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A Swedish study about how staff reason and act when they suspect domestic abuse perpetrated by informal caregivers of persons with dementia

En svensk studie om hur personal resonerar och agerar när de misstänker våld i nära relationer som begås av anhöriga till personer med demenssjukdom

Lena Östlund, Jonas Sandberg, Mikael Skillmark, Marie Ernsth Bravel and Linda Johansson

ABSTRACT

Older persons with dementia have several risk factors for being exposed to domestic abuse, for example dependency on others to manage daily life. The purpose of the study was to explore how staff act and reason when suspecting domestic abuse perpetrated by informal caregivers of persons with dementia. Eight semi-structured group interviews were conducted with staff (n = 39) working with persons with dementia living in their ordinary homes. A thematic analysis generated two themes; Missing a map for guidance and Being left to one’s own inner compass for direction indicating that staff experienced a lack of guidelines and protocols to work from when suspecting abuse. This resulted in staff taking actions based on their own norms, values, and experiences when suspecting domestic abuse. Not knowing how to act risks leading to staff ending up doing nothing or being unable to identify effective interventions, accompanied by feelings of guilt and ethical stress. The results highlight the necessity of providing staff with tools for how to act when they suspect domestic abuse, such as collaboration with others, colleagues, and other organisations where different options for interventions can emerge.

KEYWORDS
Elder abuse; old age care; group interviews; dilemmas; dementia

ABSTRAKT

Äldre personer med demenssjukdom har flera riskfaktorer för att utsättas för våld i nära relationer, till exempel att vara beroende av andra för att klara det dagliga livet. Syftet med studien var att undersöka hur personal agerar och resonerar vid misstanke om våld i nära relationer som begås av anhöriga till personer med demenssjukdom. Åtta semistrukturerade gruppintervjuer genomfördes med personal (n = 39) som arbetar med personer med demenssjukdom som bor i ordinärt boenden. En tematisk analys genererade två teman; karta saknas för att...
ge guidning och vara utlämnad till en inre kompass för att finna riktning, vilket tyder på att personalen upplevde en brist på rutiner och riktlinjer att utgå ifrån vid misstanke om våld i nära relation. Detta resulterade i att personalen vidtog åtgärder utifrån sina egna normer, värderingar och erfarenheter vid misstanke om våld i nära relationer. Att inte veta hur man ska agera riskerar att leda till att personalen inte gör något eller har svårigheter att hitta effektiva insatser, vilket kan leda till skuldkänslor och etisk stress. Resultatet belyser behovet av att ge personalen verktyg för hur de ska agera vid misstanke om våld i nära relationer, såsom samarbete med andra, kollegor och andra verksamheter där olika alternativ för insatser kan växa fram.

Introduction

Staff in health care and old age care have had an increasing workload, due to an increasing proportion of older people with care needs and decreasing allocation of resources. In addition to caring for older persons with complex needs, staff have been assigned more procedural tasks, such as extensive documentation of care. This places high demands on staff, who are also expected to meet each person in a person-centred and evidenced-based way (Hegney et al., 2019; Swedish Association of Local Authorities and Regions, 2022; Vryonides & Papastavrou, 2019).

One of the staffs’ tasks in care of older persons and persons with dementia is to pay attention to domestic abuse (HSLF-FS 2022:39). A commonly used definition of elder abuse is the Toronto Declaration for the Global Prevention of Elder Abuse: ‘a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person’ (WHO, 2002, p. 3). Abuse can be physical, psychological/emotional, sexual, financial, or simply reflect intentional or unintentional neglect (WHO, 2002). There is no specific definition regarding persons with dementia, but cognitive impairment and dependency on others to manage daily life are risk factors for being exposed to abuse (Kamavarapu et al., 2017; Storey, 2020; Yan & Kwok, 2011).

In Sweden, approximately 8% (n∼150,000) of the persons 65 years or older have a dementia diagnosis. Most individuals with dementia (~ 72%) live in their ordinary homes, often with a partner, while others live in nursing homes (~28%) (Odzakovic et al., 2019). For those with need of formal health and social care this is provided by the regions (n = 21) as well as the municipalities (n = 290) and regulated in the Health Care Act (SFS 2017:30) and the Social Services Act (SFS 2001:453). These laws contain overall goals and guidelines for social services, health care and dental care, but they do not micromanage the activities. Instead, the laws provide space for staff providing services to older persons to frame their reasoning and actions in the way they judge appropriate to be responsive to users’ circumstances. Consequently, the staff has discretion, a degree of circumscribed freedom, when performing their tasks (Lipsky, 2010; Molander, 2016).

A person with dementia can be assessed, treated, and receive care from for instance certified nursing assistants, registered nurses, occupational therapists, physiotherapists and physicians, and for dental care by dentists and dental hygienists. These staff can be working in health care and social services, either in municipalities, or the county regions. They meet the person to different extents but are all in a position where they have an opportunity but also a responsibility to identify and act on domestic abuse. For instance, when health care staff suspect domestic abuse, they have a responsibility to connect victims with the municipal social services, who have a special obligation in the Swedish welfare system to provide support and help in cases of domestic abuse (HSLF-FS 2022:39). As such, they are an important intermediary link in the work to support and protect victims of elder abuse.

It is difficult to determine the prevalence of domestic abuse among persons with dementia due to variations in recruitment methods and contexts of studies as well as the definition of domestic abuse.
used (Dong et al., 2014). These challenges are reflected in a literature review which found prevalence rates between virtually 0% to over 78% in various studies (Fang & Yan, 2018). Often older persons do not ask for help in case of exposure to domestic abuse (Fraga Domínguez et al., 2021), and given the nature of dementia, it can be difficult for a person with dementia to convey being exposed. Consequently, it can be challenging for staff to talk to persons with dementia about domestic abuse (Dong et al., 2014) and to gain consent to perform necessary examinations (Bows, 2018). Furthermore, perpetrators may use the victims’ cognitive limitations to cast doubt on his or her credibility and deny being abusive (Bows, 2018; Fraga Domínguez et al., 2021). Consequently, it may mean that the person with dementia does not seek help or cannot detail what they have been exposed to. Isolation can reduce the likelihood that the victim will report abuse or that others will witness the abuse (Storey, 2020).

There is a lack of screening instruments to detect abuse (Sakar et al., 2019), leaving staff to detect abuse by themselves. Also, support needs to be designed and implemented in the best interest of the person with dementia (Fang & Yan, 2018; Ludvigsson et al., 2022). For example, when a person with dementia is heavily dependent on their relatives for daily care and support (Pillemer et al., 2016), a direct intervention such as removing the abused person from the situation may not be the optimal way to intervene. Instead, support for both parties and additional help in the home can be beneficial in some cases. Collaboration over professional boundaries is essential for intervention efforts to be successful (Fraga Domínguez et al., 2021). At the same time, studies show a similarly low level of knowledge and lack of awareness of elder abuse and related legislation, among different staff in Sweden and internationally (Almogué et al., 2010; Brossoie & Roberto, 2015; Corbi et al., 2019; Touza Garma, 2017). If staff are untrained and unequipped to see what is happening, they may feel unsure whether and how they should act (Brossoie & Roberto, 2015).

To support and empower staff who work physically close to the person through examination, treatment care, and assisting activities in daily living to deal with domestic abuse in their work, one significant aspect is acknowledging their own experiences regarding these issues. Therefore, the aim of the study was to explore how staff reason and act when suspecting domestic abuse perpetrated by informal caregivers of persons with dementia.

**Methods**

**Design**

A qualitative design was used with semi-structured group interviews to capture staffs’ perspectives.

**Study settings, sample, and data collection**

A strategic selection was used, meaning that participants’ work should have a caring character in that they routinely work physically close to persons with dementia through examination, treatment care, and assisting activities in daily living. Consequently, staff working in either health care, social care or dental care were invited to participate. Knowing how to act when suspecting domestic abuse is important across occupational boundaries, thus the focus has not been on whether different professions have different views on these situations. In all groups except one, the managers first gave their informed consent to the study being conducted in their organisation. The managers were then asked to identify, inform, and ask potential participants about participation in the study. Physicians working in geriatric care in hospitals were not asked by a manager but instead asked personally by the researchers when attending specialist training to become geriatricians.

Data was collected during 2021 in Sweden. In total, the eight group interviews included 39 participants with 3–6 staff in each group (Table 1). Group interviews were chosen to obtain perceptions and experiences by means of dynamic group interactions (Currie & Kelly, 2012). The week before the interview, a translated version of the Caregiver Scenario Questionnaire (CSQ) was distributed to all
participants by e-mail (Cooper et al., 2012). The CSQ, which includes a vignette describing a difficult situation of a couple where one partner has dementia was only used to start the discussion by asking the participants about their thoughts regarding the vignette and their own experiences from similar situations. An interview guide developed by the researchers was also used including questions such as: What tools do you have for detecting and taking action when domestic abuse in persons with dementia occurs? How do you act in the encounter with abused persons with dementia and their relatives? During the interviews, follow-up questions were asked depending on the answers from the participants to get a deeper understanding of their experiences. Each interview lasted about one hour and was audio-recorded. Six of the interviews were conducted face-to-face and two digitally.

**Ethical approval**

Ethical issues were considered in accordance with the Helsinki Declaration (1964) and the Swedish Act concerning the Ethical Review of Research Involving Humans (SFS 2003:460). Participants received written and verbal information about the study’s purpose, confidentiality, the voluntary nature of participation, and the option to withdraw participation at any time without any explanation being required. All participants signed a form giving their consent to participate. The study received ethical approval from Swedish Ethical Review Authority (Reg. No. 2019-03031).

**Data analysis**

All interviews were transcribed verbatim and analysed using the six phases in reflexive thematic analysis. Thematic analysis is used to develop themes — patterns of meaning — across a dataset that addresses a research question (Braun & Clarke, 2006, 2022).

In *Phase one*, researchers read all the transcripts to familiarise themselves with the data. In this phase, the recorded interviews were listened to. Simultaneously, text focusing on how staff dealt
with their suspicions of domestic abuse perpetrated by relatives caring for persons with dementia was highlighted. In **Phase two**, initial codes from the data were produced. Coding is a way of organising the data into meaningful groups (Braun & Clarke, 2006; [www.thematicanalysis.net](http://www.thematicanalysis.net)). **Phase three** started with analysing the codes to identify how different codes could be combined to form different themes. Phase three involved sorting the different codes into potential themes to find an overarching theme (Braun & Clarke, 2006). Mind maps were used to assist in identifying relationships between codes and themes, and between different levels of the themes (Figure 1).

By going back to the codes and interview data, the suitability of the themes was checked (Phase four). It became evident that some candidate themes were not really themes while others could be combined or split. The themes were then defined and named (Phase five) (Figure 2) and finally the

![Figure 1. Potential themes identified during the third phase of the analysis.](image-url)
findings were written up (Phase six), as presented below. During this process, the first author had the main responsibility, but the analysis was continuously discussed among all authors until consensus was reached.

**Results**

The analysis generated two main themes: *Missing a map for guidance* and *Being left to one’s own inner compass for direction*. A map shows the location, while the compass indicates the direction, and together they make it possible to navigate and decide on the best possible path.

*Missing a map for guidance* focused on how staff lacked guidelines and protocols on how to act when domestic abuse is suspected. Suspecting that domestic abuse has occurred in someone’s home is complex and challenging. It creates uncertainty about how to act to maintain the integrity of the person. For this reason, there is a desire to have support from guidelines and protocols. Through collaboration with others, colleagues and other organisations, different options for intervention can emerge. *Being left to one’s own inner compass for direction* describes how staff acted despite the lack of guidelines and protocols and how they instead relied on their own norms and values when making decisions on how to act when they suspected domestic abuse. For staff working in the person’s home there is reticence about acting because the staff are trying to respect the person’s privacy and are unsure about how far they can go since they are in the person’s home.

*Missing a map for guidance*

A map gives an overview of a landscape or city. It can be used to explain that there is a visual or conceptual structure that can help us understand something abstract or complex. It can take the form of a description of its most important elements or steps, or a visual representation that shows its structure or relationships between different parts. In this study, the map illustrates the staff’s need to know what tools to use when they suspect domestic abuse. Missing a map for guidance includes the sub-themes *Wanting guidelines and protocols* and *Striving for collaboration*.
Wanting guidelines and protocols

Experiencing lack of guidelines and protocols created feelings of insecurity but also meant that staff avoided raising their suspicion of domestic abuse with the perpetrator and the victim. It was indicated that staff might become more sensitive to domestic abuse if they knew how to act when they detected it. It was also stated that the guidelines do not need to be very detailed, but it would be helpful in supporting staff to know when and how they can and should act. One of the participants talked about the difficulty of knowing how to act:

You are not looking for cookbook guidelines, but in some way, you need to know when … It’s a tough grey area to be in. All of a sudden, for example, there’s [someone asking], ‘Have you made a report of concern?’ What? We can’t make a report of concern. OK is that something we should be doing? Someone says the police, someone says … So, you’re in a little vacuum about what’s part of your professional role. And it creates in itself, or has the potential to create, ethical stress linked to one’s professional role. (Group 8)

Having guidelines and protocols to follow would enable staff to ask persons more often about abuse when they are suspicious that it is occurring and to not avoid asking due to not knowing what to do with the answer they might get. It was also argued that guidelines and protocols would create a more systematic way of working, as all staff would have the same map and a similar starting point. Standardised questions were described as one important preventive tool for screening and not just reacting when a suspicion of abuse arose. Abuse might therefore be detected more often and earlier if staff had proper tools. Seeing every person and situation as unique was expressed as being of great importance. Practising with a person-centred approach is seen as essential but difficult. This means that there is a desire to have standardised guidelines and protocols but to adapt these based on each individual’s needs.

Concerns were raised about accusing persons who were innocent. An unfair accusation about being abusive to a relative can persist for a long time, cause anxiety for all parties concerned, and create a lack of trust in the relationship between the staff member and relatives. A desire for knowledge about how to make notes in the care recipient’s record without being offensive to relatives emerged. Staff in home health care said that they did not know where they should document domestic abuse or suspicions of abuse in the care recipient’s medical record, and they found it difficult to know how to describe these situations in writing. There was also a fear that relatives would read the record and thus become angry or sad, which might damage a good relationship with the staff member.

Striving for collaboration

When a staff member suspected domestic abuse, concern was raised within their own organisation or with staff in other organisations regarding how to proceed, for example, through discussing the situation in team meetings. Certified nursing assistants in home help services for instance described how they acted by talking to needs assessors and interacted with physicians in primary health care. This can be understood as collaboratively drawing the map. Initially, when domestic abuse was suspected, colleagues were asked if they had noticed something that made them suspicious, too. For instance, they might have observed that food was withheld from persons with dementia or overheard threats. A reason for asking others was feeling uncertain about whether their own suspicion was a misinterpretation of the situation, or due to a general feeling of not getting along with a specific person. In these situations, it is comforting to listen to colleagues and see if their experience of suspecting domestic abuse matches one’s own:

So that more persons see the same, so that nothing has been interpreted [in a wrong way]. That’s the first step, I would say, that we’re discussing it. (Group 4)

Colleagues’ views can be a help in observing repeated warning signals in a relationship, and it was seen as a strength that more individuals suspected the occurrence of abuse. Colleagues can be helpful in creating a plan and drawing the map on how to proceed. When more staff raise the
issue and share a collective concern, someone must act in the end, which is one benefit of collaborating. However, one of the difficulties with collaboration between different organisations is that it can take a long time to get in touch with each other and reach a formal agreement to collaborate. Staff argued that a lot of bureaucracy can make you feel less inclined to initiate a collaboration for only one person. On the other hand, doing nothing might lead to more violence occurring for the person in question in the meantime. It was claimed that staff did not always ask for help from colleagues in other organisations because they knew that it takes too long time to develop a fruitful collaboration for example between home care and primary care. Instead, they resolved the situation within their own team. However, not collaborating could result in the person receiving less help and support.

Even when there is a mutual desire to collaborate, there are legal obstacles. For example, having a duty of confidentiality risks complicating the collaboration, as this means there is a need for consent from the victim of the abuse to discuss the situation with another organisation.

However, if staff in one organisation were to disclose information to another organisation against the person’s knowing, there is a risk that the trusting relationship between staff and the person with dementia and their relatives will be broken. On the other hand, there can be a risk to the person if different staff does not have access to important information. This might imply the person with dementia not receiving proper care. Staff mentioned occasions when they actually acted against the law and contacted staff in another organisation:

But you could say that we [health care staff] report concerns almost as often as we share information with needs assessors, we share information perhaps with dementia teams in the municipality social services. (Group 8)

**Being left to one’s own inner compass for direction**

Compass is a useful strategy for navigating in complex situations and for promoting reflection and getting different perspective taking in decision-making. A map might not always match terrain and there can be ethically difficult situations along the way that require staff to stop and decide on a new direction. For that, they may need an inner sense of which way to go. The inner sense can be interpreted as an inner compass which can be a help in unknown situations or in dealing with complex problems by navigating towards a reference system that is known. This reference system can be a set of values, principles or strategies that have been successful in the past and can be used as benchmarks to make decisions and act effectively. The theme Being left to one’s own inner compass for direction includes the sub-themes Being left to make their own judgements and Balancing the person’s privacy against the responsibility to act.

**Being left to make their own judgements**

Staff had to make their own assessments and rely on their own gut feelings regarding how to act when they suspected domestic abuse. This can be understood as staff being left to their own inner compass for decision-making on how to act. Relying on their own sense of what is happening can create feelings of insecurity. Also, being left to make one’s own judgements may mean overlooking abusive situations due to preconceived ideas. A staff member’s earlier experiences can affect what they consider to be appropriate behaviour or possible domestic abuse. For instance, if staff have their own experiences of domestic abuse, they may have a higher threshold for what they perceive as abuse. This was discussed:

And we have different things that we bring with us. So, but I could come from a subdued home where I think this is … [normal]. (Group 1)

Being left to make one’s own judgements can create a variety of feelings in the staff. When staff do not know what the right thing to do is, emotional stress, including feelings such as tiredness, sadness, powerlessness and being inadequate, can arise. To reduce this type of stress, guidelines and protocols could help:
I also think it’s very stress-reducing for healthcare-staff to have clear guidelines. Just this kind of emotional stress, if you are doing the right thing or knowing how to act. It makes persons tired and sad, and you feel powerless maybe if you don’t know how to do it the right way. (Group 5)

Staff sometimes act according to their own judgments, exceeding their authority and making decisions based on their own perceptions of appropriate measures. An example of staff utilising their personal judgment and deviating from their usual routines was when a patient should be discharged:

If you suspect such a scenario [abuse], it may be a reason to keep the patient there for a few extra days, if you suspect that it is an unhealthy environment at home or in a home or so. (Group 5)

Balancing the person’s privacy against the responsibility to act
To visit someone’s home and feel that something is not right, but not wanting to interfere, is difficult. It is a balancing act between seeing and understanding and knowing when and how to act. When it comes to having opinions and thoughts about what occurs in the home of the person with dementia and their relatives, staff members express a great deal of reticence. It is well known that it is often a difficult task for relatives to care for a loved one who has dementia. The family member may become tired and frustrated resulting in inappropriate situations and behaviours such as shouting, pinching, and hitting can arise. Consequently, staff who suspect an abusive relationship may not want to put an even greater burden on relatives by suspecting or accusing them of subjecting the person with dementia to domestic abuse. They may prefer to remain silent and not raise their concerns. For staff, it can also be emotionally difficult to accept that relatives are abusive to the person with dementia. This can result in staff just focusing on the approved care plan without exploring a suspicion that something is amiss in the relationship and that domestic abuse might be occurring within a relationship at other times.

Staff in home health care explained that this does not mean that they put blinders on, but working in someone’s home makes it more difficult to raise questions about domestic abuse since they consider themselves to be guests and therefore do not want to interfere:

There might be this feeling of ‘no, this is none of my business, this is their private life, I can’t intrude. (Group 1)

If staff are unable to witness domestic abuse first hand, this can create an obstacle for detecting abuse and acting on it. For instance, it can be difficult to ask a person with dementia a direct question about whether they have been subjected to a domestic abuse because the person may have trouble understanding the question or may not be able to express and explain what has happened to them. Dental staff stated that they sometimes felt that not everything was ok in a relationship, but that it is difficult to know reasons for bad oral health. It can be neglect, but also a result of frailty or medications. Also, they only met the patients for a short time and then focused on the mouth and oral health, and not the whole person. In the context of physical abuse, some staff in home health care discussed concerns about how far one can go in examining the body of the person when they suspect domestic abuse:

And how much one … And also … Should you look under sweaters if they have a long sleeve shirt? (Group 2)

Discussion
The aim of this study was to explore how staff reason and act if they suspect domestic abuse perpetrated by informal caregivers of persons with dementia. The results show that there is a lack of guidelines and protocols about how to act when they suspect domestic abuse, which formed the theme Missing a map for guidance. Consequently, staff needed to use their own intuition but also be guided by their own norms and values when they acted in such situations, which formed the theme Being left to one’s one own inner compass for direction.
The absence of guidelines and protocols results in staff often using their own norms and values to determine how to act when they suspect domestic abuse. Being left to one’s own inner compass for direction when making judgments and deciding on interventions opens the way for discussions about the staff’s discretion. Molander (2016) makes a distinction between discretionary space and discretionary reasoning. The first concerns those courses of action that are permissible in a particular situation, whereas the second concerns the reasoning leading up to judgments about what course of action is most appropriate. The reasoning aspect of discretion is of particular importance in human service work when rules for action, such as guidelines and protocols on how to act when suspecting elder abuse, are weak. If everything were to be regulated solely by laws and regulations, the work would be carried out mechanically and anyone could perform the tasks. Because the staff have their professional training, they are also expected to be skilled in assessing what is best in specific situations. However, according to the result of this study, staff are still missing a map to help them manoeuvre in their discretionary space to manage the uncertainty associated with acknowledging elder abuse. This is in line with previous research showing that staff may welcome rules to manage uncertainty (Rutz & De Bont, 2020).

At the same time, guidelines are only guidelines, and all practitioners must also make ethical decisions at the front line of their practice that draw on their discretionary reasoning. A literature review (Touza Garma, 2017) emphasised the importance of having clear procedures for responding to suspected abuse. However, the creation of guidelines must also allow an individualised approach in a case of suspected domestic abuse. In the current study, staff described how they used their discretion by sometimes allowing persons to stay longer in hospital; they don’t discharge them until a good plan and safe home environment is guaranteed. Still, making decisions on how to act is a challenge and according to our results, this is intensified when persons have a dementia diagnosis.

One key finding from this study was that getting help from colleagues allowed for a deeper understanding of the concerns raised. It helps staff to understand that they are not alone in their suspicions of domestic abuse and together they can find solutions to be able to provide help and support to the victim. Engaging in discretionary reasoning is thus not a solo activity. Instead, discretion is used collectively, adding knowledge and skill to manage uncertain situations (Rutz & De Bont, 2020). Yet, this can create ethical dilemmas since staff are not allowed to ask for help from another organisation whenever they want due to their duty of confidentiality. However, Preshaw et al. (2016), found that confidentiality, when it conflicted with other ethical principles, was deemed less important. This is in line with our study, where personal information sometimes was shared without asking the person for their consent. Consequently, staff judged that the ethical principle of doing good took precedence over duty of confidentiality and thus used their de facto discretion by acting in a way not actually permissible within their discretionary space (Molander, 2016). However, if staff in home help services were to disclose information to a physician in primary care against the person’s knowledge, there is a risk of breaking the trusting relationship between staff and the person with dementia. On the other hand, there can be a risk to the person if the physician does not have access to important information. This might result in the person with dementia not receiving proper care.

Staff highlighted that how older persons experience and act can depend on their life experiences and on societal events, such as public investigations and laws. What is considered abusive can differ from one person to the next making this even more challenging (Selwood et al., 2007). Consequently, if staff suspect domestic abuse, they might feel insecure regarding how much they can interfere in the person’s life and bring up what they suspect. Jarling et al. (2020) stated that the moral aspect of responsibility is prominent in the views of professional care providers, meaning that it is challenging to separate professional responsibility from one’s ethical responsibility towards others in need of help in their homes. Another challenge for the staff working in someone’s home, is the predetermined time that staff are expected to be in the person’s home, which makes it difficult to see if something is going on in the home that is wrong, such as domestic abuse. Even if they want to stay longer in the home, the next person is waiting for their care and they need to rush (Jarling et al., 2020).
When laws and regulations do not determine exactly how the work should be performed, it places demands on the staff’s judgement. Staff need to use their own experience and skills to make assessments of what they consider best in each situation. Molander (2016) discusses this as filling the gap between what the law prescribes and what is best in the situation. Simply sticking to rules risks causing harm to a person. However, staff need to be aware of the ethical dilemmas that might occur in their work and continuously reflect on their ethical positions, norms, and values (Scheepmans et al., 2018). Ethical principles such as protecting the rights of individual patients and families, alleviating suffering, and at the same time preserving their privacy can be everyday dilemmas for social care and health care staff. A genuine interest in the other person’s life and decisions is needed for ethical practice (Edvardsson, 2015). Staff’s feelings of worry and uncertainty can be burdensome as they do not know how to act when they suspect domestic abuse.

To help staff to be confident in actions when they suspect domestic abuse, organisations need to educate them. A high level of professional responsibility can help staff to ask more frequently about domestic abuse. Also, having less concern about damaging the relationship with the patient and knowing that the workplace has guidelines and protocols on how to act are factors that can help staff talk to older persons about domestic abuse more often (Motamedi et al., 2022). One prominent finding in this study is the importance of collective discretionary reasoning. We believe this is an important area for development to enhance staff responsiveness to elder abuse. For instance, previous research has shown that forum theatre training courses combined with group discussions (Simmons et al., 2022) and time for reflection with colleagues to find solutions to difficult situations (Jonasson et al., 2017) can make staff feel more comfortable about asking older persons about domestic abuse and knowing how to act. Ethics rounds is another tool where staff can see things from different perspectives as well as gain insight into ethical issues (Silén et al., 2016).

**Strength and limitations**

A strength of using group interviews is that the participants helped each other to broaden the perspective and reflect on what was said. The group dynamic seemed to inspire the participants to share difficulties in their work, confirming each other’s experiences which strengthens the result. This is important since we have not observed their actual practice. Instead, we have asked of concrete examples of how they act when suspecting domestic abuse. In line with previous research (Brossoie & Roberto, 2015), our results indicate similarities rather than differences across various professional groups. It might be an important task for future research to design studies with an explicit comparative focus. In the analysis and results, the map and compass metaphors helped the researchers to structure and interpret the data. Metaphors offer an alternative way of understanding a data material (Bjursell, 2015) and provide a deeper understanding of the subject. One risk of using metaphors is that the material is oversimplified and is pushed into a form that does not do justice to the data (Carpenter, 2008).

**Conclusions**

This study contributes knowledge about how staff with different educational backgrounds, when lacking guidelines, protocols, knowledge, and education, act when they suspect domestic abuse and how they rely on their own norms and values when making decisions. Health-, dental- and social care staff need training to gain a similar understanding of what constitutes domestic abuse among older persons and persons with dementia, how it is defined and how it could be prevented. Such interventions would help staff deal with the ethical dilemmas that arise when they want to act but do not know how. Collaborating with colleagues was rated highly and organisations need to develop ways of collaborating when staff suspect domestic abuse.

There is a need for more research responding to situations when an older person is victim of domestic abuse, especially persons with dementia (Burnes, 2017). Domestic abuse among persons with
dementia is a complex area and there is rarely one simple solution or approach that suits everyone. Efforts from multi-professional teams are generally required (Burnes, 2017; Ernst & Maschi, 2018; Storey & Perka, 2018).

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