



# BC PAGES

Newsletter of the B.C. Psychogeriatric Association



## President's Report

*A critical discussion is currently underway regarding amendments to Adult Guardianship Legislation in BC. Therefore, in lieu of a President's report, we are publishing the letter submitted by the BCPGA Board to the Attorney-General's Office, December 5, 2006.*

### Some Thoughts on Proposed Adult Guardianship Amendments

On behalf of the Provincial Board of BC Psychogeriatric Association, I am writing to let you know of our general support for the contents of Bill 32, the *Adult Guardianship and Personal Planning Statutes Amendment Act*, which was introduced in the legislature by the Attorney-General on April 27, 2006 and subsequently withdrawn.

As a province-wide multi-disciplinary organization of professionals working in the field of psychogeriatrics, we see clearly the need for further modernization of current adult guardianship legislation - legislation that came about through an unparalleled multi-year community-based effort culminating in the enactment of the legislation (in part) in February 2000. We believe that this community-inspired initiative, ultimately developed in cooperation with government and policy-makers, is a model in social policy development that should be embraced and utilized in any future iterations of the adult guardianship statutes.

Although we offer our support for most of the changes being proposed, there are three main concerns that we'd like to address:

**1. Resources for implementation:** Despite being supportive of the legislation itself, one thing is abundantly clear to those of us who work in this area and that is the significant lack of resources that accompanied proclamation and implementation of the legislation between 2000 and 2006. The very minimal opportunities available to management and particularly front-line staff to learn about such things as Adult Protection Services and Representation Agreements has been disappointing. As a result, the positive work that led up to enactment of the new legislation was considerably weakened due to the lack of time and resources allocated for training, education and implementation strategies both for staff and for community members. We are hopeful that this time around the significant need for implementation resources will be acknowledged and provided. The greatest legislation in the world can have minimal impact if implementation is not properly resourced.

**2. Advanced Directives:** We were surprised to see the introduction of advanced directive legislation as part of the Bill 32 amendment package, particularly given the years-long discussion that had resulted in the Representation Agreement being adopted as a modern means of ensuring meaningful and effective future care planning. We understand that Representation Agreements are not currently as widely used as many of us

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had expected following the enactment of the Representation Agreement Act in 2000. However, as mentioned in point one above, a key difficulty has been the lack of resources to inform not only professionals but also the general public about the existence of Representation Agreements, how to go about creating one, using one, etc. There has been a profound lack of access to information to date, with most of the assistance coming from the Representation Agreement Resource Centre (RARC) – a non governmental organization with broad community support, but very limited resources.

In responding specifically to the current consultation on Advance Directive Legislation, we share the broad concerns outlined by the Representation Agreement Resource Centre in their document *Charting the Course Ahead: Proposal to Enable British Columbians to Engage in Meaningful and Effective Planning for Future Care*. The status quo will not suffice. If there is to be a true choice for the citizens of British Columbia with regard to future care planning, there must be uncomplicated and cost effective access to information that will allow all citizens to more easily utilize the Representation Agreement Act. We believe that having a genuine choice about future care planning requires legislative and budgetary commitments on the part of government that would:

- ensure adequate resources are invested so that both professionals and ordinary citizens will be able to easily learn about , create and utilize a Representation Agreement;

- ensure an ongoing partnership between community and government to provide leadership to the implementation and monitoring of the legislative and policy framework for personal planning.

**3. Admission to Care Facility:** One final concern is that the legislation, once again, does not seem to address the question of admission to care facility, a concern of many of our members. We would like to see this issue tackled within the current amendment process, if at all possible.

With the above aspects addressed, the BC Psychogeriatric Association would support the amendments as originally outlined in Bill 32. If you would like to speak with us further about our views, please don't hesitate to get in touch with me.

Sincerely,  
Dawn Hemingway, MSc, MSW, RSW  
President, BC Psychogeriatric Association

**Mark Your Calendars!**

The BCPGA Annual Conference will be held in beautiful, downtown Victoria, Thursday evening, May 10 to Saturday, May 12, 2007. The conference will wrap up at mid-day on Saturday, so that there will still be a day and a half to celebrate Mothers' Day! Why not do so in Victoria?

The location will be the Harbour Towers Hotel, one block from the Inner Harbour and a five-minute walk from The Empress. We have been offered a special conference rate for guest rooms at the hotel. Details will be forthcoming in the New Year.

The theme for BCPGA 2007 is "Charting the Future." Our three sub-themes are: 1) Housing and Living Environments, 2) Labour and Training Issues, and 3) Treatments and Technologies.

We have an impressive array of plenary speakers who will inform and inspire us, and we have already confirmed several presenters who will report on new practices and new research results.

**If you would like to give an oral or poster presentation on one of the three themes, please send your ideas to Penny MacCourt at: [pmaccourt@shaw.ca](mailto:pmaccourt@shaw.ca).**

**Mark your calendars now!** There will be a special Early Bird rate for those who register early!

The British Columbia Psychogeriatric Association (BCPGA) is a professional, multi-disciplinary, non-profit interest group.

**BCPGA**  
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## ADVOCACY AT WORK

### Advocacy Committee Pursuing Two Issues

From previous meetings of the Advocacy Committee, two issues have been identified.

**Issue 1:** The section of the Health Care (Consent) and Care Facility (Admission) Act concerning admission to facility has not been included in the proposed review of the legislation. Given this fact, it is difficult to arrange for admission of adults, usually seniors with a dementia, to a long term care facility. Very few have appointed a legal representative to act on their behalf. The only options to health professionals in attempting to keep from harm those who are living on their own in community beyond their mental capacities are the Patient's Property Act and the Mental Health Act. The Patient's Property Act is a lengthy and expensive process as it requires an application to the Supreme Court of BC. The Mental Health Act removes the patient's rights and requires an acute care bed, a very expensive use of a limited resource.

**The BCPGA Advocacy Committee will try to have a meeting with the Minister(s) responsible to request that this section of the Act be considered in the next legislative sitting.**

**Issue 2:** There is a severe lack of suitable housing for the elderly who have mental health or addiction problems (other than a dementia).

Background: For the elderly with dementia, there are a number of services available. For many years, this has been the focus of care for the elderly. However, for the elderly or aging population of people with chronic mental health or addiction problems or for those with a late onset of psychiatric illness, options for any housing and support services are limited. Licensing regulations for supportive housing or group homes for elderly are designed for those with a dementia. No allowance is made for those who are physically capable of performing basic activities of daily living, including taking their medication, but do not do these tasks because of their mental health or addiction problems. Home support and other services are targeted to "nice middle class" people. Those who seem disturbed, too messy, do not respond in a socially acceptable manner, are seen as unsafe to be around, or have too many dogs, cats or smoke do not get service. This is an increasing population. Many have lived in group homes or other mental health services but are now considered too old or physically unable to continue in those locations, but yet this group in no way meets the criteria for a long term care bed.

**As above, the BCPGA will request that there be consideration to the option of having the group home concept with a live in 'carer' similar to that provided for the younger population with similar issues. Further, BCPGA would suggest a feasibility study and a pilot project be established in 2 different regions. BCPGA would be available to be involved in that process and participate in any committee struck. A number of our members have extensive research experience.**

Bev Wilden, Co-Chair [wildens@shaw.ca](mailto:wildens@shaw.ca)

## LINKS & IFADS

### Report of Premier's Council on Aging and Seniors' Issues Released

The Premier's Council on Aging and Senior's Issues was established following the Throne Speech in 2005. Council members, with Dr. Patricia Baird as Chair, were announced in October 2005. The Council was asked to examine two key issues: How to support seniors' ability to continue as contributing members of society, and how to support seniors' independence and health. The Council submitted its report—Aging Well in British Columbia—to government December 1, 2006. The full report is available from: [www.cserv.gov.bc.ca/seniors/council](http://www.cserv.gov.bc.ca/seniors/council)

The Report contains 16 recommendations for action to support older people's participation and quality of living. These recommendations include:

- increasing the number of seniors in the workplace through initiatives such as eliminating mandatory retirement;
- developing new home-support initiatives that allow people to continue living in their own homes;
- promoting greater individual retirement savings through pooled pension plans and matching RRSP contributions;
- ensuring the quality of medical services responds to the changing needs of older patients, with greater focus on the management of chronic illnesses;
- working with local governments to support the creation of accessible and inclusive neighbourhoods;
- developing initiatives to support more volunteerism among older people; and
- working with Aboriginal and other ethnocultural organizations to ensure services are delivered in ways that meet the needs of older people in those communities.

To make these recommendations happen, the Council recommended that "the Premier appoint a Minister of State Responsible for Aging and the formation of a secretariat with broad responsibility for programs, services and issues affecting older British Columbians. The secretariat should not be attached to the Ministry of Health [as was the case when this government first came to power] but should be attached to some other ministry...It should have significant ongoing funding and staff resources, and should manage programs and coordinate initiatives across government, while also working directly with people in communities to help them harness the energy and ideas that already exist." The secretariat would also "monitor and report annually on the progress made in supporting the independence, health and continuing contribution of older British Columbians."

The Report concludes by emphasizing that "dramatic demographic and social changes are underway" and that "Adapting successfully to a different age composition of our population will mean changes in our workplaces, our neighbourhoods, and our social care systems. More importantly, it will mean changes to our social norms and attitudes so we look at aging differently."

# Hallmarks of Abuse: A Framework to Identify Abusers of Older Adults

By: Giuseppe Scaletta, BA, MSW

## Introduction:

Most of the literature on elder abuse and neglect describe the symptoms or indicators of abuse as they are seen in the victim of the abuse. These include symptoms/indicators of financial abuse, physical abuse or neglect, behavioural indicators of abuse and neglect. As well, some of the literature describes indicators of abusive behaviour in the caregiver. This paper presents six “hallmarks of abuse”, seen in the behaviour of the abuser, that are ubiquitous in situations of abuse. This is so much the case that, whenever these hallmarks are present, the author would argue that an abusive situation exists. The Stockholm Syndrome, undue influence and siege mentality are presented as they relate to situations of abuse of the older adult. Finally cognitive dissonance is presented as an indicator of abuse that is experienced by health care workers and others trying to help victims of abuse. Case studies are presented to illustrate how the hallmarks of abuse are used by abusers of older adults.

## Legislation:

In Canada, all of the Atlantic provinces and British Columbia have enacted “comprehensive” adult protection legislation. In February 2000 the British Columbia government proclaimed Part 3 of the Adult Guardianship Act (AGA), which outlines the abuse, neglect and self-neglect provisions of the Act. Under this part of the AGA, Health Authorities around the province became “Designated Agencies” vested with authorities and responsibilities under the Act. The responsibilities included a mandate to respond to reports of abuse, neglect or self-neglect of a vulnerable adult. The authorities given to designated agency staff under the AGA include access to health and financial information, authority to enter premises without a court order or warrant [Section 59 (2) (a)] if necessary to protect the adult from harm and the authority [Section 59 (2) (b)] to “remove the adult from the premises and convey him or her to a safe place”. The AGA also allows the designated agency to apply to the court for court orders to protect the vulnerable adults including Support and Assistance orders to impose a court ordered care plan and Restraining Orders to keep an abuser away from a vulnerable adult.

## Hallmarks of Abuse:

Common in cases of abuse are the following hallmarks:

- Control of finances
- Control of access
- Isolation
- Alienation of previous support system
- Ingratiation to the victim of the abuse
- Threats and intimidation of those trying to help

## Definition of Abuse:

The British Columbia Adult Guardianship Act (AGA) defines abuse as: “the deliberate mistreatment of an adult that causes the adult (a) physical, mental or emotional harm, or (b) damage to or loss of assets, and includes intimidation, humiliation, physical

assault, sexual assault, overmedication, withholding needed medication, censoring mail, invasion or denial of privacy or denial of access to visitors;

A person who abuses older adults never admits to the abuse. When confronted with the abuse the abuser typically denies the abuse, diverts the conversation to a safe subject, blames others and generally uses obfuscation to cloud the issue of abuse.

## Consistency with abuse definition in the Adult Guardianship Act:

Each indicator in the Hallmarks of Abuse framework is consistent with the definition of abuse in the Adult Guardianship Act as explained below.

**Control of Finances:** Control of finances in elder abuse typically takes the form of being appointed Power of Attorney, getting access to bank accounts and results in the movement and use of the senior’s finances for the benefit of the abuser. This is clearly described in the AGA definition as “damage to or loss of assets”. Further to this, controlling finances creates a dependency by the senior on the person who has gained control of bank accounts, property etc. This dependency typically radiates out to all aspects of the victims life and grows to include the other hallmarks of abuse.

**Ingratiation to the Victim of the Abuse:** Underlying all these hallmarks of abuse is ingratiation to the victim of the abuse. This may take several forms including: “Can I stay at your house for a few days while I get established in this town”, “I will help you with gardening, cleaning, shopping, banking, walking the dog if I can stay with you for a few days”. The message changes to “I am the only person who really cares about you” and progresses to the point where others in the victim’s life are shut out. The purpose of ingratiation is to gain a foothold, a position of trust, with the victim of the abuse and to begin to exclude others in his/her life. This rapidly progresses to the point that the abuser is the only person who is trusted by the victim of the abuse. Ingratiation fits within the AGA definition of abuse in that it often results in financial loss to the victim and emotional distress at being told that her/his family and/or friends do not care for him/her. This is an integral part of the web of abuse that is woven using the methods described here as hallmarks.

**Isolation:** Isolation of the senior from previous supports is also seen early in the spiral of abuse of older adults. By isolating the older adult the abuser creates a dependency on the part of the older adult, for any contact including contact with the medical system, banking, relatives and friends. Isolation is also accomplished by restricting use of the phone, intercepting mail, telling the victim that family members, who may have been trying to contact the victim but denied access, do not care; otherwise they would have visited or phoned. This hallmark fits well with control of access. The more isolated the victim of the abuse becomes, the more dependent the victim becomes on the abuser for necessary contact covering all aspects of life – medical, financial, social, spiritual etcetera. Isolation meets the definition of abuse in the Adult Guardianship Act in that it is achieved by censoring mail, denial of privacy, denial of access to family, friends and visitors and further on through lies and intimidation.

**Control of Access:** An abuser of older adults very quickly moves to control access to the older adult. The goal of controlling access is to have all access to the older adult streamed through the abuser. Telephone access may be limited, mail may be intercepted and

access to the older adult by family or friends may be monitored or terminated. Control of access therefore meets the criteria set out for abuse in the definitions of abuse in the AGA namely “mental or emotional harm” and “censoring mail, invasion or denial of privacy or denial of access to visitors.”

**Alienation of Previous Support System:** Alienation of previous supports happens in the background while the abuser puts in place the other controls on the victim’s life. The victim of the abuse is coached into false perceptions of people trying to help them. Comments like “Your family is only interested in getting their inheritance from you as quickly as possible”, “They don’t care about you, they are just selfish and want to put you into a facility”, “I am the only person who really cares about you” and “The doctor is trying to drug you so that he/she doesn’t have to visit you, those medications are not the right ones for you” are common in the process of alienating previous supports. Alienation meets the AGA criteria for abuse in several ways including denial of access, tampering with medications, and physical, mental or emotional harm.

**Threats and Intimidation of Those Trying to Help:** If the people in a person’s life continue to try to be involved with him/her, the abuser will gradually move to using threats and intimidation to scare people away. Threats and intimidation take many forms and include threats to call the police, intimidating behaviour towards family, friends and health care workers, threatening gestures (in one case an alleged abuser made the gestures of loading a firearm and pointing it at this writer), threats of physical violence, yelling, swearing, threats to sue people trying to intervene, video recording or taping all interactions and many more. The threats and intimidation are as varied as the abusers and victims of abuse. Intimidation may also take the form of humiliating or belittling the victim of the abuse. A pattern or cycle of abuse similar to spousal abuse is often established that includes tension building, violent episode or abusive outburst that may be physical, sexual, verbal abuse or a combination of these and remorse on the part of the abuser and a honeymoon period afterwards. Threats and intimidation are clearly included in the AGA definition of abuse.

**Obfuscation:** To obfuscate is to “make obscure or to confuse” or to “make dim or indistinct: becloud, bedim, befog, blear, blur...” When an abuser is confronted with his/her abusive behaviour the typical response is to deny any abuse has taken place, redirect the conversation, threaten the person confronting the abuser and generally obscure the issue. The response from the abuser might be something like “I didn’t take the money (sometimes in the tens or hundreds of thousands of dollars), it was given to me as a gift, to pay for my car cause I drive him/her to appointments, for food as I am doing the shopping”. The abuser also often gives the indication that he/she is only being altruistic in helping the victim of abuse and is not in the situation to gain any personal reward. This assertion is often made at the same time as the abuser is being made beneficiary and executor, Power of Attorney and health care decision maker. In some cases the abuser has a history of marrying old, well to do, and very frail, men or women and becoming beneficiaries in the process. When confronted with this behaviour the art of obfuscation seems to be at its best with protestations of undying love and assertions that the abuser is not interested in the estate but that the marriage is purely based in love.

## Case Studies:

The following case studies illustrate how the hallmarks of abuse are put into action by abusers of older adults.

### Case Study 1: Emily

Emily is an 85 year old woman who has dementia and several other medical problems that make her physically frail and in need of daily care and monitoring. She uses a wheelchair and can sometimes transfer but has also fallen in attempting to transfer. She receives the maximum hours of home support plus visits from home nursing care and a nutritionist from the public health care system. Home supports are three times per day. Dennis, an unrelated young man who calls Emily his grandmother, lives upstairs with his family and claims to be the main care provider. He is responsible for Emily’s nighttime preparations, including getting her ready for bed. Emily lives in the basement suite of a house that is not suited to her needs. She would not easily be able to be moved out in the event of an emergency, as the only access is a narrow stairway down to the suite. Emily pays Dennis rent that is higher than the market rate for the area. Emily has known Dennis and his mother for the past 20 years and at one time provided childcare for Dennis. (*Ingratiation to victim of abuse in this situation was a slow process*) The home care workers complain that Dennis is argumentative, (*threats and intimidation to those trying to help*) leaves accusatory notes in Emily’s suite telling the home care workers that they are using too much coffee, care products and spending too much on Emily. Dennis does not provide adequate food or incontinence supplies for Emily and the food is sometimes not adequate for her dietary needs and causes her to choke. The care workers often bring in their own cleaning supplies and extra food suited to Emily’s needs. After her husband died, 10 years ago, Emily granted Dennis’ mother Power of Attorney (*control of finances*) and shortly afterwards the home that Emily owned was sold. Emily and Dennis’ mother bought a home in joint title and this was subsequently sold and Emily did not receive any proceeds from the sale. The health assessments on Emily indicate that she requires 24-hour care in a facility. On several occasions Emily has been found on the floor, having fallen in attempting a transfer, and on two occasions, Dennis neglected Emily’s nighttime preparations and she was left in the wheelchair all night. Emily is adamant that she wants to stay where she is and refuses care in a facility. Dennis continues to be antagonistic to care workers. Several workers from the care agency have refused to return to the home. Emily’s siblings and their children have given up trying to assist her (*alienation of previous support system*) as Dennis and his mother have controlled access to Emily for many years. (*Control of access*) Whenever confronted with their behaviour Dennis and his mother argue that they are the only people who care about Emily and that her family never visits. (*Obfuscation*) However, when anyone tried to visit they would intercept phone calls and effectively terminated any contact with family and friends. (*Isolation*)

### Case Study 2: George

George is an 85 year old widowed, childless man with moderate dementia and physical frailty. He lives in a home

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that he has owned for many years. His only relative is a nephew who lives in another province. George's nephew reports that his uncle was married for 53 years and was very devoted to his wife. George has many friends in the small community where he lives and they watch out for him. Recently a young woman has been seen entering and leaving his home. A referral has been made to the health authority as friends are concerned that they have not seen George for several days and a young woman answers the phone when they try to contact him that way. On investigation health authority staff determines that Louise, a woman in her mid-thirties approached George at a senior's fair and asked him if she could move in with him for a few days while she got established in town. (*new best friend*)

Within two weeks Louise had moved into the master bedroom in the house, had taken George to a notary and now holds Power of Attorney (*control of finances*) and is also executor and beneficiary in a newly drawn up will. When friends try to visit or phone Louise makes excuses and if they persist becomes verbally abusive towards them. (*alienation of previous support system, control of access*) When health authority workers try to assess George, Louise accuses them of abuse and threatens to have them removed by the police as George is upset by their presence. (*threats and intimidation of those trying to help*)

Louise tells George that she is the only person who cares for him and that the neighbours and his nephew just want his money. She also tells George that the health authorities and his nephew want to place him in an institution. George's nephew reports that George told him that Louise comes into his room at night and has sex with him. (*ingratiation to the victim of abuse*) Neighbours and George's nephew report that they have tried to visit and phone him when Louise is not at the home but he never answers the door or the phone. It is later determined that Louise hides the phone when she is not at the house. (*Isolation and control of access*)

When health authority staff have been able to see George he refers to Louise as the "Empress Louise" as he says that is what she tells him to call her. Louise has reportedly taken some rings and jewelry belonging to George's wife and sold them at a pawnshop. When asked about this George whispers that he doesn't want "The Empress" to know that he talked about it and makes excuses as to why she might have to take the jewelry. George tells health staff that he wants them to go away and does not want to see his neighbours.

Why, if the victim of the abuse is so adversely affected by the abuse, is the abuse allowed to continue? In many circumstances the victim of abuse will strongly defend the abuser, even when maintaining the relationship with the abuser has resulted in the alienation of family and all previous supports. The answer to these questions, in the opinion of this writer is in the Stockholm Syndrome or abuse syndrome.

### **The Stockholm Syndrome:**

The Stockholm Syndrome was named after a botched bank robbery in Stockholm Sweden in August of 1973. Four hostages were taken and held in the bank vault for six days. The hostages were mistreated including having wire snares placed around their necks so that they would be strangled if the authorities used gas to end the hostage taking by putting everyone in the bank to sleep. A picture of the hostages taken from the apartment above the bank

vault through a hole drilled through the floor (ceiling of the vault) shows the hostages with the snares around their necks. After the authorities brought the incident to an end by, in fact, using gas the hostages were critical of the authorities and defended the bank robbers and one even established a defence fund for them. The authorities were at a loss to explain why the hostages seemed to be protective of the bank robbers and even spoke highly of them afterwards. Thus the beginning of the use of the term Stockholm Syndrome.

### **Applying the Stockholm Syndrome to the abuse of older adults:**

Although, the term started being used in 1973, the broader "abuse syndrome" that has been described in the literature pertaining to all forms of abuse, spousal abuse, child abuse, elder abuse has likely been around since the beginning of time – since the first abusive interaction. Dee Graham, in her book, "Loving to Survive", on abusive relationships towards women, states that four precursors are necessary for the development of the Stockholm Syndrome.

- Victim perceives the abuser as a threat to her survival, physically or psychologically.
- Victim perceives the abuser is showing her some kindness, however small.
- Victim is kept isolated from others.
- Victim does not perceive a way to escape from the abuser.

Are the above conditions present in situations of abuse of older adults? There is a strong argument that these conditions do exist in abuse of older adults.

### **Condition (1) Victim perceives the abuser as a threat to her survival, physically or psychologically.**

The first condition in the development of the abuse syndrome for the older adult develops in a more insidious manner than the traumatic "threat to survival" described above. The abuser often presents needing the older adult's help in some way be it a loan or a place to stay for a period of time "just until I get established in this new town". The approach seems the opposite of the threatening approach but the end result is the same – namely the victim becomes dependent on the abuser and alternately has threats and small kindnesses directed towards him/her. Typically the loan does not get repaid and the older adult is often asked for more money to enable the abuser to make the money needed to pay back the entire amount.

### **Condition (2) Victim perceives the abuser as showing her some kindness, however small.**

This condition is consistent in situations of abuse of older adults. The small kindnesses shown are often achieved using the older adult's money. "He takes me out to concerts and to my doctor's appointments. No one else does that." The fact that the older adult is paying for everything, may have purchased the car or paid for the insurance is either hidden from the older adult or rationalized away. Also friends or family trying to help are accused of self-interest, "they just want your money", or are threatened to the point that they give up on trying to intervene to protect the older adult.

### **Condition (3) Victim is kept isolated from others.**

One of the strongest methods an abuser uses to gain control of the older adult's life is isolation. Isolation creates a condition that

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## Research News

## Research Committee Report

The focus of the Research Committee is to provide support to our national project, to promote and support research that is pertinent to the psychogeriatric population and to our membership.

The Research Committee provides support to the BCPGA nationally funded project, Best Practices in Seniors Mental Health Program and Policy Design. This project will be piloting the implementation of the Seniors Mental Health Policy Lens (SMHPL) across Canada at 15 sites, refining it for specific sectors based on what we learn, and then disseminating the Lens widely. The educational pilot sites are being selected: currently a Social Work and Nursing program in BC and a Social Work program in Quebec have been identified. Efforts are underway to recruit a medical program site. At their request the SMHPL has been provided to two Ontario Ministries for potential use to screen all policies affecting seniors. Initial discussions are positive, and have led to recruitment of an Ontario Task Force on Elder abuse as a pilot which will examine violence against women projects from a seniors' mental health perspective. The Advocacy Centre for Elders (ACE) in Ontario is considering the Lens as an analytical tool for their work in developing policy/position papers. An Adult Day Program and a tertiary care level psychiatric institution in Manitoba and, a new community psychogeriatric outreach program in Nova Scotia have volunteered as pilot sites. A long term care facility in BC has also volunteered. Discussions are underway with provincial mental health services in Newfoundland that is considering the Lens as a framework for planning elderly mental health services. Meetings with government and seniors organizations in Manitoba may lead to opportunities related to the Manitoba Emergency Preparedness Plan.

The Research Committee is supporting research that is pertinent to our field in a number of ways. One way is through sponsorship of a regular column for our newsletter. We will also be reviewing abstracts for the 2007 conference and will sponsor one session.

The Research Committee has agreed to review requests received from other organizations or individuals for letters of support for research applications to granting agencies. On this basis the BCPGA President has written letters of support for 2 studies: *Understanding the Needs of Caregivers of Mentally Ill Older Adults in BC: Hearing Their Voices To Inform Services*, (proposed by our members Tuokko, Wilden and Miliken) and a national proposal, submitted by Liebing et al., *Identifying Issues, Challenges, and Concerns for Community Frontline Practitioners Working with Older Adults with Severe Mental Illness*. The Tuokko et al proposal has been successfully funded, and as its title implies, will provide information that is highly pertinent to our practice.

The Research Committee also supports the involvement of BCPGA on Advisory Groups for pertinent funded projects. Linda Myers and Penny MacCourt each have different roles on the nationally funded VON project *Best Practices in Supporting Culturally Appropriate Mental Health Services for Seniors*.

Penny MacCourt  
Chair, Research Committee  
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## Membership News

## 2006 Membership Report

As we mentioned in the August BC Pages, we are now able to produce statistical reports on the BCPGA membership. These will be available at each AGM. Our ability to produce reliable reports depends on each member providing the information annually. Our new **BCPGA Membership Application Form** will capture the information we need and will be sent to each member in the Spring.

In this newsletter, we are including a sample of the type of information we can get from the database. Watch for more reports in the next BC Pages!

We currently have 97 members in good standing (including 27 new members and 70 members renewing from last year). As expected, membership in the Interior Health Region increased this year, as a result of the Annual Conference being held there.

### Members by Geographical Region

Region	Number	Percent
Northern	7	7%
Interior	30	31%
Vancouver Island	31	32%
Vancouver Coastal	18	19%
Fraser	10	10%
Out of Province	1	1%
<b>TOTALS</b>	<b>97</b>	<b>100%</b>

We have employment information for 89 members (others are students or retired from the field). The following table shows the breakdown by Professional Discipline.

### Employed Members by Professional Discipline

Profession	Number	Percent
General Practitioner	5	6%
Psychiatrist	10	11%
Psychologist	7	8%
Occupational Therapist	5	6%
Nurse	42	47%
Social Worker	18	20%
Paraprofessional	0	0%
Other	2	2%
<b>TOTALS</b>	<b>89</b>	<b>100%</b>

### Change in Membership Year:

The BCPGA Board recently approved a change to our membership year end. Our 2006-07 memberships will still be valid until May 31, 2007. **The 2007-08 membership year will be from April 1, 2007 to March 31, 2008.** This will have two benefits. It will simplify accounting at the time of the Annual Conference, usually held in May. Additionally, the new membership year will coincide with the budget year of most of our members' organizations.

Maia Kennedy  
Membership Chair and Treasurer

*Cont'd from p.6*

makes the older adult dependent on the abuser for most necessary activities of life. The relationship with the abuser then becomes more important than the relationship with friends and family.

**Condition (4) Victim does not perceive a way to escape from the abuser.**

The older adult victim of abuse often does not contemplate escaping from the abuser. The abuser has usurped the relationships with friends and family to the point where he/she is the primary relationship with the older adult. This creates a dependency on the abuser for most normal activities of living.

**Indicators that the Stockholm Syndrome has developed:**

- (1) Victim has feelings of love and hate for the abuser.
- (2) Victim is very grateful for any kindness shown by the abuser.
- (3) Victim denies or rationalizes violence by the abuser.
- (4) Victim focuses on the abuser's needs.
- (5) Victim sees world from abuser's perspective.
- (6) Victim perceives those trying to help her as the "bad guys" and the abuser is the "good guy".
- (7) Victim finds it difficult to leave the abuser even when it is okay to do so.
- (8) Victim fears the abuser will come back to get her, even if he is dead or in prison.
- (9) Victim shows signs of PTSD (Post Traumatic Stress Disorder) including depression, low self-esteem, anxiety reactions, paranoia and feelings of helplessness, and recurring nightmares and flashbacks

Many family and friends have expressed feelings of incomprehension, anger and frustration at being shut out of their loved one's life and that their loved one seems to be defending the abuser. How can he/she allow this person who is obviously abusive to become such a large part of his/her life sometimes to the exclusion of everyone else? The answer may be in the development of the Stockholm Syndrome. Are the indicators that the Stockholm Syndrome has developed seen in victims of abuse of older adults?

Indicators 1 through 7 are clearly present in situations of abuse of older adults seen in many cases where this writer has used the authorities of the AGA. Indicator 8 and 9 are present but in a modified form.

**Undue Influence:**

Mary Joy Quinn describes undue influence as the "substitution of one person's will for the desires of another". The hallmarks of abuse described above are all part of the process of establishing an environment in which undue influence is used to mould the victims thinking and behaviour so that the abuser's wishes become a priority in the victim's life. Quinn says that the best way to combat undue influence is to bring in "an agency or person who is willing to assume control over the situation."

Even with legislation like the Adult Guardianship Act in place it has been difficult to do this when the abuser is persistent in retaining the position that he/she has gained in the older adult's life. Hall, Hall and Chapman note that "In cases where contested financial decisions are brought before a jury, one must decide what standards should be used to show coercion or exploitation. The most commonly used standards involve reduced mental capacity, exploitation of increased need, or induction by fear to force older persons to inappropriately divest themselves of cash, property, or other valuable assets."

Family members and friends are often intimidated to the point where they are unwilling to take control of the situation or relinquish what control they may already hold. The best way to

deal with undue influence may be to avoid it by taking preventive steps.

**Siege Mentality:**

Another method used by an abuser of older adults is to create a situation where the victim of the abuse feels he/she is under siege from family, health authorities, friends and neighbours. This is brought in once the hallmarks of abuse have been used to isolate the victim. Family and friends are described as being self interested and only concerned about money and/or inheritance. Health care workers and family doctors are described as being incompetent and only wanting to institutionalize the older adult. A siege environment of the abuser and the victim against the authorities is created. Family, friends, neighbours and health workers are spoken of in a derogatory way and as not caring about the older adult.

**Cognitive Dissonance:**

on to the presence of the hallmarks of abuse in the behaviour of the abuser and conditions and indicators of the Stockholm Syndrome in the victim of abuse an added indicator of abuse is also present in the health care worker who is involved in trying to provide care for the older adult. This indicator is at first a sense that something is wrong. It starts as a gut feeling and it is only after some involvement with the situation that the worker consciously realizes that something in the situation is not as it seems to be. The indicator in the health care worker is cognitive dissonance. Leon Festinger first described cognitive dissonance in 1957. Typically the worker is told one thing and the actions point in the opposite direction resulting in the "gut feeling" that something is wrong with this picture.

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*This article has been edited for length. The full article can be read on [www.bcpqa.bc.ca](http://www.bcpqa.bc.ca) under Reports.*