Delport, 2011:394). A total of 22 in-depth interviews were held with key informants. The purposive sampling method, as a non-probability sampling method, was used to select the older people and the informal caregivers as participants of the focus group discussions (Bryman, 2008: 458; Strydom & Delport, 2011:392). A total of six focus group discussions were held with 53 older people, while four focus group discussions were conducted with 23 informal caregivers from both urban and rural communities.

Intervention phase:

A total of 22 female informal caregivers of older people took part in two support groups, ten (10) caregivers in the urban group and twelve (12) caregivers in the rural group. Caregivers were eligible for the study if they met the following criteria:

- A child, spouse, sibling or extended family member as primary caregiver;
- Who assist an older person with one or more Activities of Daily Living (ADL);

- Shows a willingness and availability to participate voluntarily for the duration of the programme; and
- Resides in the urban or rural constituency in the Khomas region.

2.1.5 Procedures

Needs assessment phase:

Permission was obtained from the Councillors of the Katutura Central constituency and the Windhoek Rural constituency, the two constituencies where the field work were carried out. Interview schedules were developed for the key informant interviews (Annexure 5) and the focus group discussions (Annexure 6 &7). The interview schedules were pre-tested with three older persons and the necessary amendments with regard to the order of the questions and the rephrasing of the questions were done. The interview schedules were further pre-tested by requesting inputs from two experts in gerontology. Informed consent forms (Annexure 4) were developed and signed by the participants who can read and write, while the illiterate participants gave oral consent.

Intervention phase:

The following procedures were followed:

- The recruitment and selection of participants for the rural and the urban support group.
- All the selected participants gave oral consent to participate in the groups before the groups commenced because the low literacy levels of some caregivers (Annexure 9).
- The pre-test measuring scale was completed with both the rural and urban groups before the groups have started; the post-test was completed after the groups ended and the postponed post-test was done six weeks later (Annexure 11-13).
- The Group Engagement Measure (GEM) that assessed the group process was completed by the researcher at the fourth, sixth and eighth group session (Annexure 14).
- The support group programme was implemented and evaluated in the urban and the rural area by means of open-ended questions (Annexure 15).

2.1.6 Data analysis

Needs assessment phase:

All the audio-recorded data, collected from the focus group discussions and key informant interviews were transcribed verbatim (Annexure 8). The transcripts were downloaded into the Atlas-ti software programme. The constant comparison analysis was used as a qualitative analysis technique, to generate a set of themes (Leech & Onwuegbuzie, 2008:590). After reading through the transcripts for several times, coding of the data took place in three stages, namely, open coding, axial coding and finally selective coding (Saldanha, 2009:10-12; Schurink et al., 2011: 412-413). Eventually, six major themes were generated from the data.

Intervention phase:

The quantitative data was analysed with the SPSS version 21.0. The hierarchical linear modeling, often applied in groups where elements of a group are interdependent, was an appropriate approach for this analysis. In addition, the hierarchical linear model takes into account the dependency of measurements on the same person within and across a group or cluster (McCroach, 2010:123). The Tesch approach was applied to analyse the qualitative data manually (Poggenpoel, 1998:343-344).

2.2 Results of the research

A brief summary of each article and the key findings will be presented in the section below:

Article 1: Informal caregiving, elder abuse and neglect in urban and rural of areas of the Khomas region in Namibia: A needs assessment

The purpose of the study was to explore perceptions of key informants, older people and informal caregivers on the state of informal caregiving as well as elder abuse and neglect in urban and rural communities in Namibia. The findings of this study indicate that informal caregiving of older people involves personal care, help with mobility, practical help and emotional support. The findings are consistent with Miller et al. (2006) who maintain that multiple, complex and challenging caregiving tasks

require skills from caregivers in making judgment, problem solving and effective communication. Some older people from rural areas are living without any caregiver and are at risk of neglect. Practical help required by older people from rural areas, such as collecting firewood and water are vital for basic survival, compared to practical help in urban areas, such as paying bills and doing shopping for the older person. The results indicated that older people are suffering emotionally because love and affection are not always offered to them by loved ones. Since love can be interpreted in different ways, having food was perceived by some older persons as an indication of emotional care.

Maintaining personal hygiene of older people is a challenge for caregivers since some negatively associates taking a bath with a bad smell. Furthermore, the gender and age of the informal caregiver is also an important determinant to caregiving activities that involve the personal care of older people. Thus, a youthful caregiver as well as a caregiver from the opposite sex who offer personal care may encounter resistance from an older care recipient. Although older people live in multigenerational households in Namibia, only one family member acts as a primary caregiver and has less support from other family members which causes a great deal of caregiver stress. Preferences of some older people to accept help from only one family member also contribute to reduced involvement in caregiving by other family members.

Some of the challenges affect the interpersonal relationships between older people and caregivers since conflicts may erupt. The results provide evidence that informal caregivers have poor coping skills since they avoid conflict situations and have emotional outbursts. Despite the many challenges in the caregiving of older people, there are also benefits. Results indicated that closer bonds develop between the informal caregiver and care recipient, there are spiritual benefits for the caregiver and they grow in maturity and responsibility. These findings are consistent with previous research from (Ackermann & Matebesi, 1998; Sibai & Yamout, 2012).

With regard to elder abuse and neglect between urban and rural communities, there were not that many differences. However, the unequal distribution to rural areas resulted into structural abuse.

Article 2: Factors contributing to elder abuse and neglect in community settings

In this article, an overview of the factors contributing to elder abuse and neglect in the community setting was discussed. The ecological theory considers the interactions that take place across a number of interrelated systems, and offers a better explanation to the complexity of the problem of elder abuse and neglect. In the context of elder abuse, ecological theorists have a keen interest in the interactions between the older person and the caregiver, within the caregiving as well as broader societal context (Penhale, 2010:239; Podnieks *et al.*, 2010: 161; Schiamberg *et al.*, 2011:195). The ecological theory suggests that elder abuse and neglect may occur at four systems, namely, the micro, meso, exo and macro systems (Schiamberg & Gans, 1999:93-94). The ecological theory was used to offer a comprehensive understanding of the risk factors of elder abuse and neglect within the four levels of systems. Lesser attention was paid to protective factors to elder abuse and neglect in the literature. In conclusion, elder abuse and neglect may only be addressed properly if combined actions are taken by various role players to respond to risk factors at all systems as stated in the ecological theory, which can ultimately result into multidisciplinary research and practices.

Article 3: Designing a support group work programme with informal caregivers of older people in Namibia

This article is focused on the development and content of a support group for informal caregivers of older persons in an urban and rural community setting. The programme was developed based on a needs assessment on informal caregiving situations in an urban and rural community setting as well as from a literature review. The solution-focused approach was regarded as appropriate to enable caregivers find solutions to caregiving situations within their frame of reference. The planning model was applied to the design of the support group in a systematic manner, and consisted of elements that are considered as essential when designing groups, such as agency and social context, needs of potential group members, group purpose, group composition, group structure, group content, and formation and evaluation strategies (Wayne & Cohen, 2001:90). The content of the support group programme included, amongst others, topics such as the normal processes of

aging, handling difficult caregiving situations, caregiver stress, self-care, elder abuse and neglect, and grief and loss.

Article 4: Evaluation of the effectiveness of a support group programme with informal caregivers to prevent elder abuse and neglect

This article is focused on the evaluation of a support group programme with informal caregivers from an urban and rural community setting. To a greater extent, quantitative data collection methods were used, while qualitative data were collected to a lesser extent. The effectiveness of the groups was measured in terms of both the group process and the group outcomes. In this study, it was found that rural caregivers experienced more burdens, in terms of personal strain and role strain than urban caregivers. The personal burden of caregivers has decreased significantly as a result of the group intervention.

Elder and abuse and neglect, is behaviour synonym to poor quality of care to older people, the results indicated that self-reporting abusive behaviour amongst caregivers was low, and no significant changes occurred with regards to abusive behaviour as the group have progressed. According to the Caregiver Abuse Screen (CASE), caregivers from the urban area tend to be more likely to display abusive behaviour.

The study further found that caregivers from the urban community were more engaged in the group process than the group from the rural community in the various dimensions of the Group Engagement Measure (GEM). The engagement of group members has increased steadily, especially towards the end of the group programme. The results can be ascribed to the fact that urban members seemed more willing to disclose than rural caregivers, because rural caregivers are in a close community. The qualitative evaluations have shown that group members have gained a lot of knowledge and skills and are confident in executing their role as caregivers. One can thus conclude that a support group intervention with informal caregivers can contribute positively towards care of older people in urban and rural community settings.

2.3 Aim and objectives of the study

2.3.1 Aim of the study

The aim of the study was to evaluate the effectiveness of support group interventions for informal caregivers of the older person from an urban and rural community setting that aimed at preventing elder abuse and neglect.

The aim of the research was accomplished. A support group programme for informal caregivers of older persons in urban and rural community settings did indeed lead to increased knowledge and a sense of support that can improve quality of informal care and thus prevent elder abuse and neglect.

2.3.2 Objectives of the study

The objectives of the research were the following:

- To assess the needs of informal caregivers of older persons and to determine risk factors of elder abuse and neglect in informal care giving situations. **This objective was reached in Article 1, by conducting a needs assessment on informal caregiving situations in urban and rural community settings and how it leads to elder abuse and neglect.**
- To describe existing literature on various factors that contribute to elder abuse and neglect in community settings. **The objective was attained in article 2. Based on the ecological theory the risk and protective factors to elder abuse and neglect within the informal caregiving context was discussed.**
- To design a support group programme for informal caregivers of older people from urban and rural community settings that aimed at preventing elder abuse and neglect. **This objective was accomplished in article 3. The needs of informal caregivers of older persons, as identified in the needs assessment, as well as the literature review was used to develop an eight-week support group programme for informal caregivers of older persons from urban and rural communities.**
- To implement and evaluate the effectiveness of the support group programme for informal caregivers that aimed at preventing elder abuse and neglect. **This objective was reached in article 4, whereby the implementation and evaluation of the support group for informal caregivers of older persons**

from an urban and rural community setting was carried out. Pre-test, post-test and postponed post-test were completed to assess the outcome of the group, while the assessment of the group process was done at 4th, 6th and 8th group sessions. Ongoing oral evaluations of the group took place after every group session, while an overall oral evaluation was done at the termination and follow-up group meetings. The objective was further accomplished by the submission of the articles for purposes of publication.

2.4 Testing the central theoretical argument

The research was based on the following central theoretical argument:

As not all informal caregivers are abusing or neglecting older persons, caregiver support groups can offer a platform to express both positive and negative experiences about informal care giving. Social work support groups can be useful for informal caregivers to prevent, reduce or address potential situations that may lead to elder abuse and neglect.

Based on the findings and conclusions of this research, the central theoretical argument was tested and confirmed through this qualitative and quantitative research study.

3 RECOMMENDATIONS

Recommendations will be presented according to the various articles.

3.1 Recommendations on the needs assessment

In view of the findings, this study would like to make the following recommendations

- The social work support groups serve as a platform where informal caregivers of older persons receive support from one another and find ways to cope with the challenges of caregiving. Therefore the development and implementation of a social work support group programme for informal caregivers of the older people is necessary.

- One of the critical issues affecting informal caregivers is that they lack knowledge on aging, caregiving and elder abuse. This situation can be mitigated by exposing informal caregivers to educational programmes that especially address matters related to caregiving of older people within community settings.
- Both informal caregivers and multidisciplinary professionals need exposure to the unique needs of older victims of abuse and neglect. There already exist in Namibia a host of national gender-based violence intervention programmes. These should be tapped into for the benefit of older persons.
- Substance abuse is a general concern in Namibian society. Awareness campaigns on responsible drinking, with specific messages designed for the older person who abuses alcohol and drugs would be helpful for both caregivers and care recipients.
- In tandem with the awareness campaigns on responsible drinking should be the strict enforcement of existing legislation on the excessive availability of alcohol by controlling and regulating licensed and illegal liquor outlets in the community. This will go a long way towards mitigating alcohol consumption and/or abuse among caregivers and care recipients.
- Informal caregivers live under poor socioeconomic circumstances. Incentives for informal caregivers could enable them to provide in their own needs, and prevent financial abuse of the older person. Incentives could be in the form of further development, income generation or grants.

3.2 Recommendations on the literature review

- More literature is needed on elder abuse and neglect from the developing context.
- The development of a universal definition on the concept of elder abuse and neglect can lead to better understanding on the problem of elder abuse and neglect.
- A proper theoretical framework on elder abuse can also lead to a better explanation on the problem of elder abuse and neglect.
- The protective factors to elder abuse and neglect are positive factors in community settings that needs more research and incorporated into practice.

3.3 Recommendations on the design of the support group programme

- From a solution-focused perspective, Sharry (2007:123) asserts that “the transformation of a facilitated group into a self-help group can be a very important development in empowering clients to take action for themselves.” Sands and Solomons (2004:8) argues that formally developed groups led by a social worker can eventually change into self-help groups after the groups have been completed, functioning independently without the involvement of a professional group facilitator. Therefore, depending on the interest of the group members the support group may be continued, whilst co-facilitated by caregivers who have participated in the group under the supervision of a practising social worker.
- Support groups are not the only service desired by caregivers. A multidisciplinary approach is needed to respond to the complex realities of caregiving of older people in non-institutionalized settings, which in the process can lead to improved caregiving conditions for older people.

3.4 Recommendations on the evaluation of the support group programme

- The sample size was appropriate for the design chosen, since ten caregivers from the urban area and twelve caregivers from the rural area were involved in the intervention programme. However, an experimental versus comparison design for both urban and rural groups can yield better results.
- The concurrent measuring of quantitative and qualitative data complemented the results which strengthened the study.
- The standardized measuring instruments need further adjustments to the research context, because of difficulties experienced with some items, especially with regards to the varying possible responses in the Likert scale.
- Participants of the intervention programme were selected based on their role as caregivers of older people. Selecting caregivers at risk of displaying abusive behavior towards the older person may produce different outcomes.
- Prevention programmes on elder abuse and neglect to also target other family members in multigenerational households.

- Groups with informal caregivers of older persons suffering from a specific physical or psychological condition will also allow for more meaningful exchanges.
- A multidisciplinary approach to intervention programmes for informal caregivers such as nursing care and the economic strain of caregivers could address some other pressing needs that were not met through this intervention programme.
- The support group intervention is a model for strengthening community care of older people that can be replicated in other parts of Namibia and other countries in the third world context.

4 CONCLUSION

Holistic care is offered to older persons living in old age homes, with an assumption that community care offered by informal caregivers would equally be as adequate as institutional care. During the exploration on informal caregiving situations in urban and rural communities, the role that informal caregivers fulfill to care for older persons needs more acknowledgement. It was confirmed in the needs assessment as well as the literature review that stress in caregivers may lead to inadequate care of older persons that could result in elder abuse and neglect. Therefore, supportive interventions in the form of support groups for informal caregivers can enhance community care of older people in urban and rural areas. This support group programme, can offer a model for community care of older persons in rural and urban communities, and as such can be replicated to other parts of Namibia and the rest of Africa.

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SECTION D:

ANNEXURES

ANNEXURE 1: LETTER FROM THE ETHICS COMMITTEE OF THE NORTH WEST UNIVERSITY



Privaat sak X6001, Potchefstroom
Suid-Afrika, 2520

Tel: 018 299-1111/2222
Web: <http://www.nwu.ac.za>

Etiëkomitee
Tel: 018 2994237
Faks: 018
E-pos: 10055355@nwu.ac.za

18 April 2012

Aan wie dit mag aangaan

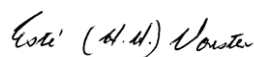
Geagte Mnr./Me.

Etiëkaansoek: NWU-00012-12-S1

"An evaluation on the effectiveness of Social Work support groups with informal caregivers to prevent elder abuse and neglect"

Die antwoorde is volledig en goed uiteengesit. Die komitee is tevrede dat die etiese aspekte voldoende aangespreek is en etiese goedkeuring word aanbeveel.

Vriendelike groete



Prof. H.H. Vorster
Voorsitter

ANNEXURE 2: ETHICAL PERMISSION FROM THE MINISTRY OF HEALTH AND SOCIAL SERVICES, NAMIBIA



REPUBLIC OF NAMIBIA

9 - 0/0001

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia
Enquiries: Ms. E. Shaama

Ministerial Building
Harvey Street
Windhoek
Ref.: 17/3/3

Tel: (061) 2032510
Fax: (061) 222558
E-mail: eshaama80@yahoo.com
Date: 04 April 2012

OFFICE OF THE PERMANENT SECRETARY

Ms. Janet A. Ananias
P.O. Box 8705
Bachiberecht

Dear Ms. Ananias

Re: An evaluation of social work support groups with informal caregivers to prevent elder abuse and neglect: A Namibian perspective

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
 - 3.1 The data to be collected must only be used for completion of your PhD in Social Work;
 - 3.2 No other data should be collected other than the data stated in the proposal;
 - 3.3 A quarterly report to be submitted to the Ministry's Research Unit;
 - 3.4 Preliminary findings to be submitted upon completion of study;
 - 3.5 Final report to be submitted upon completion of the study;
 - 3.6 Separate permission should be sought from the Ministry for the publication of the findings.

Yours sincerely,

MR. K. KAHUURE
PERMANENT SECRETARY

MINISTRY OF HEALTH AND
SOCIAL SERVICES
OFFICE OF THE DIRECTOR
2012 -04- 1 8

P/BAG 13322, WINDHOEK
DIRECTORATE KHOMAS REGION



Handwritten notes:
10 PHC clinics
Supervisors
Please allow the holder of the letter to inform the relevant PHC at part of the study
at part of the study
Cm
Health for All

ANNEXURE 3: MAP OF NAMIBIA



ANNEXURE 4: LETTER OF CONSENT TO THE RESPONDENTS OF THE NEEDS ASSESSMENT

NORTH WEST UNIVERSITY, Potchefstroom campus

Dear Sir/ Madam

The purpose of the research is to gain an understanding of informal care older people receives at their houses and to determine what situations lead to elder abuse and neglect in the Katutura Central and Windhoek Rural constituencies of the Khomas region. As part of this needs assessment, I will be holding focus group discussions and individual interviews with community leaders, older people and informal caregivers. The results gathered at this needs assessment will be used to develop, implement and evaluate a social work support group programme with informal caregivers that will focus on improving caregiving to the older person and the prevention of elder abuse and neglect. Responses from the focus group discussions and individual interviews will be tape recorded for further analysis and interpretation.

During the focus group discussions and individual interviews, research assistants will be present, to assist with translations and will make brief field notes during the focus group and individual interviews. All the focus group discussions will be tape recorded, and stored securely by myself, until such time when I will interpret and analyze the recorded information in order to write the research report.

Should you choose to participate, your identity will remain anonymous. Your participation is completely voluntary. You may withdraw from the study at any time you may wish to do so.

I(name) agree to participate in a focus group or one on one interview in the study **AN EVALUATION ON SOCIAL WORK SUPPORT GROUPS WITH INFORMAL CAREGIVERS TO PREVENT ELDER ABUSE AND NEGLECT: A NAMIBIAN PERSPECTIVE.**

I give my consent for the focus group or individual interview to be tape recorded. I have received verbal information about the research project and fully understand the purpose of the study. I also understand that my answers will be kept confidential and my privacy assured.

Signature (research participant).....

Signature (researcher).....

Date.....

ANNEXURE 5: KEY INFORMANT INTERVIEW SCHEDULE

Date of interview:.....

Length of interview:.....

Rural vs urban:.....

1. Introduction of the researcher and research assistants. Invite key informant to introduce themselves.
2. Explain the purpose of research and purpose of the interview. Obtain informed consent.
3. Ask for the following demographic data:
 - a. Profession or position in community.
 - b. Number of years serving in that specific position
 - c. Gender
4. Tell me about the services your profession/office is rendering to older people/caregivers?
5. What are the main social problems of the older person/caregivers in your area?
6. Could you tell me about your impressions/observations on informal care to older people? Who are the typical caregivers? What type of care is offered? How adequate is the care provided by informal caregivers?
7. Have you noticed any challenges that informal caregivers may experience because of their caregiving role? Physical challenges? Psychological /emotional challenges? Financial challenges? Other challenges?
8. Tell me about the formal and informal support services/resources that are available to informal caregivers and older persons in your community? Family? Government offices, various ministries? Other organizations, eg Catholic AIDS Action, Red Cross, church? Training opportunities for informal caregivers?
9. Situations of poor care from informal caregivers or the lack of care may lead to the neglect of older people. Please tell me about the situation of neglect of older people in your community?
10. Abuse and violence in our society in general, we talk about women and child abuse. What about elder abuse? Probe for types of elder abuse.
11. What are the contributing factors of elder abuse and neglect? Any protective factors for elder abuse and neglect?
12. What can be done to address elder abuse and neglect in your community?
13. Do you have any further suggestions/ comments/ questions?

THANK YOU VERY MUCH

ANNEXURE 6: FOCUS GROUP INTERVIEW SCHEDULE: OLDER PERSONS

Date of focus group discussion:.....

Length of the focus group discussion:.....

Rural vs urban:

1. Introduction of the researcher and research assistants. Invite all older persons to introduce themselves.
2. Explain purpose of research and purpose of meeting. Obtain informed consent from all the older persons.
3. Ask the older persons to provide the following demographic data: age, gender, and marital status.
4. Do you require assistance to carry out activities of daily living? Tell me about the assistance you receive from family or informal caregiver. Who normally provides the assistance or care to you? Are there some other family members who also care for you?
5. Tell me about your impressions /satisfaction about the care you receive from informal caregivers?
6. Could you tell us of any worries/concerns about the quality of care you receive?
7. If you could make a wish, what would be the ideal/ improved care you would want?
8. Tell me about the formal and informal support services/ resources that are available to older people and informal caregivers? Family? Government eg clinic, social workers, school, councilor, police etc.? Other organizations, eg church, Red Cross, Catholic AIDS action? Training opportunities for informal caregivers?
9. Situations of poor care from informal caregivers or the lack of care may lead to the neglect of older people. What is the situation of neglect of older people in your community?
10. Abuse and violence in our society in general, we talk about women and child abuse. What is elder abuse? Probe for types of elder abuse.
11. What are the contributing factors to elder abuse? Any protective factors for elder abuse and neglect?
12. What must be done to prevent/ reduce elder abuse, neglect/ poor caregiving?
13. Do you have any further suggestions/ comments/ questions?

THANK YOU VERY MUCH

ANNEXURE 7: FOCUS GROUP INTERVIEW SCHEDULE: INFORMAL CAREGIVERS

Date of focus group discussion:.....

Length of the focus group discussion:.....

Rural vs urban:

1. Introduction of the researcher and research assistants. Invite caregivers to introduce themselves.
2. Explain purpose of the research and the purpose of the meeting. Obtain informed consent from the caregivers.
3. Ask the caregivers for the following demographic data: Age, gender, marital status, educational level and employment status.
4. Tell us how and when your caregiving role started? Your relationship with the care recipient? Are you the primary caregiver? Other family involved in caregiving?
5. How did your life changed because of your caregiving role? Socially? Financially? Family life? School? Work?
6. Could you elaborate on your caregiving responsibilities? The caregiving tasks that are easy, and also the most difficult/challenging tasks.
7. Are there any positive aspects about caregiving?
8. Can you tell me about the challenges/problems you encounter because of your caregiving role? Physical challenges? Psychological /emotional challenges? Eg stress, depression. Financial challenges? Other challenges?
9. How do you currently cope with these challenges/ problems?
10. Tell me about formal and informal support services /resources available to both the older person and the informal caregiver. From family, friends, neighbours? Government, eg clinic, hospital, social worker, Police, councilor office? Other organizations, eg. Catholic AIDS action, Red Cross, Life change center, church? Training opportunities for informal caregivers?
11. Situations of poor care from informal caregivers or the lack of care may lead to the neglect of older people. What is the situation of neglect of older people in your community?
12. Abuse and violence in our society in general, we talk about women and child abuse. What about elder abuse? Probe types of elder abuse.
13. What are the contributing factors to elder abuse? Any protective factors for elder abuse and neglect?
14. What must be done to prevent/ reduce elder abuse, neglect/ poor caregiving?
15. Do you have any further suggestions/ comments/ questions?

THANK YOU VERY MUCH

ANNEXURE 8: EXAMPLE OF A TRANSCRIPT OF THE KEY INFORMANT INTERVIEW

R: Researcher; **KI:** Key informant

R: Good morning Mr. XXX. I thank you very much for agreeing to this interview.

KI: Good morning, Madam.

R: As I have told you over the telephone, I am doing a research project for my postgraduate studies. The purpose of this interview is to learn more about the community care that older people receives from family, friends and neighbours, the quality of care they receives and the vulnerability of older people to abuse and neglect. Are you ready for the interview?

KI: Yes, please proceed, because I still have other appointments for the day.

R: Could you tell me about your impressions on informal caregiving to older persons?

KI: There are a lot of elderly people who need care but they do not end up in an institution who take care of them (old age homes). They (older person) need physical care, that they are not really able to do A, B, C and D. You find that some elderly people,... they have stayed for one month, they did not bath because they cannot properly bath themselves.

In African culture my grandchildren are part of me, he (older person) is not able to take care of himself but he is still taking care of the grandchildren. You have the right to tell your child ...“come take your child, I (already) raised you”. But still, they (older person) will feel, ...but it (grandchild) is part of me. ...But they (adult children) tell you (older people), to take your (grand) child, there is nothing that I can do, because I need to go do the domestic work and I sleep at my workplace. They (employer) does not want the child there, the money which she gets there pay her food. Some (employers) they pay 600 -500 Rand per month. She (adult child) will say the 500 Rand (pension is enough for my mother and grandmother. Then they (adult child) get another child.

A probing question was asked, to draw the interview back to informal caregiving:

KI: The son or daughter, the grandchild..... who says it is my responsibility, to see that water is running in Katutura..... sometimes, there is water, food, etc but elderly people do not get love, no time to spend with them. The child stays in Windhoek but now for 18 months..... you call him... he is busy, he cannot come, he cannot come and talk with you. You see now it is another loneliness. He is getting everything but he wants this child to be there in person.

There are those elderly people who are caring people, but they lack love. They feel rejected they feel lonely. You can see that the hole (emptiness) there.

R: Have you noticed any challenges around caregiving?

KI: They (family members) don't have the time to do it (providing care to older person)..... and employ the nun (paid caregiver), but the so-called nun (paid caregiver) are not trained. It is just someone picked up who knows how to iron, and washing the clothes. There is a difference in taking care and ironing /washing, it is just to take care holistically of the elderly person.

We went to a house in Katutura the way the nun (paid caregiver) was shouting at the elderly ' *get up yourself, I am tired*' ... she was not aware that we were around.. we just wanted to surprise her. .. I think we spend almost 15 minutes... she did not know that we were there. They (caregivers) need some training. I don't know of any institution that offers training. I think somewhere there must be such an institution that trains how to take care of elderly people. Some nuns (paid caregiver) are indirect family members,....they never went to school, are coming from the north, to take care of the elderly person. Some they are being employed, they caregivers are not completely family members.

I can give you an example of my father-in-law who is blind and bedridden. All of us, .. we do not have that time to look after him. That was why we brought a girl from the North, but she is not giving proper care. Every time you go there, you find grandfather wet, and you ask (the caregiver) what did you do all day. She (caregiver) will reply... 'no, I cooked, clean'... you see,.. they need to be trained. We experienced many difficulties. Maybe my father in law could have a long time to live,

but the stress he was under My father in law used to say that it is better for him to die.

I asked the caregiver ... to let grandfather walk around the house for some time during the day.... But they (caregiver) let the (grandfather) stay in bed all day long. ... When you go home ... you have to fight with the caregiver. ... I think if someone can know how to take care of the elderly person, and the training of these people that could help.

You can look at Katutura Old Age Home... although their caregivers are trained but while the elderly person is listening (can hear), the caregiver will communicate with someone else '*This old man... have just wet his pants*'. The caregiver is insulting the old man, as he can hear how the caregiver speaks about him in a disrespectful and shameful manner. This caregiver from the old age home is just same as the caregiver from home who does not know anything. This shortens the life of that elderly person.

I was asking the nun (paid caregiver) , 'when last did you brushed the teeth of grandpa? She (paid caregiver) replied ... 'I don't do that'. She is giving food without cleaning the teeth of the elderly person. We do not take the health part of elderly people seriously. But these elderly people, they can live longer but.... In my father in law.... the words which they are giving the elderly person, how they are shouting at the elderly person.

Love is not there..... these people are not treated with love.... the way we interpret the love is very interesting. You know we interpret the love somewhere else(different). You know when I grew up, I never saw my mother being kissed by my father, holding hands in public. Now I married, today, my wife maybe saw it to her mother there and may conclude ' you don't love me.... You don't hold my hands.... The point that I want to make , giving food ... is interpreted by some people as love. The person may just need you to sit next to them... put a touch... not rejected... feel he is still a human being . cause now, you become paralyzed and old. Then then this is what really shorten their lives. Because they feel like they are not really human beings, especially my father in law – he said it directly.

R: Now let us talk about situations of poor care or elder abuse, have you noticed any such situations?

KII: Both older men and women are victims, but most women are victims of elder abuse. I can estimate that out of ten older victims of elder abuse, seven are women and three are men.

Now the people who are abusing the elderly are mostly men who stay in the house with the elderly person. Elder abuse mainly happens inside (the household). You find some older couples who stay together with no one else in the house, some lives with the grandchildren, and some live with tenants.

Our experience shows that these grandchildren cause problems for the elderly people. For example, an older couple adopted this child, gave this child tertiary education. This grandchild performed well (in high school), came to the tertiary institution but and started to smoke dagga and become just violent in the house. It happened one day the grandchild just pick up a cup and hit the grandmother. Older people are abused physically, emotionally psychologically.

Our tradition in Africa... we are cleaved to biblical norms of ... 'honour your parents so that you get longtime'. Now in honour them we say in Africa we can supply them physically.

Just to add another example on the suffering of elderly people. An (older) husband has no income, the (older) wife has no income, they stay in the house. They have this 1000 Rand (pension of the 2 older couple combined) and the water and electricity bill is 300 or 400 rand ,... they have no renters, but still have to buy food. The money (pension) is not enough. It is emotional to them (older people). My child is there, (s)he is getting (a salary) 'but cannot even afford to give me a 200 rand. You find that type of emotional or psychological abuse.

Physically, it is these (grand child) who are drinking, the elderly person say ' I don't know what can I do with my grandchild', if there is no food then he is beating his grandmother. There must be food. Last year we referred the boy to the psychologist. This boy, it does not matter whether he comes home at one or two' o' clock (in the morning), the grandmother have to get up, and the door must be opened. And if the boy is out there the grandparents cannot sleep.

ANNEXURE 9: LETTER OF CONSENT TO SUPPORT GROUP PARTICIPANTS

North West University, Potchefstroom campus

AN EVALUATION OF SOCIAL WORK SUPPORT GROUPS WITH INFORMAL
CAREGIVERS TO PREVENT ELDER ABUSE AND NEGLECT: A NAMIBIAN
PERSPECTIVE

I understand that the purpose of this study is to evaluate the support group programme in which I am a participant. I understand that participation in this study involves participation in an 8-week group programme, the completion of a questionnaire at the beginning of the group programme, at the end of the group programme and six weeks after the group has ended.

I understand that my participation is completely voluntary and that I may choose to withdraw at any time from the study. However full cooperation in the completion of the programme will be appreciated.

All the information that I choose to provide will be held in confidence by the researcher. All identifying information will be omitted in any publications. Should I have any questions. I am able to contact Janet Ananias at 081 288 5344.

.....

Researcher

.....

Date

.....

Participant

.....

Date

ANNEXURE 10: INTERVIEW SCHEDULE OF DEMOGRAPHIC DATA AT FIRST GROUP SESSION

AN EVALUATION OF SOCIAL WORK SUPPORT GROUPS WITH INFORMAL CAREGIVERS TO PREVENT ELDER ABUSE AND NEGLECT NORTH WEST UNIVERSITY, POTCHEFSTROOM CAMPUS

Demographic data:

A: Identifying details of the care recipient:

1. How old is the care recipient?.....
2. What is the gender of the care recipient?
☐ Male ☐ Female
3. What is the marital status of the care recipient?
☐ Single ☐ Married ☐ Divorce ☐ Widow/er
4. With whom does the care recipient live?
 Lives with me (caregiver) ☐
 Lives with other family members ☐
 Lives with other people ☐
 Lives alone ☐

B: Identifying details of the caregiver:

1. What is your date of birth?
 (day) (Month) (year)
2. What is your gender? ☐ Male ☐ Female
3. What is your marital status?
☐ Single ☐ Married ☐ Divorce ☐ Widow/er

4. What is your highest educational level?

Never been to school

☐

Completed grade 7 (primary school)

☐

Grade 10

☐

Grade 12

☐

Vocational training

☐

University degree

5. Where is your home located?

☐

Urban

☐

Rural

6. Employment status

☐

Employed

☐

Unemployed

☐

Retired

7. If employed, the type of employment?

.....

8. What is the total monthly income of your household?

0-N\$500

☐

N\$500-N\$1000

☐

N\$1000-N\$5000

☐

N\$5000-N\$10000

☐

More than N\$10000

☐

Other (please specify).....

9. What is your relationship with the older person you care for? He/she is my

☐

- Parent ☐
- Spouse ☐
- Child ☐
- Sibling ☐
- In-law ☐
- Grand parent ☐
- Friend ☐
- Neighbour ☐
- Other relative (please specify).....
- Other (please specify)

10. How long have you been providing care to the care recipient?

- Less than one year ☐
- Between one to five years ☐
- 5-10 years ☐
- More than 10 years ☐

11. What are the health problems of the older care recipient that you are aware of?

You may tick more than one answer.

- Hypertension ☐
- Asthma ☐
- Diabetes ☐
- Mental illness ☐
- Heart problems ☐
- Stroke ☐
- Blindness ☐
- Cancer ☐
- Accident ☐
- Other (please specify).....

ANNEXURE 11: ZARIT BURDEN INTERVIEW (ZBI)

The list of questions below reflects how people sometimes feel when they are taking care of another person. Each question asks about 'your relative'; please answer about your care recipient even if they are a friend or a neighbour. After each question, choose the word that best describes how often you feel that way. Please mark the correct response with an 'x'. There is no right or wrong answer.

HOW OFTEN	Never	Almost never	Sometimes	Most of the times	All the times
	0	1	2	3	4
1. Do you feel that your relative asks for more help than (s) he needs?					
2. Do you feel that because of the time you spend with your relative that you don't have enough time for yourself?					
3. Do you feel stressed between caring for your relative and trying to meet other responsibilities for your family or work?					
4. Do you feel embarrassed over your relative's behaviour?					
5. Do you feel angry when you are around your relative?					
6. Do you feel that your relative currently affects your relationships with other family members or friends in a negative way?					
7. Are you afraid what the future holds for your relative?					
8. Do you feel your relative is dependent on you?					
9. Do you feel strained when you are around your relative?					
10. Do you feel your health has suffered because of your involvement with your relative?					
11. Do you feel that you don't have as much privacy as you would like because of your relative?					
12. Do you feel your social life has suffered because you are caring for your relative?					
13. Do you feel uncomfortable about having friends over because of your relative?					

14. Do you feel your relative seems to expect you to take care of him/her as if you were the only one (s)he could depend on?					
15. Do you feel that you don't have enough money to take care of your relative in addition to the rest of your expenses?					
16. Do you feel that you will be unable to take care of your relative much longer?					
17. Do you feel you have lost control of your life since your relative became ill/dependent?					
18. Do you wish you could leave the care of your relative to someone else?					
19. Do you feel uncertain about what to do about your relative?					
20. Do you feel you should be doing more for your relative?					
21. Do you feel that you could do a better job in caring for your relative?					
	Not at all	A little	Moderately	Quite a bit	Extremely
	0	1	2	3	4
22. Overall, how burdened do you feel in caring for your older relative?					

ANNEXURE 12: POTENTIALLY HARMFUL BEHAVIOUR (PHB) SCALE

How often did you use the methods below use when the older care recipient did not behave in a desirable way. Please make a cross (x) at the most appropriate column.

Five indicators of psychological abuse: In the last three months, have you ever....

Psychological abuse	Never	Almost never	Sometimes	Most of the times	All the times
	0	1	2	3	4
Screamed or shouted at the older care recipient?					
Threatened to send older person to an old age home?					
Threatened to use physical force on the older person?					
Threatened to stop taking care of the older person?					
Used a harsh tone of voice, insulting, swore at the older person or call him names?					

Five indicators of physical abuse: In the last three months, have you ever

Physical abuse	Never	Almost Never	Sometimes	Most of the times	All the times
	0	1	2	3	4
Withheld food from the older care recipient?					
Hit or slapped the older person?					
Shaken the older care recipient?					
Handled the older care recipient roughly in other ways?					
Make the older person fearful that you may hit or harm them?					

ANNEXURE 13: CAREGIVER ABUSE SCREEN (CASE)

Please answer the following questions as a helper or caregiver, by selecting either 'yes' or 'no'. Mark the correct response with an 'x'.

Response	Yes 1	No 2
1. Do you sometimes have trouble making the older care recipient control his/her temper or aggression?		
2. In caring for the older care recipient do you often feel you are being forced to do things you feel bad about?		
3. Do you find it difficult to manage the older care recipient's behaviour?		
4. Do you sometimes feel that you are forced to be rough with the older care recipient?		
5. Do you sometimes feel you can't do what is really necessary or what should be done for the older care recipient?		
6. Do you often feel you have to ignore the older care recipient?		
7. Do you often feel so tired and exhausted that you cannot meet the older care recipient's needs?		
8. Do you often feel you have to yell at the older care recipient?		

ANNEXURE 14: GROUP ENGAGEMENT MEASURE

(GEM-27)

Leader(s) Name _____ Member Date of birth: _____
 Today's Date: _____ Session Numbers Rated: _____

Please use the following scale to rate each statement

Rarely or none of the time	A little of the time	Some of the time	A good part of the time	Most or all of the time
1	2	3	4	5

Statement Rating (circle)

I. Attending

- (1) The member arrives at or before start time 1 2 3 4 5
 (2) The member stays until the end of sessions or leaves only for important reasons 1 2 3 4 5
 (3) The member does not hurry to leave at the end of sessions 1 2 3 4 5
 Attending Score (sum total divided by number of items completed):

II. Contributing

- (4) The member contributes his/her share of talk time (not too much, not too little) 1 2 3 4 5
 (5) The member seems to follow and understand what others are saying 1 2 3 4 5
 (6) The member responds thoughtfully to what all others are saying (not just one or two) 1 2 3 4 5
 (7) The member verbally interacts with members on topics related to the group's purpose 1 2 3 4 5
 (8) The member participates in group projects/activities 1 2 3 4 5
 Contributing Score (sum total divided by number of items completed):

III. Relating to worker

- (9) The member follows guidance of the worker (e.g., discusses what worker wants group to discuss, is involved in activities suggested by worker) 1 2 3 4 5
 (10) The member shows enthusiasm about contact with worker (e.g., demonstrates interest in the worker, is eager to speak with worker) 1 2 3 4 5
 (11) The member supports work that the worker is doing with other members (e.g., by staying on topic or expanding on discussion) 1 2 3 4 5
 Relating to Worker Score (sum total divided by number of items completed):

IV. Relating with members

- (12) The member likes and cares for other members 1 2 3 4 5
- (13) The member helps other group members to maintain good relations with each other (e.g., by encouraging members to work out interpersonal problems, by stopping unproductive arguments among members, by cheering up members, and so forth) 1 2 3 4 5
- (14) The member helps and encourages other members 1 2 3 4 5
- Relating with Members Score (sum total divided by number of items completed):

V. Contracting

- (15) The member expresses continual disapproval about the meeting times 1 2 3 4 5
- (16) The member expresses continual disapproval about the number of meetings 1 2 3 4 5
- (17) The member expresses continual disapproval about what the group members are doing together 1 2 3 4 5
- Contracting Score (sum total divided by number of items completed):

VI. Working on own problems

- (18) The member partializes problems and works on their parts 1 2 3 4 5
- (19) The member makes an effort to achieve his/her particular goals 1 2 3 4 5
- (20) The member works on solutions to specific problems 1 2 3 4 5
- (21) The member tries to understand the things s/he does 1 2 3 4 5
- (22) The member reveals feelings that help in understanding problems 1 2 3 4 5
- Working on Own Problems Score (sum total divided by number of items completed):

VII. Working with others' problems

- (23) The member talks with (encourages) others in ways that help them focus on their problems 1 2 3 4 5
- (24) The member talks with (encourages) others in ways that help them partialize or specify their problems 1 2 3 4 5
- (25) The member talks with (encourages) others in ways that help them do constructive work on solving their problems 1 2 3 4 5
- (26) The member challenges others constructively in their efforts to sort out their problems 1 2 3 4 5
- (27) The member helps others achieve the group's purpose 1 2 3 4 5
- Working with Others' Problems Score (sum total divided by number of items completed):

TOTAL ENGAGEMENT SCORE (OUT OF NUMBER ITEMS COMPLETED):

ANNEXURE 15: OPEN-ENDED QUESTIONS TO EVALUATE THE SUPPORT GROUP PROGRAMME

1. Do you think you have learnt something from the support group programme?
.....
.....
2. Would you be able to respond differently in caregiving situations now that the group came to an end?
.....
.....
3. Which topics in the support group programme was the most interesting for you?
.....
.....
4. Which topic were the least interesting for you?
.....
.....
5. Which other topics would you like to suggest to be included in future support group programmes for caregivers?
.....
.....
6. If you have to change anything about the programme, what would that be?
.....
.....
7. Do you think other caregivers can gain from participating in support group programmes?
.....
.....
8. How was the group of value to improve your knowledge and skills on caregiving?
.....
.....

ANNEXURE 16: AGREEMENT TO USE THE ZARIT BURDEN INTERVIEW (ZBI)

USE OF THE ZARIT BURDEN INTERVIEW (ZBI) AND ITS TRANSLATIONS

Date : ! 2_! 3_! 0_! 4 !_1_!3_!
 day month year

PART 1. LICENSEE'S DETAILS

LICENSEE Name: ***Please have the information type written*** Janetta A. Ananias.....

LICENSEE Title: Ms.

Company : University of Namibia.....

Address : Private Bag 13301, Windhoek, Namibia.....

.....

.....

Country : Namibia

Phone : + 264 81 288 5344..... Fax :+ 264 88 643 295

Email : jananias@unam.na.....

VAT number (if applicable):

Contact name if different from above: ***Please have the information type written***

Contact Title:.....

Company :

Address :

.....

.....

Country :

Phone :

Fax :

Email :

PART 2. CONTEXT OF ZBI USE

1. Individual clinical practice ☒x

- Expected duration of use: Indefinite ☐ or Number of years 2
months _____

2. Research study/project ☐

- **Title:** An evaluation of social work support groups with informal caregivers to prevent elder abuse and neglect _____

- **Disease or condition:** Burden and stress of caregivers

- **Type of research:**

x ☐ clinical trial - Phase II ☐ / Phase III ☐

☐ epidemiologic/observational

☐ other:

- **Questionnaire used as primary end point:** yes x ☐ no ☐

- **Number of expected patients (total):** 20

- **Number of administrations of the questionnaire per patient:** 3

- **Length of the follow-up (if any) for each patient:** 6 weeks

- **Planned study/project date:** start 05 13 end 07 13

- **Mode of administration:**

x ☐ Paper

☐ Electronic version

If electronic administration, please precise the type of medium:

- PDA ☐

- Web-based ☐

- CDr / DVD ☐

- Other ☐ (please precise):.....

3. Other project ☐ N/a

- **Title:** N/a

- **Disease or condition:** N/a

- **Expected duration of use:** N/a

- **Brief description of the project:**

This evidence based research study is conducted with informal caregivers of older people in Namibia, that aims at improving caregiving skills and acquire knowledge on caregiver stress and ultimately reducing elder abuse and neglect.

• **Presentation Format:**

☒ Article

☐ Book

☐ Electronic version (please precise type of medium):

☐ Other (please precise):

☐ Book

☐ Electronic version (please precise type of medium):

☐ Other (please precise):

PART 3. PROJECT FINANCING (tick the appropriate box)

Not funded academic research/project, individual medical practice

☒ x

Projects not explicitly funded, but funding comes from overall departmental funds or from the University or individual funds.

Funded academic research/project

☐

*Projects receiving funding from commerce, government, EU or registered charity.
Funded academic research– sponsored by industry- fits the “commercial study/project” category.*

Commercial study/project

☐

Industry, CRO, any for-profit companies

Grants / Sponsoring from (if any) (name of the governmental/foundation/company or other funding/sponsoring source):

PART 4. TRANSLATIONS

Please indicate in which language(s) and for which country(ies) the **ZBI** is needed:

Language:	For use in the following country	Language:	For use in the following country	Language:	For use in the following country
e.g. English	USA				
e.g. Spanish	USA				
English	Namibia				

Note: The ZBI translation(s) may not be available in the country required or may not have undergone a full linguistic validation process.

Please check availability and status of translations with MAPI Research Trust.

If not available in the language(s) required, a Linguistic Validation must be undergone.

PART 5. USER AGREEMENT

On behalf of Prof. Steven H. Zarit ("OWNER"), copyright owner of the ZBI, MAPI Research Trust grants LICENSEE the non-exclusive, non-transferable right to use the ZBI in the countries listed in Part 4 (TRANSLATIONS) above, subject to the following terms, conditions, and only upon signature of this agreement by LICENSEE:

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1.2 No modification

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LICENSEE shall not translate the ZBI, without the prior written agreement of the OWNER. For any new translation of the ZBI, a Translation Agreement shall be signed with MAPI Research Trust.

In the context of commercial studies or any project funded by the pharmaceutical industry, the translation work must be coordinated by the Linguistic Validation Department of MAPI Institute.

1.4 No reproduction

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In no other event shall LICENSEE distribute copies of the ZBI to third parties that are outside the scope of the defined study by sale, rental, lease, lending, or any others means, or publish copies of the ZBI without the prior written agreement of the OWNER of the ZBI and /or MAPI Research Trust.

1.5 Publication

In case of publication in an article, poster, presentation or in a book, LICENSEE shall:

- Cite the reference publications:
 - Zarit SH, Reever KE, Bach-Peterson J. Relatives of the Impaired Elderly: Correlates of Feelings of Burden. *Gerontologist*.1980;20(6):649-55
 - ZBI 12 items: Bédard M, Molloy DW, Squire L, Dubois S, Lever JA, O'Donnell M. The Zarit Burden Interview: A new short version and screening version. *The Gerontologist* 2001; 41:652-657.
- Insert the OWNER's copyright notice
- Mention the following information: "ZBI contact information and permission to use: MAPI Research Trust, Lyon, France. E-mail: PROinformation@mapi-trust.org – Internet: www.mapi-trust.org "
- Not include a copy of the Questionnaire. If the inclusion of the Questionnaire is necessary, LICENSEE shall include the following note: "Sample copy – Do not use without permission" and the OWNER's copyright notice in the background of the page.
- Submit the last version of the publication to MAPI Research Trust before distribution for approval and to check that the above-mentioned requirements have been respected.
- Provide a copy of the article, poster, presentation or book to MAPI Research Trust.

1.6 E-Application

In case of e-application of the instrument in clinical trial and practice, LICENSEE shall:

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- Insert the copyright owner's copyright notice on all pages/screens on which the ZBI will be presented
- Mention the following information: "ZBI contact information and permission to use: MAPI Research Trust, Lyon, France. E-mail: PROinformation@mapi-trust.org – Internet: www.mapi-trust.org "
- Submit the screenshots of all the WebPages where the ZBI appear to MAPI Research Trust before release for approval and to check that the above-mentioned requirements have been respected.

In case of e-application of the instrument for dissemination purpose:

* On a public website, LICENSEE shall:

- Cite the reference publications
- Insert the copyright owner's copyright notice on all pages/screens on which the ZBI will be presented
- Mention the following information: "ZBI contact information and permission to use: MAPI Research Trust, Lyon, France. E-mail: PROinformation@mapi-trust.org – Internet: www.mapi-trust.org ”
- Not include a clean copy of the ZBI, but a protected copy of the instrument, with the following note: "Sample copy – Do not use without permission" in the background of the page.
- Submit the screenshots of all the WebPages where the ZBI appear to MAPI Research Trust before release for approval and to check that the above-mentioned requirements have been respected.

* On a password-protected website, LICENSEE shall:

- Cite the reference publications
- Insert the copyright owner's copyright notice on all pages/screens on which the ZBI will be presented
- Use a protected version of the ZBI that would be locked with a password so that it is not publicly available on the Internet but strictly accessible to the users who are part of this program and have a restricted access to this program
- Include the following information in their license: "The authorization to use the ZBI is restricted to this project. The inclusion of the instrument in this program does not imply permission for any other uses. It is the LICENSEES' responsibility to contact MAPI Research Trust to find out if there are any restrictions or fees applicable on the use of the questionnaire. Please check with MAPI Research Trust for the conditions of use of the questionnaire for all other projects using the questionnaire www.mapi-trust.org”
- Mention the following information: "ZBI contact information and permission to use: MAPI Research Trust, Lyon, France. E-mail: PROinformation@mapi-trust.org – Internet: www.mapi-trust.org ”
- Submit the screenshots of all the WebPages where the ZBI appear to MAPI Research Trust before release for approval and to check that the above-mentioned requirements have been respected.

2. License Fees

2.1 Royalty fees (OWNER)

- The use of the ZBI in commercial studies involving “for-profit” organizations is subject to the following royalty fees payable to MAPI Research Trust on behalf of the OWNER: 1,000 (one thousand) Euros per protocol/application plus an additional charge of 500 (five hundred) Euros per existing translation to be used in the protocol/application.
- If a LICENSEE sponsors the linguistic validation of a new translated version of the questionnaire, royalty fees will be waived for this protocol/study. For any new projects using this translation, LICENSEE shall anticipate paying the royalty fees for the use of this version (per protocol/study fee & per language version fee).

2.2 Processing Fees (MAPI Research Trust)

- The use of the ZBI in commercial studies involving “for-profit” organizations is subject to a distribution fee payable to MAPI Research Trust, of an amount of 700 (seven hundred) Euros per study/project plus an additional 300 (three hundred) Euros per existing language version supplied.
- The use of the ZBI in funded academic research is subject to a distribution fee payable to MAPI Research Trust, of an amount of 300 (three hundred) Euros per study/project plus an additional 50 (fifty) Euros per existing language version supplied.
- The use of the ZBI in non funded academic research and individual clinical practice is free of charge.

2.3 Invoicing and payment

Upon execution of this Agreement, MAPI Research Trust shall promptly provide LICENSEE with a definitive invoice, and LICENSEE shall pay the invoice within thirty (30) days of the date indicated on the invoice.

The questionnaire and requested translations shall only be delivered to LICENSEE upon either receipt of payment or proof of payment (in the form of a copy of the check or wire transfer details) of all due fees.

3. **Provision of Data**

All data, results and reports obtained by or prepared in connection with, the authorized use of the ZBI shall remain the property of the LICENSEE.

4. **Infringement**

If, at any time during the term of this agreement, LICENSEE learns of any infringement by a third party of any intellectual property rights in connection with the ZBI, LICENSEE shall promptly notify MAPI Research Trust. MAPI Research Trust shall notify the OWNER of such infringement who may at their discretion decide to institute or not institute proceedings against the infringing party.

5. **Confidentiality**

All and any information related to the ZBI including but not limited to the following: information concerning clinical investigations, creations, systems, materials, software, data and know-how, translations, improvements ideas, specifications, documents, records, notebooks, drawings, and any repositories or representation of such information, whether oral or in writing or software stored, are herein referred to as confidential information.

In consideration of the disclosure of any such confidential information to the other, each party agrees to hold such confidential information in confidence and not divulge it, in whole or in part, to any third party except for the purpose specified in this Agreement.

6. **Use of name**

It is agreed that MAPI Research Trust shall not disclose, whether by the public press or otherwise, LICENSEE's Company name or LICENSEE's name (if LICENSEE is not a company), to any third party except to the OWNER.

LICENSEE shall not use the name of the OWNER in any public announcements, publicity or advertising with respect to the subject matter of this Agreement without prior written approval of the OWNER.

7. Copy to the OWNER / OWNER Third Party Beneficiaries

It is understood that a copy of this User Agreement may be provided to the OWNER, and that the OWNER shall be third party beneficiaries of this Agreement and that as such, the OWNER shall have the right to enforce against LICENSEE for the OWNER's benefit, the obligations and covenants of the LICENSEE which are included for the OWNER's benefit in this Agreement.

8. Liability

8.1 In case of breach of contract

In the event of total or partial breach by MAPI Research Trust of any of its obligations hereunder, MAPI Research Trust's liability shall be limited to the direct loss or damage suffered by LICENSEE as a result of such breach and shall not include any other damages such as consequential damages, loss of profit and operating losses. LICENSEE acknowledges that the OWNER shall not have any liability to LICENSEE in the event of any breach by MAPI Research Trust of any of its obligations under this Agreement.

8.2 In the scope of the use of the ZBI

Under no circumstances may the OWNER or MAPI Research Trust be held liable for direct or consequential damage resulting from the use of the ZBI or for consequences resulting from the use of the ZBI.

8.3 In the event of non-renewal of this Agreement

In the event of non-renewal of this Agreement by MAPI Research Trust for any cause or failure by MAPI Research Trust to conclude a new agreement with LICENSEE upon the expiry of this Agreement, neither MAPI Research Trust, nor the OWNER will have any liability for payment of any damages and/or indemnity to LICENSEE.

9. Term and Termination

This Agreement shall be effective as the date of its signature by LICENSEE and shall continue until expiry of the term of the study/project referred to in PART 2 (CONTEXT OF ZBI USE) of the present Agreement.

Either party may terminate this Agreement immediately upon providing written notice to the other party in the event of:

- the other party's unexcused failure to fulfil any of its material obligations under this Agreement
- or
- upon the insolvency or bankruptcy of, or the filing of a petition in bankruptcy or similar arrangement by the other party.

Upon expiration or termination of this Agreement MAPI Research Trust may retain in its possession confidential information it acquired from LICENSEE relating to the ZBI during the term of this Agreement.

10. Assignment

This Agreement and any of the rights and obligations of LICENSEE are personal to the LICENSEE and cannot be assigned or transferred by LICENSEE to any third party or by operation of law, except with the written consent of MAPI Research Trust and the OWNER.

11. Separate Agreement

This Agreement shall apply only to the study/project as referred to and defined in PART 2 (CONTEXT OF ZBI USE) above. The use of the ZBI in any additional study/project of the

LICENSEE will require a separate agreement and the payment of related distribution and royalty fees.

12. Entire Agreement, Modification, Enforceability

This Agreement contains the entire agreement between LICENSEE and MAPI Research Trust and cancels and supersedes all prior agreements, oral or written, between the parties with the respect to the subject matter hereto.

This Agreement or any of its terms may not be changed or amended except by written document and with the written permission of the OWNER and the failure by either party hereto to enforce any or all of the provision(s) of this Agreement shall not be deemed a waiver or an amendment of the same and shall not prevent future enforcement thereof.

If any one or more of the provisions or clauses of this Agreement are adjudged by a court to be invalid or unenforceable, this shall in no way prejudice or affect the binding nature of this Agreement as a whole, or the validity or enforceability of each/and every other provision of this Agreement.

13. Governing law

This Agreement is made in and shall be governed by and interpreted in accordance with the substantive laws of France, without regard to conflicts of laws.

14. Forum

Any controversy arising under this Agreement if litigated, shall be adjudicated in the court of the competent jurisdiction in Lyon, France, notwithstanding the plurality of defendants or claim in warranty, even in the event of emergency procedures or protective procedures, and the parties hereby submit to the exclusive jurisdiction of such court.

IN WITNESS WHEREOF, the party hereto has caused this Agreement to be executed by its duly authorised representative as of the date written above.

AGREED

LICENSEE's Signature (handwritten): _____ Title: Ms _____ Company/Organisation: University of Namibia _____ Date: 23 April 2013_____	Company/Organisation Stamp (if applicable):
--	---

ANNEXURE 17: PERMISSION TO USE THE ZARIT BURDEN INTERVIEW (ZBI)

RE: 32166 - permission: zarit burden interview

Piero Bindi [pbindi@mapigroup.com]

The message sender has requested a read receipt. [Click here to send a receipt.](#)

You replied on 4/25/2013 2:33 PM.

Sent: Monday, April 15, 2013 9:40 AM

To: [Ananias, Janeta](#)

Dear Janeta,

Thank you for your message. I will be pleased to provide you with the requested version of the ZBI (if available) but first I invite you to complete and sign the User Agreement that is downloadable from our website at:

<http://www.mapi-trust.org/services/questionnairelicensing/catalog-questionnaires/307-zbi> Please remember to indicate clearly in this User Agreement in which language(s) you want to receive your version.

Once completed, you have to send it to me by regular mail to the address indicated in my signature. To speed up the process, you can send me a copy by fax or email (with your signature).

I will provide you with the requested version (if available) as well as the Scoring Manual upon reception of your User Agreement. Please note that the ZBI is free of charge in not funded academic research and MAPI Research Trust does not require any research proposal.

Do not hesitate to contact me should you need any additional information or may have any other questions.

I look forward to hearing from you.

Best Regards,

Piero

Generally out of the office on Wednesday afternoons

Piero BINDI

Information Resources Specialist

PROs & ClinROs Information Support Unit

MAPI Research Trust

27 RUE DE LA VILLETTE | 69003 LYON | France

Tel.: +33 (0)4 72 13 65 75 | Fax: +33 (0)4 72 13 55 73

pbindi@mapigroup.com | www.mapigroup.com

-----Message d'origine-----

De : Ananias, Janeta [<mailto:jananias@unam.na>]

Envoyé : jeudi 11 avril 2013 23:19

À : PROinformation TRUST.ORG

Object : permission: zarit burden interview

Dear Sir or Madam

My name is Janet Ananias, I am from Namibia, but registered as a PhD student at the North West University, Potchefstroom campus in South Africa.

In many literature I have come across Zarit Burden Interview, and also think it can be useful in answering the research questions in my study. The title of my study is 'An evaluation of social work support groups with informal caregivers to prevent elder abuse and neglect: A Namibian perspective'.

I hereby would like to request for permission to use the Zarit Burden Interview Scale, for pre and post measurements of a support group intervention with informal caregivers of older people. In addition, could you please supply me with an explanation how to analyze the data. I intend to give you full credit for the instruments throughout all the publications.

If you would like further details concerning my research, I can provide you with the research proposal. Once the study has been completed, I am also prepared to provide you a copy of the completed research project.

Thank you in advance for your time and consideration.

Yours sincerely

Janeta Ananias

ANNEXURE 18: PERMISSION TO USE THE POTENTIALLY HARMFUL BEHAVIOUR (scale)

RE: permission to use potential harmful behaviour scale
Beach, Scott Richard [scottb@pitt.edu]
You replied on 4/24/2013 7:50 AM.
Sent: Tuesday, April 23, 2013 9:32 PM
To: [Ananias, Janeta](#)

Janeta,

The PHB is public domain - feel free to use.

Scott Beach.

-----Original Message-----

From: Ananias, Janeta [<mailto:jananias@unam.na>]
Sent: Tuesday, April 23, 2013 4:20 PM
To: Beach, Scott Richard
Subject: permission to use potential harmful behaviour scale

Dear Sir or madam

I have read one of your publications that made reference to the potential harmful behaviour scale.

I am a postgraduate student, and would like to use the Potential Harmful Behaviour scale for my research.

Please provide me with the contact details of the person to whom I will have to address my request for permission to use the PHB scale.

Janeta Ananias

Lecturer: Social Work

Human Science

University of Namibia

Tel: 3711 - E-mail: jananias@unam.na - Web: <http://www.unam.na> - Fax:

Private Bag 13301, 340 Mandume Ndemufayo Ave, Pionierspark, Windhoek, NAMIBIA

ANNEXURE 19: PERMISSION TO USE THE GROUP ENGAGEMENT MEASURE (GEM)

RE: RE: requesting permission to use the GEM

Mark [Macgowan@fiu.edu]

Sent: Monday, June 25, 2012 7:03 PM

To: [Ananias, Janeta](#)

Attachments:  [Group Engagement Measure ~1.pdf \(186 KB\)\[Open as Web Page\]](#);  [Group Engagement Measure ~2.pdf \(144 KB\)\[Open as Web Page\]](#)

I have attached some additional information if I haven't sent it already. Thanks.

Mark

From: J Ananias [mailto:jananias@unam.na]

Sent: Monday, June 18, 2012 3:23 PM

To: Mark

Subject: Re: RE: requesting permission to use the GEM

Dear Mark

thank you very much for your permission granted. I have already peruse two of your articles on GEM namely

Macgowan, M. J. 2003. Increasing Engagement in Groups: A Measurement Based Approach. *Social Work with Groups*, Vol. 26(1): 5 – 28.

Macgowan, M. J. 2006. The Group Engagement Measure: A Review of Its Conceptual and Empirical Properties. *Journal of Groups in Addiction & Recovery*, Vol. 1(2): 33- 52

If you could suggest some more literature that could enhance my understanding of the instrument or evidence informed group work practice, I would appreciate it very much.

Best regards

Janet

On Sat, 06/09/2012 01:51 AM, "Mark" <Macgowan@fiu.edu> wrote:

Dear Janet:

Nice to hear from you. Yes, please feel free to use the GEM for your research. Please let me know if you would like to a copy if you do not have it. Thank you.

Mark

From: J Ananias [<mailto:jananias@unam.na>]

Sent: Monday, June 04, 2012 3:05 PM
To: Macgowan@fiu.edu
Subject: requesting permission to use the GEM

Dear Prof Mark Macgowan

My name is Janet Ananias, I am from Namibia, but registered as a PhD student at the North West University, Potchefstroom campus in South Africa. I learnt about your works from Prof. Carol Cohen, who speaks highly about your work. After reading some of your publications on group work found it very informative.

I have already completed my proposal which is titled, 'An evaluation of social work support groups with informal caregivers to prevent elder abuse and neglect: A Namibian perspective', and have also started doing some initial fieldwork.

I hereby would like to request for permission to use the Group Engagement Measure (GEM) in my study. This measuring instrument will be useful during the support group intervention phase of my study. I intend to give you full credit for the instruments throughout all the publications.

If you would like further details concerning my research, I can provide you with the research proposal. Once the study has been completed, I am also prepared to provide you a copy of the completed research project.

Thank you in advance for your time and consideration.

Yours sincerely

Janet Ananias

University of Namibia

Private Bag 13301

Windhoek

Namibia

ANNEXURE 20: MAATSKAPLIKE WERK/SOCIAL WORK

Instructions to authors

The Journal publishes book reviews and commentary on articles already published from any field of social work. Contributions may be written in English or Afrikaans. All articles should include an abstract in English of not more than 100 words. All contributions will be critically reviewed by at least two referees on whose advice contributions will be accepted or rejected by the editorial committee. All refereeing is strictly confidential. Manuscripts may be returned to the authors if extensive revision is required or if the style or presentation does not conform to the Journal practice. Articles of fewer than 2,000 words or more than 12,000 words are normally not considered for publication. Two copies of the manuscript as well as a diskette with the text, preferably in MS Windows should be submitted. Manuscripts should be typed in 12 pt Times Roman double-spaced on one side of A4 paper only. If possible the manuscript should be sent electronically to hsu@sun.ac.za. Use the Harvard system for references. Short references in the text: When word-for-word quotations, facts or arguments from other sources are cited, the surname(s) of the author(s), year of publication and page number(s) must appear in parenthesis in the text, e.g. "... (Berger, 1967:12). More details about sources referred to in the text should appear at the end of the manuscript under the caption "References". The sources must be arranged alphabetically according to the surnames of the authors. Note the use of capitals and punctuation marks in the following examples.

TWO AUTHORS/TWEE OUTEURS: SHEAFOR, B.W. & JENKINS, L.E. 1982.
Quality field instruction in social work. Program Development and Maintenance.
New York: Longman.

COLLECTION/BUNDEL ARTIKELS: MIDDLEMAN, R.R. & RHODES, G.B. (eds)
1985. Competent supervision, making imaginative judgements. New Jersey:
Prentice-Hall.

ARTICLE IN COLLECTION/ARTIKEL IN BUNDEL: DURKHEIM, E. 1977. On
education and society. In: KARABEL, J. & HALSEY, A.H. (eds) Power and ideology
in education. New York: Oxford University Press.

JOURNAL ARTICLE/ARTIKEL IN TYDSKRIF: BERNSTEIN, A. 1991. Social work and a new South Africa: Can social workers meet the challenge? Social Work/Maatskaplike Werk, 27(3/4):222-231.

THESIS/TESIS: EHLERS, D.M.M. 1987. Die gebruik van statistiese tegnieke vir die ontleding van gegewens in maatskaplikewerk-navorsing. Pretoria: Universiteit van Pretoria. (M tesis)

MINISTRY FOR WELFARE AND POPULATION DEVELOPMENT. 1995. Draft White Paper for Social Welfare. Government Gazette, Vol. 368, No. 16943 (2 February). Pretoria: Government Printer.

NEWSPAPER REPORT/KOERANTBERIG: MBEKI, T. 1998. Fiddling while the AIDS crisis gets out of control. Sunday Times, 8 March, 18.

INTERNET REFERENCES/VERWYSINGS: McKIERNAN, G. 1998. Beyond bookmarks: schemes for organizing the Web. Available: <http://www.public.iastate.edu/CYBERSTACKS/CTW.htm>. [Accessed: 18/06/1998].

ANNEXURE 21: THE SOCIAL WORK PRACTITIONER- RESEARCHER/DIE MAATSKAPLIKE WERK NAVORSER-PRAKTISYN

NOTES FOR CONTRIBUTORS

Editorial scope

The *Social Work Practitioner-Researcher* is a refereed interdisciplinary journal for social workers and social service professionals concerned with the advancement of the theory and practice of social work and social development in Africa and in a changing global world. The purpose of the journal is to promote research and innovation in the practice of helping individuals, families, groups, organizations and communities to promote development and human well-being in society. The journal is committed to the creation of empowered, humane, just and democratic societies.

Manuscripts that would be appropriate are: (1) conceptual analyses and theoretical presentations, (2) literature reviews that provide new insights or new research questions, (3) manuscripts that report empirical work. Topics that will be considered include, but are not limited to, the following: lifespan, populations at risk, poverty, livelihoods, anti-discriminatory practice, welfare systems, development management, social security, social policy, human rights, community-based development, social development, comparative health, mental health, education, urban and rural development, civic service, voluntarism, civil society, social movements and social change.

As it is the intention of this journal to maintain a balance between theory and practice, contributors are encouraged to spell out the practical implications of their work for those involved in social work practice and the social services in the African context.

Submissions

A decision to submit an article to this journal means that you will not be able to simultaneously submit the same article to another journal in South Africa or elsewhere. If there is more than one author, we require a letter stating that all the

authors agree to submit the article. If a person has contributed to the research of the article and is not going to be included as a co-author, then that person needs to be acknowledged at the end of the article.

The reviewing process

Each manuscript is reviewed by the Editor and Assistant Editor. If it is judged suitable for this journal, it is sent to two reviewers for blind peer-review. Based on their recommendations, the editorial committee decides whether the manuscript should be accepted as is, revised or rejected. If a manuscript is published, the author or their institution will be invoiced for page fees at the rate of R100,00 per page.

Presentation

1. Manuscripts should be submitted as electronic attachments to the journal administrator swjournal@uj.ac.za in Word format. All authors should be shown but the authors should not be identified anywhere in the article.
2. A *minimum length* of 3 500 words and a *maximum length* of 5 000 words (excluding references). No footnotes, endnotes and annexures are allowed.
3. On a separate page, a *title* of not more than ten words should be provided. The author's full name and title, position, institutional affiliation and e-mail address should be supplied.
4. An *abstract* of 150 words plus up to six *keywords*, which encapsulate the principal topics of the paper, must be included. The abstract should summaries the key argument/s of the article and locate the article in its theoretical practice and context. Please note that abstracts are not summaries of research studies. No sub-headings should be used in the abstract.
5. *Headings* must be short, clear and not numbered. Headings should be formatted in capitals and bold, and subheadings in bold only (not underlined or italics). Refer to a copy of the journal.

6. Figures and tables:

- All figures (diagrams and line drawings) should be copied and pasted or saved and imported from the origination software into a blank Microsoft Word document and submitted electronically. Figures should be of clear quality, black and white, and numbered consecutively with arabic numerals. Supply succinct and clear captions for all figures.
- In the text of the paper the preferred position of all figures should be indicated by typing on a separate line the words “Place figure (No)”.
- Tables must be numbered consecutively with arabic numerals and a brief title should be provided. In the text, typing on a separate line the words “Place Table (No)” should show the position of the table.
- The maximum width for diagrams, line drawings and tables, should not exceed 104mm for portrait and 164mm for landscape (with a maximum depth of 104mm).

7. References:

- References to other publications must be in modified Harvard style (see below) and checked for completeness, accuracy and consistency. Include all authors' names and initials and give any journal title in full.
- You should cite publications in the text: (Adams, 1997) or (Mbatha et al., 2005). At the end of the paper a reference list in alphabetical order should be supplied using the following style. Do not use indentation when formatting your references.
- If a direct quote is used in-text references should include name of author, date and page number. All other references should not include page numbers.
- Ensure that only references cited in the text are included in the final reference list at the end of the article. Please cross check that only references cited in the text are included in the final reference list and that references follow the format set out below.
- Books: Last name, Initials. (year). Title of Book Place of publication: Publisher.

Swanepoel, H. and De Beer, F. (1996). *Community Capacity Building*
Johannesburg: Thomson Publishing.

For book chapters: Last name, Initials. (year). "Chapter Title" in Editor's last name, Initials. (Ed.) *Title of Book* Place of publication: Publisher, Edition, pages.

Boult, B.E. (1998). "Adoption" in Bezuidenhout, F.J. (Ed.). *A Reader in Selected Social Issues* Pretoria: van Schaik Publishers, Second Edition, 41-52.

For journals: Last name, Initials. (year). "Title of article" *Journal Name* Volume(number):pages.

Mda, C.J. (2004). "Population ageing and survival challenges in rural Ghana" *Journal of Social Development in Africa* 19(2):90-112.

For electronic sources: If available online the full URL should be supplied at the end of the reference.

Louisiana State Board of Social Work Examiners. (1998). "Guidelines for Child Custody Evaluations", <http://www.labswe.org/child.htm> (Accessed on 23/08/2006).

Content:

- Manuscripts should contribute to knowledge development in social work, social welfare or related professions and the practice implications of the research should be spelled out. Sufficient and appropriate recent literature should be cited. Where the study is based on empirical research, the research design and methodology, results, discussion and conclusion should be addressed. All manuscripts should locate the issue within its social context and the conceptual and theoretical framework informing the study should be clearly outlined.

The journal will consider articles based on research studies but we will not publish articles which are merely a summary of a research report. The article should have a clear focus that contributes to knowledge building or informs policy and/or practice

ANNEXURE 22: JOURNAL OF FAMILY VIOLENCE

Instructions for Authors

General

Manuscripts, in American English, should be submitted to the Editor's Office via the journal's web-based online manuscript submission and peer-review system:

www.jofv.edmgr.com

Manuscript Submission

Inquiries regarding journal policy, manuscript preparation, and other such general topics can be sent to the Editor's editorial assistants:

Dr. Robert Geffner, Ph.D., ABN, ABPP
Institute on Violence, Abuse and Trauma
Alliant International University
10065 Old Grove Road
San Diego, CA 92131

Editorial Assistants: Amber K. Ulrich and Sarah Nicholson: journals@alliant.edu

The online system offers easy straightforward log-in and submission; supports a wide range of submission file formats [such as Word, WordPerfect, RTF, TXT, and LaTeX for manuscripts; TIFF, GIF, JPEG, EPS, PPT, and Postscript for figures (artwork)]; eliminates the need to submit manuscripts as hard-copy printouts, disks, and/or e-mail attachments; enables real-time tracking of manuscript status by author; and provides help should authors experience any submission difficulties.

Manuscripts should be checked for content and style before submitting (must follow latest version of the American Psychological Association Publication Manual; correct spelling, punctuation, and grammar; accuracy and consistency in the citation of figures, tables, and references; stylistic uniformity of entries in the References section; etc.), or the editorial assistants will return the manuscripts before outside

reviews. Page proofs are sent to the designated author for proofreading and checking. Typographical errors are corrected; authors' alterations are not allowed.

Publication Policies

Submission is a representation that the manuscript has not been published previously and is not currently under consideration for publication elsewhere. A statement transferring copyright from the authors (or their employers, if they hold the copyright) to Springer Science+Business Media, LLC will be required before the manuscript can be accepted for publication.

The necessary forms for this transfer can be found on the journal website and on the journal's Editorial Manager log-in page.

Such a written transfer of copyright, which previously was assumed to be implicit in the act of submitting a manuscript, is necessary under the U.S. Copyright Law in order for the publisher to carry through the dissemination of research results and reviews as widely and effectively as possible.

Manuscript Style

The entire manuscript should adhere to APA 6th edition standards including: Times New Roman 12 pt. font, 1" all around page margins, with a page header at ½" and entire manuscript should be double spaced, left aligned with .5" first line indents. Quotations, references, figure-caption list, and tables must also adhere to APA 6th edition guidelines. With quotations of 40 or more words, DO NOT use quotation marks. Set off the quotation in Block style format indented ½". Number all pages consecutively with Arabic numerals, with the title page being page 1 and include a running head on all pages. The suggested running head should be less than 40 characters (including spaces) and should comprise the article title or an abbreviated version thereof

A title page should be uploaded as the first page of the manuscript and should include only the title of the article. Do not include author's name or author's affiliation or other identifying names since the manuscripts undergo anonymous reviews. An abstract is to be provided, and should be no more than 150 words. Abstract should be flush left and left-aligned. A list of 4–8 key words is to be provided directly below

the abstract. Key words should express the precise content of the manuscript, as they are used for indexing purposes.

List references alphabetically at the end of the paper and refer to them in the text by name and year in parentheses. Where there are six or more authors, only the first author's name is given in the text, followed by et al., unless there are more than two references with the same author surname and same year. In this case, list as many others as needed (usually no more than two or three) to indicate which reference you are referring to followed by et al.

References

Journal Article - Elements Needed: Author's surname and initials of first and middle name (if given). (Year of publication). Title of article. Publication information which includes: Journal title and volume number (*italicized*), the inclusive page numbers, and the digital object identifier (DOI) if one is assigned.

Periodicals with Three to Seven Authors

Georgesén, J. C., Harris, M. J., Milich, R., & Young, J. (1999). "Just teasing...": Personality effects on perceptions and life narratives of childhood teasing. *Personality and Social Psychology Bulletin*, 25(10), 1254-1267.

Periodical with More than Seven Authors (cite first six authors, three ellipsis points, and final author. If seven authors, list all seven).

Kaukiainen, A., Bjorkqvist, K., Lagerspetz, K., Osterman, K., Salmivalli, D., Rothberg, S., ... Jones, K. (1999). The relationships between social intelligence, empathy, and three types of aggression. *Aggressive Behavior*, 25(2), 81-89.

Book - Elements needed: Book authors or editors, date of publication, book title, city and state in which publisher is located, and name of publishing company.

Elkind, D. (1978). *The child's reality: Three developmental themes*. Hoboken, NJ: Lawrence Erlbaum Associates.

Contribution to a Book – Elements needed: Author's surname and initials of first and middle name (if given), date of publication. Title of article or chapter. "In" book

author or editors “(Eds.)”, book title (“pp.” page numbers), city and state in which publisher is located, and name of publishing company.

Duckworth, J. C., & Levitt, E. E. (1994). Minnesota Multiphasic Personality Inventory-2. In D. J. Keyser & R. C. Sweetland (Eds.), *Test critiques: Vol. 10* (pp. 424- 428). Austin, TX: Pro-Ed.

Footnotes

Footnotes should be avoided. When their use is absolutely necessary, footnotes should be numbered consecutively using Arabic numerals and should be typed at the bottom of the page to which they refer. Place a line above the footnote, so that it is set off from the text. Use the appropriate superscript numeral for citation in the text.

ANNEXURE 23: AGE AND MENTAL HEALTH

Instructions to authors:

Aging & Mental Health considers all manuscripts on the strict condition that they have been submitted only to Aging & Mental Health, that they have not been published already, nor are they under consideration for publication or in press elsewhere. Authors who fail to adhere to this condition will be charged with all costs which Aging & Mental Health incurs and their papers will not be published.

Contributions to Aging & Mental Health must report original research and will be subjected to review by referees at the discretion of the Editorial Office.

Taylor & Francis make every effort to ensure the accuracy of all the information (the "Content") contained in our publications. However, Taylor & Francis, our agents, and our licensors make no representations or warranties whatsoever as to the accuracy, completeness, or suitability for any purpose of the Content. Any opinions and views expressed in this publication are the opinions and views of the authors, and are not the views of or endorsed by Taylor & Francis. The accuracy of the Content should not be relied upon and should be independently verified with primary sources of information. Taylor & Francis shall not be liable for any losses, actions, claims, proceedings, demands, costs, expenses, damages, and other liabilities whatsoever or howsoever caused arising directly or indirectly in connection with, in relation to or arising out of the use of the Content. Terms & Conditions of access and use can be found at <http://www.tandfonline.com/page/terms-and-conditions>.

Aging & Mental Health welcomes original contributions from all parts of the world on the understanding that their contents have not previously been published nor submitted elsewhere for publication. We encourage the submission of timely review articles that summarize emerging trends in an area of mental health and aging, or which address issues which have been overlooked in the field. Reviews should be conceptual and address theory and methodology as appropriate. All submissions will be sent anonymously to independent referees. It is a condition of acceptance that papers become the copyright of the publisher.

Manuscripts

Manuscripts may be in the form of: (i) regular articles not usually exceeding 5,000 words (under special circumstances, the Editors will consider articles up to 10,000 words); or (ii) short reports not exceeding 2,000 words . These word limits exclude references and tables.

All submissions should be made online at Aging & Mental Health 's ScholarOne Manuscripts site . New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre.

Authors should prepare and upload two versions of their manuscript. One should be a complete text, while in the second all document information identifying the author should be removed from files to allow them to be sent anonymously to referees. When uploading files authors will then be able to define the non-anonymous version as "File not for review". [Click here for Information regarding anonymous peer review](#)

All submissions should be in the style of the Publication Manual of the American Psychological Association (6th edition). Papers should be double spaced throughout (including the references), with margins of at least 2.5 cm (1 inch). All pages must be numbered.

The first page should include the title of the paper, first name, middle initial(s) and last name of the author(s), and for each author a short institutional address, and an abbreviated title (for running headlines within the article). At the bottom of the page give the full name and address (including telephone and fax numbers and e-mail address if possible) of the author to whom all correspondence (including proofs) should be sent. The second page should repeat the title and contain an abstract of not more than 250 words. The third page should repeat the title as a heading to the main body of the text.

Structured abstracts: The main text should be preceded by a short structured abstract, accompanied by a list of keywords. The abstract should be arranged as follows: Title of manuscript; name of journal; abstract text containing the following headings: Objectives, Method, Results, and Conclusion.

Key words: A list of 3-5 keywords should be provided. Words already used in the title should be avoided if possible

The text should normally be divided into sections with the headings Introduction, Methods, Results, and Discussion. Long articles may need subheadings within some sections to clarify their content.

Style guidelines

Description of the Journal's article style. Any consistent spelling style is acceptable. Use single quotation marks with double within if needed. If you have any questions about references or formatting your article, please contact authorqueries@tandf.co.uk (please mention the journal title in your email).

Units of measurement

All measurements must be cited in SI units.

Figures

All illustrations (including photographs, graphs and diagrams) should be referred to as Figures and their position indicated in the text (e.g. Fig. 3). Each should be submitted numbered with Figure number (Arabic numerals) and the title of the paper. The captions of all figures should be submitted on a separate page, should include keys to symbols, and should make interpretation possible without reference to the text.

- It is in the author's interest to provide the highest quality figure format possible. Please be sure that all imported scanned material is scanned at the appropriate resolution: 1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour.
- Figures must be saved separate to text. Please do not embed figures in the paper file.
- Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).

- All figures must be numbered in the order in which they appear in the paper (e.g. Figure 1, Figure 2). In multi-part figures, each part should be labelled (e.g. Figure 1(a), Figure 1(b)).
- Figure captions must be saved separately, as part of the file containing the complete text of the paper, and numbered correspondingly.
- The filename for a graphic should be descriptive of the graphic, e.g. Figure1, Figure2a.

Figures should ideally be professionally drawn and designed with the format of the journal (A4 portrait, 297 x 210 mm) in mind and should be capable of reduction.

Colour Charges

Colour figures will be reproduced in colour in the online edition of the journal free of charge. If it is necessary for the figures to be reproduced in colour in the print version, a charge will apply. Charges for colour pages in print are £250 per figure (\$395 US Dollars; \$385 Australian Dollars; 315 Euros). For more than 4 colour figures, figures 5 and above will be charged at £50 per figure (\$80 US Dollars; \$75 Australian Dollars; 63 Euros).

Tables

Tables should be submitted on separate pages, numbered in Arabic numerals, and their position indicated in the text (e.g. Table 1). Each table should have a short, self-explanatory title. Vertical rules should not be used to separate columns. Units should appear in parentheses in the column heading but not in the body of the table. Any explanatory notes should be given as a footnote at the bottom of the table.

Reproduction of copyright material

As an author, you are required to secure permission to reproduce any proprietary text, illustration, table, or other material, including data, audio, video, film stills, and screenshots, and any supplementary material you propose to submit. This applies to direct reproduction as well as “derivative reproduction” (where you have created a new figure or table which derives substantially from a copyrighted source). The reproduction of short extracts of text, excluding poetry and song lyrics, for the

purposes of criticism may be possible without formal permission on the basis that the quotation is reproduced accurately and full attribution is given. For further information and FAQs, please see

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ANNEXURE 24: LETTER FROM THE LANGUAGE EDITOR

From: Trpickering [trpickering@iway.na]
Sent: Friday, November 08, 2013 9:40 AM
To: Ananias, Janeta
Subject: letter re:editing of thesis

Hi Janetta

Please find as requested the letter concerning the editing of the thesis

TO WHOM IT MAY CONCERN

I, Theresa Rachel Pickering, hereby certify that I did the language editing and proof reading of the thesis entitled “An evaluation of social work support groups with informal caregivers to prevent elder abuse and neglect: A Namibian perspective”, submitted to me by Janetta Ananias.

T R PICKERING

Dated this Friday November 8, 2013, at Windhoek, NAMIBIA

SECTION E:

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