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Living in the Margins: The ICE (Intersectional-Intergenerational Cultural and Ecological) theory of EM of Pakistanis living in the UK.

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Abstract

Elder mistreatment (hereafter EM) is a complex, diverse and universal health and social problem (Burnes et al., 2015b) which has hitherto been predominately researched in the indigenous (white) populations of western countries. As a result, the predominant explanations are considered to be universal, potentially masking important cultural and ethnic differences. There is, however, a growing body of literature suggesting that variations exist in the perception, understanding and reporting of EM among different ethnicities of majority populations in western countries. The United Kingdom (UK), like other ethnically diverse western countries, has a heterogeneous population which includes sizeable numbers of Pakistani older people. At present, however, no comprehensive theoretical framework exists which explains the diverse and multi-etiological nature of EM among Pakistani communities; this thesis addresses this knowledge gap.

A qualitative approach was used for this study underpinned by the philosophical basis of constructivist grounded theory (CGT) to explore the understanding of EM among Pakistanis living in Sheffield, UK. Two focus groups (male = 1; female = 1) and 22 in-depth individual interviews were conducted with a diverse range of participants: older people, young family members and community stakeholders. The data were analysed using the CGT principles of analytic coding, memo writing, constant comparison, theoretical sampling and theoretical saturation.

The findings suggest that if EM among Pakistanis is to be better understood, then consideration has to be given to older peoples' lifetime migratory advantages and disadvantages, their current social, economic and health status, and the existing and past relationships and interactions with their family members and with the wider society. Based on the results, a cultural and ecological theory of EM was constructed. This theory argues that intersectional and intergenerational (hereafter IG) factors help to explain who is at risk of EM in four different ecological systems: the individual, relational or family, the community and wider society. The power and privileges and consequently the marginalization of others are

central arguments of the theory. It was also found that Pakistanis follow a complex but prescriptive process in addressing the issues around EM in the community. Finally, the thesis concludes with the implications and recommendations for practice, future research and policies. Widening IG relationships, changing caregiving trends and the mistreatment of older people in the target society are three examples of these implications.

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Operational definitions of key terminologies

Abuse: Abuse was defined as a violation of an individual's human and civil right by any other person or persons. Abuse may consist of 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.

Neglect: Neglect was defined as the 'repeated deprivation of assistance needed by the older person for important activities of daily living.

Mistreatment: The word mistreatment was used to describe both abuse and neglect

Caregiver: A person who bears or has assumed responsibility for providing care or living assistance to an adult in need of such care or assistance

Vulnerable adult: Vulnerable adult is defined as one who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.

Ethnicity: Ethnicity is a 'multi-faceted and changing phenomenon' that may reflect a combination of a number of features including country of birth, nationality, language spoken at home, ancestral country of birth, skin colour, national or geographical origin, racial group and religion.

Joint family: Joint family includes both lineally extended and collaterally extended families

Chapter 1

Introduction and overview

1.1 Introduction

EM is a growing social, human rights, and public health problem that affects everyone, yet little is known about mistreatment among Pakistanis living in the UK. This introductory chapter of the thesis draws attention of the reader to the context of the thesis and the motivations that led me to undertake this study. The chapter begins with an introduction to my background and the various influences (i.e. migratory, professional and academic) that inspired me to study the topic that this PhD thesis is based upon. Next, the focus is drawn to the rationale and context of the topic, an understanding of EM in community dwelling Pakistanis living in the UK. Finally, the chapter maps out the journey undertaken in this study and provides a brief outline of its constituent chapters.

1.2 Personal background and rationale for the research

The decision to select EM as the focus of my PhD was influenced by many factors and primarily by my professional, migratory and academic knowledge and experiences.

I obtained my professional degree, Bachelor of Science in Nursing, in 2003 and moved to the UK in 2004 after a brief experience of working as a registered nurse in a local hospital in Pakistan. My first job in the UK was in a nursing home. However, I must acknowledge that I had limited knowledge and experience of working with older people at the time, particularly in care homes: first, because I was newly qualified and had recently moved to the UK; second, there were no nursing homes in Pakistan and neither we were exposed to the concept of gerontological nursing and care. During my nursing supervision period, I always wondered why families would leave their older parents to be looked after by someone else in an environment other than the family. These questions were triggered mainly because I came from a culture where the care of an older person is seen as a responsibility of the family. As my experience of working in nursing homes progressed, my knowledge of the care of older people also widened. However, I rarely saw Asian elders, let alone Pakistanis in nursing homes at that time (i.e. 2004), but there were some older people from other minority ethnic backgrounds. This may have been because of their limited numbers, as Mold *et al.* (2005b)

estimated that there are only 25,166 ethnic elders including BME (Black and Minority Ethnic) in care homes in the UK. Hence, this first question inspired me to explore the perceived barriers that Pakistanis assume in relation to care in nursing homes.

My second job was in an NHS hospital. Here, I met with many Asian patients and their families. This provided me with some insight into the social, familial and health issues of older people from ethnic minority groups, including Pakistanis. One of the important things that I learned from these interactions concerned the older peoples' care receiving experiences; both in hospital settings and home settings. Interestingly, many older Pakistanis expressed being less positive about care in both institutions (i.e. home and hospital). I remember neglect and the discriminatory attitude of staff towards older Pakistani patients in the hospital setting. For example, care staff serving food often told Pakistani patients, "Here you go, your foreign food, Curry", or Pakistani patients were told to ask their families to bring food in for them, or patients were not able to order *halal* food which led to them missing their main course and eating only the pudding. I observed that Pakistani patients' needs were often delayed or ignored in hospital. A latent interest in the caregiving experiences and beliefs of Pakistani communities emerged from this time.

Besides working as a registered nurse, I undertook further part time study on a postgraduate course, a master's in public health, in 2008. During this time, I began to learn a lot about health promotion, health policies, and the social and economic issues around older people in the UK. Within these subjects, among the interesting topics that attracted my attention was the rise in health and social care inequalities and their impact on socioeconomically deprived groups in the UK, such as older people. The more I learned about the inequalities in the community, the more I began to relate them to Pakistani older people. This learning motivated me to extend my knowledge further by exploring the multiple social factors that impact the health and wellbeing of older people and specifically those of Pakistani origin.

Coupled with my academic knowledge and professional experience was my personal bewilderment; consequently, my personal attachment with older people in the community motivated me to undertake research in this area. When I came to the UK, I was about 22 years old. I was ambitious, but uncertain and unaware of so many things about the UK. One thing that I was not sure about was whether I would make the UK my country of future residence. Should I adopt the UK culture and what would be the implications for my own culture? These

were serious and thought-provoking questions for me. The preservation of native cultural norms and their potential assimilation into the UK culture, and their impact on future relationships with, and the reaction of, children born in the UK and the wider society were the major sources of my bewilderment. I wanted more clarification from the perspectives of older people who have already been through these experiences.

1.3 Rationale and context of the study

EM, predominantly known as elder abuse, is a complex, diverse, and universal health and social problem (Chokkanathan and Lee, 2005; Lachs and Pillemer, 2004; Burnes et al., 2015a) that is associated with morbidity, mortality, and hospital and nursing homes admissions. Current knowledge on EM is focused on indigenous (White) populations of the western world (Erlingsson, 2007b) and, therefore, research that takes in the perceptions, manifestations and actions of ethnic communities is warranted to fully understand the phenomenon. The United Kingdom is an ethnically diverse country with a sizeable minority of older Pakistanis, whose migratory, historical, and native experiences are important in terms of understanding their health and wellbeing and their help seeking approaches. My own knowledge and experience of being a migrant, academic and a healthcare professional suggest that variations in interpretations and experiences are often complex, subtle and culturally rooted, although under explored. It is my personal interest in the variations (different cultural interpretations/meanings) that exist among ethnic communities that stimulated the study described in this thesis.

As it will be illustrated in chapter four when discussing the choice of methodology adopted in the thesis, I suggest that the current research on EM is predominantly based on quantitative measures and people's crucial/pivotal accounts of their meanings and perspectives of EM are missing; but important. Meanwhile, those studies which have adopted qualitative approaches have often considered the perspectives of either the older people or the professionals involved (Hudson and Carlson, 1998), whereas the involvement of families and the wider community in the lives of older people is a neglected area. Care needs of older people in the community, for example, are often met by the family members, usually the children or partner. Pickard et al. (2007) estimate that care by the family will rise to 60 percent by 2031 in England and Wales. The community, on the other hand, plays a vital role in shaping views on this topic, and addressing the health and social problems older people experience in their

daily lives. In this regard, the role of religious and community leaders is of central importance, particularly on sensitive issues such as family conflicts or EM. Therefore, the perceptions of these stakeholders on EM are important not only in expanding the knowledge on the topic but also exploring the ways in which they respond to the issue of EM.

From my personal experience, I believe that acknowledging and exploring the diverse interpretations of Pakistani elders, the family members involved in the care of older people, and the community stakeholders may be a way forward. Based on this understanding, the following broad objectives informed my reasoning at the start of this study.

- What do community members understand by the term EM?
- What are the underlying narratives that shape, justify, and maintain the practice of EM?
- How do community members respond when faced with EM?
- Based on these questions, is it possible to construct a theory that could inform the mistreatment of older people in Pakistani communities who are living in the UK, which can be used to improve practice and research

It is from this point I started my journey toward exploring various interpretation in EM.

1.4 Overview of the thesis

The thesis is organized as below:

Chapter Two is divided into two parts (A and B). Part A provides a critical analysis of available definitions and explanations of EM among majority populations. In addition to this, it highlights the reasons why EM needs attention in research, particularly in ethnic minority communities. In part B there is some discussion about Pakistanis/Asian experiences of living in the UK and the influences and experiences of this migration on their cultural understanding of EM.

Chapter Three present the results of a review of the literature, which was primarily focused on the mistreatment of older people from South Asian and specifically Pakistani communities. In this, the analysis is focused on key themes of review, such as perception, aetiology and reporting trends of EM. It is also here that I begin to propose the grounded theory (GT)

methodology. As such the role of literature in GT and its use in identifying the sensitizing concepts, and consequently the foreshadowed questions, are discussed in the chapter.

Chapter Four describes the methodology, which guided the study, the GT. The chapter provides the justification and the application of the philosophical underpinnings, the strategies of inquiry and the methods and instruments of data collection and analysis used in the study.

Chapter Five consists of the first part of finding chapters and reports the background and contextual results of the study. Analysis of data revealed three categories, the lifetime disadvantages that first migrant Pakistanis experienced in the UK; the current social, economic and health status of older Pakistanis; and the caregiving expectations and perspective on both the formal and informal sources of support.

Chapter Six outlines the second part of the findings. In this, the perception, aetiology and reporting trends of EM in Pakistani communities are analysed from the perspective of older people, family caregivers and relevant community stakeholders.

Chapter Seven present the resultant theory, *living in the margins*, constructed and grounded in the data. In this, the key underpinning and findings are illustrated in the light of two main categories – intersectionality (IS) and intergenerationality – of the theory.

Chapter Eight discusses the quality of study as credible, original, resonant, and useful. Next, the role of reflexivity and the influences that I brought to the study are highlighted. The chapter goes on to explain the significance of my findings in the light of current research and theoretical knowledge. In doing so, it provides the implication and recommendation for research, policy and practices.

Chapter 2

EM: Background and Context

2.1 Introduction

The ageing population is currently at its highest level in human history and a recent UN World Population Ageing Report (2015) stated that every country in the world is seeing a growth in the number and proportion of older people in their populations. In the UK, the population is not only ageing but also ethnically diversifying. The recent figures also show the highest numbers of older people from ethnic groups following the same longevity trends as the indigenous majority (UK Office for National Statistics, 2011). Although the longevity trends are similar, the socio-cultural way of life of ethnic communities, particularly older Pakistanis, is distinct from that of the general UK population. Time and space are also argued to have implications for the first Pakistani migrants growing old in the UK as the familial relationships inherent in their culture are believed to be going through changes or at least being challenged (Parveen et al., 2013). Together, all these factors influence how their communities perceive later life and conceptualize EM. This chapter provides the background and context of EM and the significance of further exploration among Pakistani elders living in the UK. The chapter is divided into two parts (A and B). First, explanations about EM and the reasons within this phenomenon for further investigation, particularly in the context of ethnicity, will be given. In the second part, the importance of the topic in terms of the numbers, culture and experiences of Pakistanis living in the UK will be explored.

Part A

2.2 What is EM?

The abuse of older people first emerged as a social phenomenon (Blumer, 1971) in a British publication on 'granny battering' (Burston, 1975). Since then, various studies have been conducted to understand the phenomenon of EM (Lachs and Pillemer, 1995; Erlingsson et al., 2005; Naughton et al., 2011) but ambiguities still exist about what constitutes EM (Phelan, 2008). At present, therefore, there is no universally agreed definition of EM. The definition which is frequently and widely used in both research and practice (Mysyuk et al., 2013; Lachs

and Pillemer, 2004) was offered by a British charity, Action on Elder Abuse (1995), and subsequently adopted by the World Health Organization (WHO), it 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.

(Krug *et al.*, 2002)

This definition can be seen to comprise three concepts: the *behaviours* connoting acts of commission and omission (such as neglect); the *relationships* which structure the expectation of trust and therefore exclude mistreatment by a stranger; and the *impact* denoting the consequences, such as injury or pain, the loss or violation of human rights, and a decreased quality of life in such relationships for an older person (Dixon *et al.*, 2009; Brammer and Biggs, 1998; Erlingsson, 2007a). However, variations exist in the ways in which these main concepts are interpreted (Wallace and Bonnie, 2003); for instance, the concept of ‘older person’, for which the chronological, social and biological perspective is culture- and country-specific, and the notion of ‘trust’ is also circumstantial and contextual (Wallace and Bonnie, 2003; Dixon *et al.*, 2009; Anetzberger, 2005).

In addition to being described as “definitional disarray” (Pillemer and Finkelhor, 1988), the issue also lacks a strong theoretical framework to explain the phenomenon of EM (McCreadie and Jack, 1996). At present, there is no unifying theory or perspective dominating the explanations of EM given the fact that it is a relatively new yet complex phenomenon of family violence (Wallace and Bonnie, 2003; Killick *et al.*, 2015; Anetzberger, 2005). Researchers have adopted or adapted various theories (*see* Table 2.1) on EM from other fields of study, including criminology (for example, routine activity theory), sociology (for example, social exchange, power-control theory, situational theory) and family violence (for example, social learning theory, psychopathology) (Anetzberger, 2005; Norris *et al.*, 2013; Wolf, 1984; Steinmetz, 1988). These theories provide useful insights into EM, but because of their limited validity and reliability they have failed to identify independent risk factors which are useful, reproducible and have high predictive value (Jackson and Hafemeister, 2013; Lachs *et al.*, 1997). At present, it appears that much of the empirical research which has been carried out on EM is based on these abstract theories in which explanations are focused on a single

aetiology. Caregiver stress theory, for example, states that “EM occurs when an adult family member caring for an impaired older adult is not able to manage his or her caregiving responsibility” (p.7) (Burnight and Mosqueda, 2011). However, EM is argued to be a complex and multi-aetiological issue, and the current literature lacks diversity in terms of ethnicity and culture. Experts in EM therefore place an emphasis on developing mid-range theories which provide detailed insights into the contextual and culturally specific nature of EM (Anetzberger, 2005). Developing a mid-range theory is one of the objectives of this current study and I shall come back to this later in the following chapters.

Table 2. 1. Theoretical explanations of EM

Theory	Description
Routine Activity Theory	Victimization is likely to occur when a suitable target and motivated offender intersect in time and space in the absence of capable guardianship
Feminist Theory	Abuse against women results from structural inequalities in society which disadvantage women and other marginalized groups
Situational Theory	Circumstances such as social isolation and excessive stress on a caregiver can render an older person vulnerable to abuse
Social Learning Theory	Abuse is learned from and reinforced by those in perceived authority
Bio-psychological/ Psychopathological theory	Violence is linked to characteristics of the abuser, such as personality disorders and mental illness
Exchange Theory	Older people are dependent on those who abuse them out of a sense of power or power loss, but find that the cost in terms of the abuse is less than the benefit of receiving care
Political Economic Theory	The changing role of older people removes them from the labour force and decreases their autonomy, which prompts mistreatment

Adapted from Anetzberger (2005)

From the existing empirical research, however, the US National Research Council (2003) has reviewed, identified and categorized the risk factors for EM on the basis of their predictive values as (1) risk factors validated by substantial research (such as shared living, dementia and isolation); (2) contested risk factors (such as frailty and stress); and (3) possible risk factors

(such as gender and race) (see Table 2.2). The NRC report was based on a comprehensive study to identify the risk and prevalence of elder abuse and neglect for the development of a national policy in the US. Again, however, these risk factors have been explored in general western populations but their relevance to other minority cultures and communities are missing; I shall discuss this in greater detail next.

Table 2. 2. Risk Factors for EM

Risk factors validated by substantial evidences	Risk factors – contested	Risk factors – possible
Shared living arrangements	Physical impairment of older person	Gender
Social isolation	Victim dependency	Relationship of victim to perpetrator
Dementia	Caregiver stress	Personality characteristics of victim
Intra-individual characteristics of abuser (mental illness, hostility, alcohol abuse)	Inter-generational transmission of violence	Race
Abuser dependency (for housing or money)		

Adapted from Wallace and Bonnie (2003)

Despite that the definition is fragmented and its theoretical foundations are inconsistent, EM is nevertheless a pervasive public health and social problem which needs further consideration in research.

2.3 Why EM needs further research

Research into the field of EM has increased and the topic has recently attracted public and professional interest (Killick et al., 2015). However, the discovery of EM in the literature still appears as a ‘concept without context’ (Biggs, 1996b) compared with other forms of familial violence. Both child abuse and intimate partner violence, for example, boast a rich body of research, clearer theoretical foundations and a solid legal framework compared with EM. Recent systematic reviews have revealed the dearth of empirical evidence on EM (Erlingsson, 2007b; Daly et al., 2011). For example, in the health-care and criminal justice literature, Daly *et al.* (2011) found only 590 original articles out of 6676 citations. Similarly, Erlingsson (2007)

found about 48,000 citations on child abuse and 21,000 references to intimate partner violence compared with 2418 unique references on EM. It is not only the limited number of studies conducted which makes EM research an important issue; EM is also a significant problem given its pervasive nature, its serious impacts on the victims and its under-reported trend. These three points will be discussed further below.

2.3.1 The growing prevalence of EM

Despite the definitional disparity being linked to the under-recognition of EM (Anetzberger, 2005), recent statistics have demonstrated that EM is sufficiently widespread to be a major public health concern (Pillemer et al., 2015). In a systematic review of prevalence studies, Cooper *et al.*, (2008) reported that the overall global prevalence of EM ranged between 3.2% and 27.5% in the general population. In Asia, however, the prevalence of EM was observed to be high, ranging between 22% to 62% (Yan et al., 2015). Many of the Asian studies have found emotional and/or psychological abuse to be the most reported forms of EM. Oh *et al.*, (2006), for example, found that 6.3% of their 15,230 Korean participants stated experiencing emotional abuse. Similar findings have been observed in India: in a random sample of 9852 older adults, Skirbekk and James (2014) reported that 10% of their participants had suffered verbal abuse. Although these studies provide meaningful insights into the rising prevalence of psychological mistreatment in Asian communities, the results should be interpreted with caution because of the studies' methodological and definitional shortcomings. On the other hand, these results also imply a weakening of the cultural values of elder veneration in Asian communities. Clearly, the influences of these changes are considerable and they will be discussed in greater detail in the second part of this chapter.

In the UK, an early prevalence study by Ogg and Bennet (1992) reported an EM rate of 3.5%, with physical abuse accounting for 1.6%, financial abuse 2.0% and psychological abuse 5.6%. The prevalence reported by Ogg and Bennet (1992), however, has been criticised for using narrow and single-item questions to determine the magnitude of EM. The first large-scale and systematic study conducted on EM in the UK was carried out by O'Keeffe *et al.*, (2007), who reported an EM rate of 2.6% (n = 267,000) in 'trusted relationships' in the general population. Unlike the results reported by Asian studies, O'Keeffe *et al.* (2007) found that neglect (1.1%) and financial abuse (0.7%) were the most prevalent types of EM in the UK, potentially suggesting a variation in the perception and manifestation of EM across ethnicities and

countries. A recent report by a British charity suggested that about 800,000 older people faced mistreatment in the previous year in the UK (Action on Elder Abuse, 2017). Despite this growth in the number and incidence of EM, British research and the response to it have been criticized as inadequate compared with actions taken by other countries such as Canada and the US (Biggs, 1996). For example, until 1990 the UK Department of Health had neither a policy, nor had it commissioned any research on EM in the UK and only recently has it introduced the Care Act 2014 to address the issue. Furthermore, a true estimate of EM has been difficult to make in the UK because existing studies excluded non-English speakers, people with dementia, and hard-to-reach groups such as BME communities (O'Keeffe et al., 2007; Manthorpe and Bowes, 2010). Although EM has been described as a hidden but widespread problem among BMEs (Bowes et al., 2008), little academic attention has been paid to the issue of EM in ethnic communities. Three decades ago, a few researchers did offer some limited discussions and passing references to EM in BME communities (Blakemore and Boneham, 1994; Biggs, 1996a) but it was only more recently that Bowes *et al.*, (2012a) conducted a qualitative study with BMEs and found that their respondents viewed EM differently from the general British population. EM is a real and growing issue for rising numbers of BME elders. Whether the health and social care system in the UK is prepared to address this and has the necessary services for this reality is a critical question.

It has been difficult to compare the prevalence of EM across and within countries (Yan and Tang, 2001). The definitional differences, methodological flaws and contextual features form a major critique of previous surveys, suggesting one reason why EM numbers vary greatly across different regions, countries and cultures. Despite this, current evidence confirms a disturbing rise in the number of reported cases of EM. Twenty years ago, around one in ten older people were reported to be at risk of mistreatment (Glendenning, 1997). From an analysis of reports from 28 countries, the WHO (2018) reported that around one in six older people aged sixty and above had experienced some form of mistreatment in their community settings during the previous year. It has been further claimed that the numbers of cases of EM are expected to rise with an increasingly ageing population, so more attention is urgently needed.

2.3.2 The greater impact of EM on older victims

The rising prevalence of EM has a significant impact on the health and well-being of older victims. Psychological, physical and economic deprivations are documented consequences of EM. Bristowe and Collins (1988) reported that psychologically abused elders were found to suffer depression in greater severity and frequency than those not abused. Studies have found that the risks of mortality and morbidity were also significantly higher among older people who were abused and neglected than those who were not (Lachs and Pillemer, 2004; Dong *et al.*, 2011b). In a thirteen-year longitudinal study, Lachs *et al.*, (1998) found that confirmed cases of EM had a poorer survival rate (9%) than those either of self-neglect (17%) or other non-investigated cases (40%). Dong and Simon (2013) found a correlation between EM and an increased risk of hospitalization: the annual rate of hospitalization for older people who were abused was 1.97% compared with 0.62% among those who were not. Dong (2015) suggested that the direct and indirect costs of financial abuse on elders and society have devastating consequences. He reported that federal agencies in the US spent about \$11.9 million on EM-related activities. It has also been argued that the implications of EM are likely to include premature institutionalization and a decreased quality of life (Choi and Mayer, 2000).

2.3.3 Under-reporting and barriers

The rising prevalence and increasing impact of EM is a significant issue because of under-reporting and the barriers to the reporting of EM. Anetzberger (2005) stated that under-reporting is leading to the under-estimation of EM. Although prevalence studies have claimed that the recognition and reporting of EM has increased (Pillemer *et al.*, 2015), they are still lower compared with other forms of family violence (Choi and Mayer, 2000; Erlingsson, 2007b). For example, one in ten cases of EM are reported to the authorities compared with one in three child-abuse cases (Erlingsson, 2007b; Acierno *et al.*, 2010). Some sources, however, have suggested that only one in fourteen cases of EM is reported (Bruce, 1994), indicating that the actual numbers of EM cases might be under-estimated (Payne *et al.*, 2001), consequently leading to the under-development of adult safeguarding interventions. Different studies have reported a wide range of barriers preventing victims from reporting EM (Bowes *et al.*, 2012a; Mowlam *et al.*, 2007; Kosberg *et al.*, 2003). Empirical evidence has suggested that the barriers to reporting are related to personal circumstances and concerns

about the consequences of actions, views on the role and remit of support services (Mowlam *et al.*, 2007) and controversy over contextual and cultural boundaries around the term 'EM' (Anetzberger, 2005; Choi and Mayer, 2000).

Although EM is an under-studied phenomenon, the scope of the problem is substantial given that it is pervasive, complex and universal, and has major implications for society and for individual victims and their families. In order to develop a better understanding of EM, far wider knowledge is needed and I shall consider this next.

2.4 Issues with existing knowledge: ethnicity

At present, knowledge about EM is predominantly derived from health and social care professionals and based upon samples derived from indigenous populations and is regarded as authoritative and westernized (Kosberg *et al.*, 2003; World Health Organization, 2002). In an annotated bibliography, Erlingsson (2007b) identified 432 empirical references and found that more than 85% of the research references on EM were from the US, the UK, Canada and Australia. Among these, more than 50% of the samples were from professionals and only 3% were from ethnic minority elders. The empirical knowledge of EM is therefore centred on the majority (white) populations of the western world. However, little information or research exists to support the idea that the majority whites' definition or explanation of EM is universal. Experts have suggested that this generalization masks important group differences (Biggs *et al.*, 1995; Kosberg *et al.*, 2003). Studies conducted with different minority ethnicities have suggested that the meanings of EM within different cultures and ethnicities living in the western world are distinct, often differing between professionals, policy-makers and the general public, and are mainly embedded in their own unique socio-cultural, religious, economic and migratory experiences (Anetzberger *et al.*, 1996; Anetzberger, 2005; Moon and Williams, 1993), so more cross-cultural research is required (Kosberg *et al.*, 2003). In western countries, for example, the most acknowledged range of behaviours which fall under the rubric of EM are physical, psychological, financial and sexual abuse, and neglect (O'Keeffe *et al.*, 2007). However, EM is approached in distinctly different ways in different parts of the world (World Health Organization, 2002). Kosberg *et al.* (2003) identified many variations in the definitions of EM; for example, Norway includes 'family disharmony', Hong Kong includes 'elder dumping', India includes 'disrespect' by a daughter-in-law, Japan includes 'silent mistreatment' by children, and France reports 'moral cruelty' under the rubric of EM.

Various studies have sought to determine the effect of cultural values on the perception of EM (Moon et al., 2002) and found that ethnic minority victims of EM under-report culturally normative behaviours not falling into commonly known types of abuse because they may not perceive acts as either abusive or reportable (Tomita, 1994; Moon, 2000). Dong *et al.* (2011) and DeLiema *et al.* (2012) also reported participants identifying culturally specific forms of EM associated with their traditional teachings and concepts, such as filial piety, *la familia* (family), and *el respeto* (respect). Similarly, Tomita (1994) and Anetzberger *et al.* (1996) studied the contribution of cultural factors to the perception of EM among Japanese elders and found psychological neglect, including avoidance, silence and ignoring behaviours being used by Japanese adults to punish elders, who experienced such abuse as just as emotionally devastating as physical abuse (Anetzberger *et al.*, 1996b; Tomita, 1994). Lee and Lightfoot (2014) studied the literature on EM in Asian communities and linked the increasing psychological mistreatment with a breakdown in cultural norms of filial piety and family obligations.

Inquiries into the causative factors of EM among different minority ethnic groups have identified culturally specific types of risk factor such as low income, poor health and inverse generational family support (Oh *et al.*, 2006; Dong *et al.*, 2010; Lee and Lightfoot, 2014). For instance, Hall (1987) studied minority EM in Texas and found that Hispanic victims were more likely to be female, poor and isolated. These findings suggest that EM could be linked with the intersection of multiple disadvantaged statuses, so attention should be paid to looking at EM from this angle.

Moon and Williams (1993) stated that the perception of a situation as abusive or non-abusive within a community is a key determinant of people's help-seeking behaviours. For instance, Korean Americans were substantially less likely to perceive a situation as abusive when compared with Afro-Americans and Caucasian Americans, and were therefore less likely to use formal services (Moon and Williams, 1993). The problem extends beyond these broader ethnic groups: the literature shows a substantial variability in reporting trends within a particular culture group. For instance, Moon *et al.* (2002) reported that Korean participants differed significantly from three other Asian American groups; they had a greater tolerance of financial abuse, were more likely to blame elder victims for their own mistreatment and resented outside interventions. This suggests a clear diversity in the perception that ethnic

culture is broader, regional or similar, it might affect reporting rates, therefore, the potential influence of cultural factors is considerable.

Part B

The UK is an ethnically diverse country in which a wide range of minority communities live and Pakistanis are one of the largest ethnic communities which has its own distinct culture, language, religion and history. In order to gain a better idea about the situation of EM in Pakistani communities, three areas are considered to need attention: the numbers (statistical significance), the culture (the IG significance) and the history (the intersectional significance), and these will be considered next.

2.5 Statistical significance

Evidence suggests that some of the main drivers for changing the demography of a country are global migration (Massey et al., 1993) and the rising numbers of ageing people (UK Office for National Statistics, 2011). According to International Organization for Migration (2015), one in every thirty people in the world is an international migrant. Furthermore, the United Nations (2017) report on 'ageing population' published that 13% of the global population comprises people aged sixty and over. A healthy lifestyle, advancements in technology and medicine, better standards of health-care and improved nutrition are recognised as the main reasons for the rapid rise in human longevity over the last century. As a result of this declining mortality, the ageing population is expected to grow even more. In 2010, for example, there were 894 million people aged over sixty, and according to a UN estimate, the number will increase to 2.43 billion by 2050 (Rutherford and Socio, 2012). The Office for National Statistics (2012) indicated that the UK is no different and that the number of people aged 65 and over will reach 16.9 million by 2035 and will represent 23% of the total population.

Interestingly, the population of the UK is not simply growing and ageing, but ethnically diversifying as well (UK Office for National Statistics, 2014; ONS, 2012). People identifying with non-white ethnic backgrounds are increasing in numbers and these are projected to grow from about 8.5 million in 2011 to 20.7 million by 2051 (UK Office for National Statistics, 2012). Immigration, the youth age structure and increasing birth rates among minority ethnicities are driving factors behind the changes in the UK's demographic structure. The ONS

(2011) has shown that the number of people in the UK born overseas increased by 62% from 4.6 million in 2001 to 7.5 million in 2011. Similarly, the fertility rate is also recorded to be higher among women from ethnic minority groups (born in the UK or overseas) compared with UK-born white women. The birth rate among Pakistani women living in the UK is 2.2 compared with 1.79 among white British-born women. In addition, a youthful age structure is another explanation for the growing ethnic minority population, particularly of Pakistanis, in the UK. The Centre for Policy on Ageing has shown that about 30% of the Pakistanis in the UK are under the age of fifteen. Statistics further indicate that the age structure and life expectancy of ethnic minority people will follow the local majority population trends and it is projected that by 2051, the non-white minorities aged fifty and over will make up 30% of the ageing 17.1 million population of England and Wales (Lievesley, 2010). This is a significant number forming the ethnicity and age of a population.

Although increased longevity is a great success in personal terms, it has implications for the economy, for public services, for society and for the individual. The cost of long-term care (Pickard *et al.*, 2007), for example, whether it is formal or informal, is a critical question. The increasingly ageing population is linked with EM, so the health and well-being of older people needs to be considered. Whether the potential support providers have appropriate knowledge and resources to guarantee safeguarding to older people is an important concern. The importance of acknowledging the diversity involved in understanding EM, family relationships, culture and support networks for older people within Pakistani communities are all research priorities in terms of ensuring their safety in the UK. 'Do they look after their own?' (Katbamna *et al.*, 2004) is a debated but nevertheless important question when discussing cultural care in British ethnic communities. I shall address this issue of culture next.

2.6 Culture and IG significance

The mass migration of Pakistanis to the UK began in the final decades of the twentieth century, but its root causes began much earlier than that. The partition of greater India, the construction of the Mangla Dam by the British government in Azad Kashmir and even the industrial revolution in the UK were all major contributory factors to the eventual movement of Pakistanis to the UK (Shaw, 2004; Ballard, 2003). Pakistanis did not just migrate, they brought with them their culture, which is a strong part of their lives and represents the entire

database of their values, beliefs, customs, language and traditions. To study Pakistanis thoroughly, it is necessary to consider the array of cultural dimensions of their lives. In this section, therefore, I shall explain the characteristics and the culture of the Pakistani people living in the UK.

Pakistanis living in the UK are primarily exposed to two different and distinct cultures; the native, traditional culture which the first migrant Pakistanis brought with them and the local, modern UK culture with which they have regular interaction in their everyday lives. It is therefore argued that the UK Pakistani communities live in the constant process of redefining their cultural boundaries by being influenced by both their inherited traditionalism and their lived modernity, both of which further shape their IG and wider relationships.

Within the traditional Asian culture, a multi-generational living system is emphasized and children, women, elders and other family members all have their obligations and specific roles in the family (Inman et al., 2014). Multi-generational family systems are valued and viewed as representing family cohesion, strength and power (Mullatti, 1995). Large houses are preferred for accommodating married and unmarried children and grandchildren and other relatives (Nagpaul, 1997). Traditional families foster a collective identity and interdependence but discourage changes to their conservative orientations (Sinha, 1984). All social, material and health-related concerns are dealt with inside the family (Segal, 1999; Jamuna, 2003).

In the traditional Pakistani and Asian context, later life is associated with wisdom and assured authority (Segal, 1999; Jambunathan et al., 2000) so elders are the first to be consulted for advice, support and the resolution of family affairs. Elders in the family also become the main source of cultural learning and transition (Inman et al., 2007). Asian culture regards the care of older people an honour for a child, and the religious texts reward this act (Segal, 1999; Jambunathan *et al.*, 2000). Elders therefore often live with their children, preferably with their son(s), in joint households.

Children, on the other hand, are brought up in an authoritarian environment in which submission to and respect for parents, valuing the honour of the family, and caring for the elders are fundamental obligations (Dhruvarajan, 1993; Jambunathan and Counselman, 2002). From a very early age, children are aware of their filial responsibilities towards their elders, their parents, grandparents and other senior family members. In addition to love and

responsibilities, socio-economic exchanges are strong factors in these parent/child relationships (Jamuna, 2003; Nagpaul, 1997). For example, children are ensured material rewards in exchange for cultural obligations (Nagpaul, 1997; Skirbekk and James, 2014).

Furthermore, the roles for men and women are gendered; men are primarily responsible for the financial needs of the family, whilst female obligations are centred on the home and the family, such as child-rearing and domestic chores (Dhruvarajan, 1993; Inman *et al.*, 1999). In traditional Asian families, a male child is a preferred and valued member, whereas the birth of a girl in some families is rarely welcomed (Sinha, 1984; Nagpaul, 1997). After marriage, a woman lives with her husband and his family, and she is obliged to serve the husband and her in-laws.

Although the traditions inherited from native Pakistani culture still exist, it is argued that the Pakistani community is going through a transitional phase in the western world, and that the perspective and interpretation of the cultural and religious obligations to provide care, the expectations from relationship and the roles in families are changing (Inman *et al.*, 1999; Lee and Lightfoot, 2014). The UK annual report on families and households, for example, showed that multi-generational households in Asian communities are still common (21.6%) compared with other groups, and there had been a rise in the number of married couples' household types (UK Office for National Statistics, 2017). These trends raise critical questions about older people's care which is often seen as a cultural issue (Katbamna *et al.*, 2004). Despite the fact that most of the care for older people is currently assured by families in the UK, Pickard *et al.* (2007) predicted that care of the older person by their children will decline in the future. Although these findings do not explicitly report care-giving trends in Asian communities, they do provide meaningful insight into the issue. The rise in the need for and use of formal sources of support in elder care in Asian families (Sin, 2006), on the other hand, confirms these findings. In the US, Gupta (2002) found that more Indian and Pakistani people were considering the option of a nursing home for the care of older relatives despite its subversion of the traditional values. Caregivers who experience role conflict, for example, were about 47% more likely to report their intention of sending their parents to nursing homes. At present, little is known about the access to and use of nursing homes by Pakistanis; Mold *et al.* (2005) reported that there were about 25,166 residents from all ethnic communities in care homes in England and Wales.

Jamuna (2003) stated that the new generations are inclined towards an outlook which advocates fluidity, with changing norms across the world and the recognition of individualism, personal identity and equality. Whether to retain or reject particular norms of tradition or modernity is therefore leading to what Fenton (1987) described as “inseparable tensions”; suggesting that South Asian elders are facing “psychological jeopardy” as a consequence of the changing family structures and role relationships. Recent research suggest such IG tension is not changed (Bowes et al., 2012a), therefore, much more considerable.

Many Pakistani elders continue to live with their families, enjoying the respect and status prescribed to them by their culture and religion. The rapid societal changes in the UK such as industrialization, individualism and modernism, however, present threats to traditional values, potentially changing or at least questioning the value, care and status of older Pakistanis. It is therefore very important to consider the potential impact of the changing cultural values on the perception of older people and the construction of their abuse.

2.7 History of Pakistani living in the UK: intersectional significance

In the UK, the older population face a number of problems because of ageism; however, older people in minority groups reaching retirement have different experiences of multiple ‘ethnic penalties’ (George, 1994). To understand the position and experiences of Pakistani older people living in the UK, it is important to understand the effects of different significant events and changes such as migration and settlement, the multiple identities and social roles which they have adopted, and importantly the wider social exclusions determining their recognition, position and acceptance in the UK.

A significant proportion of Pakistani immigrants entered the UK with few professional or technical skills (Evandrou, 2000) so their socio-economic status and upward mobility in work has remained a major issue. The earlier discrimination in employment (Blakemore and Boneham, 1994), the increasing trend for self-employment (Department for Work & Pensions, 2010) and the awareness of state and private pensions (Nesbitt and Neary, 2001) are now linked with the socio-economic dependency of Pakistanis in later life. The Family Resource Survey (2017), for example, reported that 6% of Pakistanis compared with 26% of white British received a state pension. Pakistani women experience additional problems in later life because most of them have never been in paid work (Ahmad and Walker, 1997) so they have no pension from employment and will be in greater need of welfare (Patel, 1993). Despite

some progress, inequalities in unemployment support still persist today and people from BME communities continue to face major jobs gaps in the UK. The Annual Population Survey (2017), for example, reported that the rate of unemployment among Pakistanis was an alarmingly 10% compared with 4% in the white population. These findings are important to the reliance as well as the treatment of older people in society.

Racial discrimination in housing is another important problem which people in Pakistani communities continue to face in the UK (Moriarty, 2008). Overcrowding, poor housing and deprived neighbourhoods are typical Pakistani living conditions. Data from the English house condition survey (2007), for instance, indicated that Asian homes were almost three times more likely than the average home to have serious condensation and mould problems; for those most deprived, keeping a house warm and dry is a major issue. The ONS (2018) reported that there were an estimated 51,100 extra winter deaths in England and Wales, potentially linked with fuel poverty. The annual fuel poverty report by the Department of Business, Energy and Industrial Strategy (2016) estimated that approximately 13% of all households in the UK were affected. These numbers are higher among ethnic groups. The General Household Survey 2007 estimated that about 28% of Pakistani older people lived in houses with no central heating (UK Office for National Statistics, 2007). These issues are important because of their impact on people in later life. Ahmed and Walker (1997), for example, reported that one-third of their Asian participants reported living in overcrowded houses, which was perceived to be linked with their poor health.

It also appears that some ethnic communities more than others have experienced greater exclusion and discrimination in British society (Ballard, 2003; Mir and Tovey, 2002). For example, prejudice against Muslims is common and sometimes socially accepted. Hanes and Machin (2014) reported a significant rise in hate crimes against Asian and Arab communities in the wake of the 9/11 and 7/7 terror attacks. Racism, on the other hand, has been confirmed as an additional form of abuse (Biggs, 1996). All this clearly shows that Pakistanis encounter double jeopardy by being both Muslim and Pakistani, and how the interplay of an additional disadvantaged status affects people's integration and exclusion for being old is an important question, particularly for the Pakistani migrants who are now growing old.

Some scholars have also claimed that interest in ethnic elders has historically been preoccupied with stereotyped assumptions in research and health and social care and policy

(Blakemore, 2000). For example, despite the significant size of the ageing population recorded in the 1991 and 2001 UK censuses, their numbers were considered to be “too small to cause concern” (p.5). In addition, the stereotypes of South Asian families that ‘they look after their own’ or ‘they will return back to their country of origin’ in later life have been used by some service providers to explain their low use of the services (Katbamna et al., 2004; Victor and Yang, 2012), rather than examining the services failures for the failure of access. The literature on inequalities in health and social services has suggested many barriers for ethnic communities in access to and use of services (Aspinall and Jacobsen, 2004; Scheppers et al., 2006). In a review of 54 articles, Scheppers *et al.* (2006) reported that the attitude, skills, behaviours, cultural knowledge and sensitivities of the staff of the interpretation and communication services were major restrictive factors preventing ethnic minorities from using health services. Such barriers in services and the disadvantages to health, which they create, generate the need for family-based care. In a study of informal support for South Asian carers, however, Katbaman *et al.* (2004) found that Asian families were deprived of domiciliary support for older people because of insensitivity, the unavailability of care and language barriers. These findings show the significant consequences for families in undertaking the burden of care, so listening to the voice of informal caregivers is important (Sawatzky and Fowler-Kerry, 2003).

The interaction of multiple disadvantages based on the social categories age, gender and ethnic group can pose serious social and health consequences for the deprived groups in the population. As the Pakistanis in Britain continue to age, understanding their current situations in the light of their historical marginalization and the existing inequalities in later life should be a research priority for the development of appropriate services and policies and, most importantly, their safety.

2.8 Conclusion

Although EM is an under-researched phenomenon, it is pervasive and universal and is linked to serious health and social consequences. EM is expected to increase in line with a growing ageing population. It has also been established that different ethnic minorities hold distinct interpretations of EM, different from the general population leading to the under-recognition and under-reporting of EM and the under-development of appropriate interventions. There has been limited research into the perspectives of different ethnicities reported in the UK,

particularly the views of older people, their families and relevant others. In addition, limited data is available for demonstrating the severity of EM among ethnic groups as that population has been given the least research priority in UK surveys. Some studies, however, have indicated that the hidden mistreatment of older people in ethnic communities is widespread.

Pakistanis form the largest ethnic minority in the UK and include a sizeable ageing population. Recent studies among Pakistanis living in the UK have shown that historical stereotypes such as 'the family is always there to look after their elders in a large household' and they return home in later life are simply myths and that the traditional familial structures, roles and culture are now being significantly challenged. Increasing numbers of Pakistanis are still living with or dependent on their families because of historical marginalization and persistent discrimination in the health and social care sectors. These factors emphasise the need to explore further the issue of older Pakistanis' well-being and safeguarding, particularly from a cultural and contextual perspective. A review of the relevant literature was therefore undertaken to further explore the nature of EM within Pakistani communities, including the barriers and facilitators for taking action in face of EM. This review will be discussed in the next chapter.

Preface to the Literature Review

This study was initially aimed at South Asian populations primarily the subcontinent Indian populations i.e., Bangladeshis, Indians, and Pakistani. However, the study is now only aimed at Pakistani communities after considering multiple aspects listed below:

- Pre-protocol fieldwork was undertaken to identify various factors I wanted to clarify before the conduct of the study; these included as selected-population's homogeneity/heterogeneity, the development of interview guides, and the feasibility of the study that include issues around the access, gatekeepers, and language competencies of the researcher (see Appendix 1 for Pre-protocol fieldwork report). The limited time available within a PhD, the recruitment related issues were also considered.
- The further review of the research studies and consultation with supervisors, it was identified that Pakistanis are under researched group compared to other South Asian communities (see data analysis of this literature review); therefore, they were considered as a research priority.
- The researcher background plays pivotal role in qualitative research (Denzin and Lincoln, 2011), particularly within the constructivist GT, the methodology adopted for this study. My role as a researcher in this study is covered in detail in other sections. In brief, I am from Pakistan and it was considered that the lingual, cultural, and native knowledge of the country will be helpful for me to focus only on Pakistani populations (see also methodology chapter).
- In addition, the selected populations, the South Asian (here Subcontinent Indians) share same pre-partition history; therefore, their culture, values, and many aspects of life are similar. Besides this, they have similar migratory patterns in the UK (this was covered in chapter 2).

I also did not want to lose the interesting finding from the literature review with a broad range of communities, so it was published it as a journal article (Talpur et al., 2018) (see Appendix 2).

Chapter 3

Literature Review

3.1 Introduction

This chapter presents the process and results of a review of the literature which was primarily focused on the mistreatment of older people in South Asian and specifically Pakistani communities. The chapter begins with a discussion of the role of a literature review in GT research, the methodology adopted for this study. A detailed account of the choice of research methodology is given in Chapter 4 but the relevance of the methodology to the literature review is discussed in this chapter. This is followed by an explanation of the research strategies used in previous studies in order identify sources most relevant to the current study. Later, the key findings and themes which emerged from the analysis of the literature will be discussed. Finally, the conclusions drawn from this chapter and explanations of their relevance to this study will be presented, and the research/foreshadowed questions which resulted from the sensitizing concepts will be set out.

3.2 The literature on GT: the chicken or the egg?

The use of the previous literature – research or theoretical - in GT research is a disputed and misunderstood area. The ambiguity particularly lies in the time, the stages and the extent to which the literature should be consulted in GT studies. Full details and a definition of GT are given in Chapter 4; here, its role in the literature review will be considered.

Glaser and Strauss (1967), who introduced GT, advocated not consulting existing literature for the purpose of ‘pure’ induction, advising researchers “literally to ignore the literature or theory and focus on the area under study, in order to assure that the emergence of categories will not be contaminated” (p. 45). Strauss subsequently changed his stance and together with Corbin recommended consulting the previous literature – technical or non-technical – in “all phases of study”, acknowledging that a researcher already brings a considerable background into the inquiry (Strauss and Corbin, 1998). GT advocates, however, such as Glaser (1998), contended that conducting a literature review prior to a study is problematic because it would undermine the focus, the authenticity and the quality of the GT methodology. Engagement with the literature, they believed, would contaminate the researcher because he/she would

not be able to see any emergent findings with fresh eyes and would be more likely to impose assumptions and preconceptions in all phases of theory development.

In contrast to Glaser, constructivist grounded theorists such as Charmaz (2014) opposed the classic GT approach of refraining from a literature review and pointed out the multiple benefits of conducting a review of the relevant literature at all phases of a research study.

I compiled a list of some of the advantages of undertaking a literature review prior to data collection in order to locate, evaluate and defend my position.

First, GT is the predominant choice of methodology for studying topics on which there is a paucity of knowledge (Charmaz 2014). My initial contact with existing knowledge of EM confirmed that it has been a less studied phenomenon compared with other forms of family violence. I was not convinced, however, that mistreatment in ethnic groups is a severely under-researched topic. Although I was interested in the topic, 'learning to know' that it is under-studied inspired me further to take this subject as my PhD study. I therefore believe that a literature review is important, agreeing with McGhee et al. (2007), who asked "How can this paucity of knowledge be ascertained unless an initial review of the literature is undertaken?" (p. 339-340).

The second advantage of conducting a literature review before undertaking GT research is that it provides a cogent rationale for a study. By reviewing the literature, I wanted to see how the phenomenon of EM has been studied so far, identify what gaps exist in the existing knowledge, and determine whether my proposed study is similar to work which has previously been reported. I believed that this would help me to design and justify the research objectives as well as plan the appropriate research approaches to address those objectives in my intended study. Furthermore, if I had delayed the literature review (Glaser, 1998), I might have ended up reinventing the wheel (Clarke, 2003) and replicating a study which had already been completed; I therefore felt that it was important to ensure that my study is original, substantive, critical and developed on existing knowledge.

Charmaz (2014) suggested that early contact with the literature helps researchers to compare, analyse and critique current studies to show why they favour a particular argument and evidence. As a PhD student at the University of Sheffield, I was expected to defend my position in a confirmation review report and examination so it was important for me to know

why I had accepted or rejected some evidence or concepts in the study. Dunne (2011) said that “not informing oneself about relevant literature at an early stage can leave the researcher open to criticism” (p. 116).

This raises another reason why a literature review is important at all stages of a study of inquiry. Purely from a pragmatic viewpoint, not carrying out a literature review is idealistic and impractical for PhD researchers, particularly when I need to request ethical approval to conduct the study. In addition, progress through the doctoral process depends heavily on producing a detailed literature review prior to commencing primary data collection.

Having made clear the reasons for consulting the literature, I now discuss the role of sensitizing concepts and foreshadow questions in the study.

3.3 The role of the sensitizing concept and research/foreshadow questions in guiding the study

The term ‘sensitizing concept’ was coined by Blumer (1945) who explained that “a sensitizing concept ... gives the user a general sense of reference and guidance in approaching empirical instances” (p. 7).

In qualitative research, Faulkner (2009) argued that the sensitizing concept often emerges from the literature review as something worth problematizing or addressing. In GT research, the approach adopted by this study, Charmaz (2014) suggested that sensitizing concepts offer ways of seeing, organizing and understanding experiences and ideas in the field. She recommended that potential sensitizing concepts should be considered as the starting point of empirical research derived from a literature review. These concepts ultimately shape the research/foreshadow questions to be explored.

The sensitizing concepts which form the research/foreshadow questions do not, however, emerge solely from the literature, but from other sources too, such as a researcher’s prior knowledge and early engagement with the research field. In my case, these concepts and questions were partly the product of my prior engagement with the research field: my health-care experiences, the knowledge which I gained through MPH and my personal interaction with older people. Inter-generational relationships, for instance, were one of the main sensitizing concepts which acted as a starting point for this study and they emerged from my

interactions with older people as well as my initial contact with the literature. It will also become clear how these concepts shaped the participants' views and experiences of EM.

In qualitative research, the research/foreshadow questions serve as a guide to beginning the data collection. Unlike structured questionnaires in cross-sectional or quantitative research, the foreshadow questions in qualitative studies are often broader and changeable as the data collection and data analysis progress. Rodwell and O'Connor (1998) argue that foreshadow questions are the inquirer's inquiry and the product of his or her own autobiography because they are potentially shaped by his/her technical, non-technical or tacit knowledge. The research/foreshadow questions which emerged from the literature review and other sources in this study will be set out at the end of this chapter.

Because of the importance of the previous literature in CGT research and subsequently its role in the formation of the research questions for this study, I realised that it would be useful to appraise the previous literature in order to:

- gain insight, direction and familiarity from previous work and develop a better understanding of important concepts related to my study;
- identify gaps in the existing knowledge and justify the need to conduct the study; and
- identify potential sensitizing concepts to inform the study and use them to develop the research/foreshadow questions.

3.4 Search methods

In order to know what information and evidence exists in relation to EM among South Asians and particularly Pakistanis living abroad as an ethnic minority community, the most significant electronic databases in the international health and social sciences were searched (see the flow chart in Appendix 3). Search terms included the following key words singly and in combination: "elder mistreatment" OR "elder abuse"; "South Asian" OR 'Pakistan*'; 'community' OR 'family caregiving' (see Appendix 4 for the detailed search strategy). In addition to the electronic databases, a number of sources where grey literature can be found, such as Google Scholar, Centre for Policy on Ageing, Help Age India, Action on Elder Abuse and Age UK were also searched. A manual search of reference lists for relevant articles was

also conducted. Because little published research is available on EM in general and on ethnic minorities in particular (Erlingsson, 2007), qualitative and quantitative studies and literature review papers published in English worldwide during the period 1970-2015 were included. These dates coincide with the concept of EM being introduced (Baker, 1975) and South Asian mass migration (Anwar, 1978) to the UK. The mapping review method was used to review the available literature, bearing in mind the time and scope constraints (Grant and Booth, 2009). This form of review is useful for identifying gaps by mapping out and categorizing the existing literature on a specific topic. Grant and Booth (2009) stated that mapping reviews “enable the contextualization of in-depth systematic literature reviews ... offering ... researchers an explicit and transparent means of identifying narrower ... questions” (p. 97).

3.5 Data management and extraction

In total, 145 articles were located. Non-relevant studies were excluded after reading the titles, abstracts, and full texts using the inclusion and exclusion criteria (see Table 3.1). The flow chart shows the process for including the selected studies and filtering irrelevant studies (see Appendix 3)

Table 3. 1. Inclusion and exclusion of studies

Studies included	Studies excluded
Had a focus on South Asian, particularly Bangladeshi, Indian and Pakistani, participants	Had a focus on other than South Asian participants
Were conducted in home settings or community settings	Were conducted in institutions including nursing homes, care homes, hospitals, hospices
Had a focus on perspective, reporting, understanding and experiences of EM	Had a focus on the evaluation of training and screening programmes
Indicated the presence of risk factors of EM in South Asian communities	Had a focus on family violence where EM findings were either limited or confounded with data
	Articles written by the same author(s), published in different journals with the same methodology and findings.

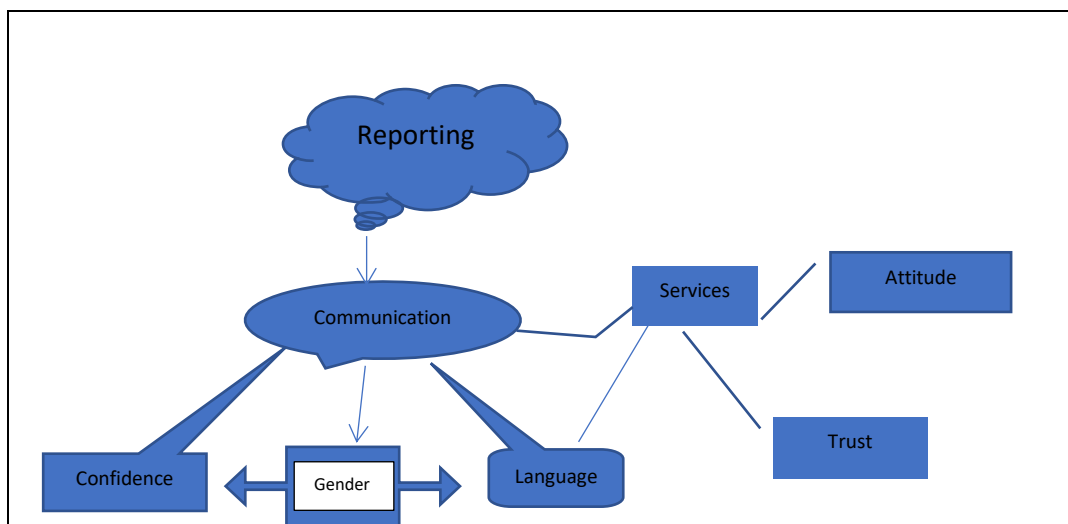
Nineteen articles were selected for the review which a) had a primary focus on understanding, experiences and reporting of EM among South Asians; b) indicated the presence of risk factors

of EM among South Asians living in western countries as ethnic minorities, preferably the UK, to assess their migration and other experiences relevant to the study topic, including five articles for their usefulness to the subject of study; and c) were relevant as a point of reference.

3.5.1 How findings from the literature review were extracted

For analysing the selected studies, a review process was used in order to identify relevant themes. First, I read the full text of the articles, highlighted their key findings, and then took a note of key words and later wrote a summary of important concepts on separate pages. A form of 'mind mapping' was used to structure and organize the themes (see Figure 3.1 for an example). Then the findings of each selected article on EM were matched and compared. These findings (themes) were then compared with the wider literature to see whether they were relevant, distinct and made sense. Finally, all these findings were examined to select key themes which appeared frequently in the literature or were significantly relevant to the participants of this study. The three key themes identified will be discussed after describing the data analysis of the selected studies.

Figure 3. 1. Mind mapping example of Reporting



3.6 Data analysis

Although the quality of the included articles was not assessed since this was not intended to be a systematic review, the strengths and limitations of the studies were appraised and are included in Appendix 5 with a description of the studies' purposes, methods and key findings.

Despite the fact that I did not use any checklist to evaluate the selected papers, both EM specific and EM relevant, the key concepts of two standard checklists/tools: CASP (Critical Appraisal Skills Program) and JAMA (Journal of American Medical Association) were applied when appraising the usefulness of selected papers for the review. All papers were assessed considering the following concepts:

- Were there a clear description of the study and that study questions are relevant to my field?
- Was the selected methodology appropriate to answer the research questions and important potential sources of bias?
- Was the recruitment strategy appropriate to the aims of the research?
- Were the measures accurately measured to reduce bias?
- Was the analysis of data sufficiently rigorous?
- How have ethical issues been address, especially the consent, privacy, and confidentiality?
- Was the transferability or generalisability of results to wider population explained?

Besides this, we selected papers that met the inclusion and exclusion criteria developed using the PEC (Population, Exposure, and Context) framework.

Population: South Asian, particularly Bangladeshi, Indian and Pakistanis

Exposure: Perspective or experience of EM or its relevant risk factors and most importantly the reporting and help seeking trends

Context: Community or family settings

As already noted, there is no universally agreed definition of EM; different authors used a variety of EM terms, sub-types and operational meanings of EM to measure the extent of EM in their cross-sectional surveys. This inconsistency in the terms and definitions used was my main concern in making a true comparison between the studies. Additionally, the tools used

to measure the prevalence of EM were not reflective of culture or country sensitivities, and some studies used non-standard measures which did not report the internal reliability and validity of their tools. Generalizability of findings was also found to be an issue in a few studies which did not clearly define their target population and did not ensure that their sample was representative of the defined population. Statements on the researcher influence in data collection and ethical issues such as consent, and approval were major missing data in qualitative studies (Nagpaul, 1997; Ploeg et al., 2013).

The analysis of the literature identified many important gaps, which supported my argument about the need for this study. Some of them are discussed next.

First, the literature search yielded no study in relation to EM which had been specifically conducted with Pakistanis living overseas, except for two qualitative studies in which Pakistanis were a sub-sample of broader ethnic groups (Ploeg *et al.*, 2013; Bowes *et al.*, 2012). This clearly suggests that Pakistanis are an under-researched group in overseas countries where they live as an ethnic minority. Bearing this in mind, a further five empirical studies were screened and selected which were relevant to the study population or had shown the presence of risk factors of EM in the selected population. However, these studies were not specifically focused on EM (*see Appendix 5*). These five additional studies were selected after reviewing the wider literature on the topic of EM. This strategy of cross-comparing EM studies on South Asians with the general literature identified some important concepts which were missing from the existing literature. Furthermore, as already explained, although caregiving stress has been identified as a major risk factor of EM, it was not the focus of many of the selected EM studies, so the other selected studies on caregiving trends in Asian populations provided a valuable insight into this problem.

Second, most of the EM studies had adopted a cross-sectional or quantitative design and only five were qualitative. The inherent limitations associated with a cross-sectional design (Chokkanathan and Lee, 2005) and the limited number of qualitative studies on the topic suggested that there is space for an in-depth exploration of the topic using qualitative measures.

It is important to take diverse perspectives in order to better understand the phenomenon of EM. Many of the previous studies were found to have participants who were predominantly

older people or professionals. One study was also found to have gathered the characteristics of caregivers (and potentially perpetrators) from the older participants because caregivers had not been recruited (Chokkanathan, 2014), clearly introducing a form of bias in the findings. I argue that taking diverse perspectives such as those of caregivers and other relevant groups and stakeholders, for example, community or volunteer members of organizations in addition to older people, is important for our understanding of EM. For example, a care provider can better provide an adequate and comprehensive account of caregiving stress compared with a care receiver or another person. If this information is gathered from someone other than a caregiver him/herself, it might actually hinder determining the appropriate interventions necessary to address the problem.

3.7 Theme 1: What is the understanding and extent of problem?

3.7.1 Is EM a foreign problem? Prevalence in South Asian populations

The literature review suggested that EM has been considered as an external or foreign problem among Asian communities living in South Asia or overseas (Chokkanathan and Lee 2005, Nagpaul 1997). Recent studies, however, clearly showed that EM is a growing social and public health problem among increasingly ageing Asian populations. For example, the analysis of cross-sectional studies included in this review showed that the prevalence of EM ranged between 9.3% and 40.94 % in South Asian communities. In a qualitative study of EM in ethnic communities in the UK, Bowes *et al.* (2012) found that 62% (n=40) of older participants perceived that older people are not treated well in today's society, both within families and more widely. Not only this, the literature review also showed that the incidence of EM is rising with growing numbers of ageing people when I compared two prevalence studies conducted on the same population ten years apart. Chokkanathan and Lee (2005) found that 14% of their 400 community-dwelling older participants reported EM where psychological abuse was reported as 10.8%, physical abuse 4.3% and neglect 4.3%, whilst ten years later, the mistreatment had risen to 21%, with findings on psychological abuse at 19.2%, physical abuse 12.3% and neglect 12.4% (Chokkanathan, 2014). These figures clearly indicate that EM is a growing social issue in Asian communities. Behind those figures, however, there was a perception which is distinct and predominantly culturally rooted. This will be discussed next.

3.7.2 What is perception of South Asians about EM?

The literature review revealed two significant limitations associated with exploring the perception of EM in South Asian populations: the types of EM and the behaviours explored in these types. The majority of the previous studies measured the specific types of EM which are predominantly studied in western populations in order to develop an understanding of EM in South Asian populations. I would argue that South Asian populations may not necessarily consider all these types as EM or would discuss them as EM. Sexual abuse, for example, was one of five major types of EM studied, and to a degree found prevalent, in western literature and among western populations. However, it was found to be the least discussed form of EM in the Asian literature, perhaps as a consequence of the cultural boundaries associated with discussing sexual matters in public or with strangers (Kaur et al., 2015; Tareque et al., 2015; Bowes et al., 2012a). In a qualitative study of EM in BME communities, Bowes *et al.* (2012) reported that South Asians do not identify sexual abuse as a type of mistreatment.

Disrespect, on the other hand, was the least studied form of EM in the selected studies. Only two studies specifically studied disrespect as form of EM in their populations (Bowes et al. 2012, Skirbekk and James 2014). As was explained in Chapter 2, the loss of respect and status are critical issues for older people in the face of changing societal norms. This suggests that exploring culturally specific types of EM is important. In India, Skirbekk and James (2014) reported that disrespect (6%) was the most common form of EM. In the UK, similarly, Bowes *et al.* (2012) reported that 74% of ethnic participants identified disrespect as a culture-specific type of mistreatment, suggesting that those people identified and perceived EM differently from the general public. This also exemplifies that people do not simply migrate; they bring their cultural values with them. These findings are important and help to contextualize the current study.

The behaviours examined by many of the selected studies in order to develop an understanding of EM in South Asian populations was another major theme which emerged from the literature review. Most of the previous studies conducted with South Asian populations were cross-sectional and/or quantitative, they often adopted measures which have been used in western studies to identify the behaviours which count as EM in their own populations. However, the nature of structured interviews and the western tools used are

critical limitations to exploring the taken-for-granted meanings and understanding of EM among ethnic groups. Bowes *et al.* (2012), for example, reported that rather than acknowledging some behaviours as abusive in structured categories, the ethnic communities recognize acts on a bad and good treatment continuum.

Similarly, Nagpaul (1997) made a distinct and interesting finding on EM: a participant reported experiencing psychological neglect and starvation as a Hindu vegetarian because families did not adhere to the religious restriction of not cooking meat and vegetables in the same utensils. This finding is relevant to the current study because Muslims also put great importance on *halal* food.

In ten focus group discussions, Ploeg *et al.* (2013) found that ethnic groups held a different perspective of EM from native Canadians. For example, a Latvian participant made a comparison with Canadian behaviour and regarded the institutionalization of older people as elder neglect because it represented the failure of familism. Similarly, Asian participants identified EM predominantly in public places. For example, a participant in Ploeg *et al.* (2013:411) study reported that: *“First they started with verbal abuse. Then the teenager girls, they pushed the turban, it came down and they just ran away with the turban! (FG4-3)”* These findings are relevant to the current study and suggest the importance of gathering information on behaviour which has not been otherwise explored in the western literature.

Diversity in perception is an important source for gathering rich and thick information on EM, but it was lacking in several of the selected studies. Only a few studies provided meaningful insight over a wide range of perceptions across different ethnicities (Ploeg *et al.* 2013, Bowes *et al.* 2012), and the majority of the studies focused only on older people (Chokkanathan *et al.*, 2014; Kaur *et al.*, 2015; Saikia *et al.*, 2015) and yet failed to explore the influence of age and other important factors on the understanding of EM. As was noted in Chapter 2, the younger migrant generations are said to be experiencing rapid societal changes. Given that they are, or are likely to be, the main care providers for older parents, their perspective on EM is of significant importance. By exploring participants' views on a series of hypothetical statements, for example, Nagpaul (1997) reported that young people and older people held different opinions on each statement. On one statement, for example, older people believed that it is a grandparent's right to be involved in their grandchildren's upbringing whereas young participants respectfully disagreed.

It is therefore important to explore what behaviours could be added into knowledge which is specific and/or relevant to particular communities, in this case Pakistani people. It is not only how people perceive a phenomenon which need to be explored, but what causes it is also an important question, so I shall consider this theme next.

3.8 Theme 2: What are the causes of EM for South Asian Elders?

The risk indicators which describe the vulnerability of older South Asians at different interpersonal, contextual and societal levels are discussed below.

3.8.1 Social structures and processes and EM

Recent changes in social structures and processes, notably modernization, individualism and urbanization, have been linked with the weakening of cultural values and family relationships in Asian communities (Nagpaul 1997, Jamuna 2003, Chokkanathan and Lee 2005). However, much of the literature has focused predominately on material losses such as care giving and financial abuse, and these are trends which occur in family relationships. Jamuna (2003), for instance, analysed two Help Age India reports to identify the financial loss from elder care suffered by children. He reported that in 1984, 91% of adult children regarded it as their duty to care for their older parents compared with 77% in 1994. Discussing the rise of individualism in India, Nagpaul (1997) similarly explored financial abuse and reported that it was a result of children “becoming restless” and greedy, and thus defrauding their parents.

How the recent rapid societal transformation has shaped and influenced the perceptions and experiences of older peoples’ emotional and psychological well-being are also critical questions which have received little attention in previous studies. By studying the factors which influence the quality of life of older ethnic people in the UK, Grewal *et al.* (2004) reported that having a role in the family was an important aspect of older people’s psychological well-being which older participants believed gave them a sense of purpose and a feeling of usefulness. Similar findings were reported by another study suggesting that the loss of role and status was an important factor in older people’s perception of EM: in the UK, Bowes *et al.* (2008) interviewed 58 older ethnic participants with the aim of identifying the impact of cultural diversity on their understanding of EM. They found that social factors such as ageism were strongly linked with EM when the social position of the older person was lost. The older participants in the study reported that they were not well respected in their society because their children were not living up to their traditional cultural and religious values

whilst living in the UK. These results show that growing old in a foreign land might have greater psychological implications for traditional older people, and consequently their perception of EM.

In order to explore the importance of key issues such as migration and modernization, Nagpaul (1997) compared the different perspectives of EM in the context of traditional cultural values and the effects of modernization in India and the acculturation among Indian minorities in the US. The participants in India reported few distinct factors leading to their financial and psychological mistreatment. In the US, the researchers used hypothetical statements adopted from Anetzberger *et al.* (1996), whose study had included four different ethnic American groups, to gather their respondents' views on EM. Even though the methodological limitations associated with questionnaire methods discussed above only generated popular findings, Nagpaul (1997) found that older people feared that the traditional values were being replaced by western individualism, and as a result, they often felt excluded.

Although Asian traditions and cultural norms are being diluted in today's world, they are still pervasive, and some of them have a negative impact, particularly in terms of gender, and this theme will be discussed next.

3.8.2 Gender and relationship status

Consistent with major survey findings about gender, older women have been reported to be more at risk of abuse in Asian communities (Chokkanathan and Lee 2005, Skirbekk and James 2014, Saikia *et al.* 2015). For example, Chokkanathan and Lee (2005) found that women (31.5%) compared with men (15.8%) were more frequently mistreated (X^2 value = 13.53, $p < 0.001$) in India. A significant number of older women were psychologically abused (F-31.3% vs M-14.4%, X^2 value = 16.35% $p < .001$), physically abused (F-6.6% vs M-2%, X^2 value 5.16%, $p < .05$) and neglected (F-9.1% vs M-4.0%, X^2 value = 4.331%, $p < .05$). Similarly, Skirbekk and James (2014) found that more women than men reported experiencing mistreatment in most forms of EM.

One of the key factors associated with the experience of mistreatment of women was their dismal socio-economic status, particularly their literacy rate, in society. Studying the relationship between economic well-being and EM in Bangladesh, Rahman *et al.* (2010) found

that participants with little or no education were 2.59 times more likely to face EM compared with other reference categories. These findings were supported by another Bangladesh study which reported that limited education and economic status were linked with female victims' lack of awareness of resources and support (Tareque et al. 2015).

Nevertheless, a few studies found that power and control in their relationships was a major cause of women experiencing EM. Bowes *et al.* (2012), for instance, reported that BME participants stated that the restriction of women's social mobility reduced their chances of social support, potentially increasing their vulnerability to mistreatment. Similarly, Dildar and Saeed (2012b) found that women were less valued and more controlled, and were therefore more vulnerable in male-dominant societies such as Pakistani communities. A widow participant told them, "I am shocked at his [her son's] verbal abuse When his father was alive, he used to control him", and another woman reported that " ... he [her son] stole all the money that I had accumulated"(p.665). These comments clearly indicate that marital status is a significant indicator and that being widowed can heighten the risk of older women being mistreated. Rahman *et al.* (2010) reported that older widows were 2.36 times more likely to experience EM than married women.

Although the studies discussed above explored and reported interesting findings, the researchers seem to have looked at single causative explanations when investigating gender variations. By analysing the results of these studies, I realised that the risk factors (such as socio-economic status and marital status) could overlap and that where they intersected potentially exacerbated women's risk of mistreatment, and I consequently decided that this issue needs further exploration.

The findings discussed above are relevant to the current study because female literacy levels are low in Pakistan, and it will be interesting to look for a link between the education levels of migrated women and their risk of EM. It will also be important to find out how widowed Pakistani women cope with being migrants in the UK, especially if they possess low socio-economic skills. Socio-economic status is one of the key factors in understanding EM and I consider this next.

3.8.3 Socio-economic status

Poverty in later life has been identified as a significant source of EM among Asian ageing populations (Rahman et al. 2010, Chokkanathan 2014). For example, Rahman *et al.* (2010) found that poverty, a decreased capacity to earn and economic dependency were the combined causes reported by 21.3% of the victims of EM in their study. Other studies have supported this view, finding that older people with moderate to high material and economic resources were in a better position to resist the threat of mistreatment or to contact services for help, so they were less likely to encounter abuse (Tareque et al., 2015; Gaikwad et al., 2011).

Globally, there is a considerable debate about how poverty shapes and influences IG relationships and consequently family harmony in the household. At present, however, previous studies were found to have explored only the socio-economic dependence of older people on their children and *vice versa*. Similar to the studies discussed above, for example, Chokkanathan (2014) investigated the factors associated with EM in rural India and reported that unemployment of the perpetrator was a significant variable of EM. Grewal *et al.* (2004) reported interesting results about the relationship between the low income of older people and its impact on their IG relationships. Being the (traditional) head of the household, older Pakistanis reported their failure to fulfil their proper parental obligations towards their children because of their poor socio-economic status.

The wider literature suggests that household income, rather than the poor socio-economic status of an individual, is an important aspect of looking into the causes of family disharmony and consequently EM. I believe that one of the reasons that this issue was missing from the literature relates to the limited diversity in the participants recruited for those studies. Not only wealth, but also health status plays important role in increasing vulnerability of EM in later life, therefore, I shall consider this next.

3.8.4 The characteristic of health

It was stated in the previous chapter that physical impairment and/or dependency and mental health are recognized as predictive risks of EM, and the findings from the literature review on this issue were also consistent in Asian populations (Chokkanathan and Lee, 2005; Rahman et al., 2010; Gaikwad et al., 2011). For instance, in an analysis of 400 community-dwelling older people in India, Chokkanathan and Lee (2005) found that older people who were more

depressed and less satisfied with life faced EM more frequently than those who were not. Specifically, multi-faceted mistreatment was significantly positively associated with depression ($r = .30, p < .05$) and negatively associated with life satisfaction ($r = .49, p < .00$). Similarly, Rahman *et al.* (2010) reported that cognitively fit individuals were generally healthier, wealthier and lived more social lives and were therefore less likely to face EM.

From these findings, it seems that physical and mental impairment leads to the dependence of older people on others, which potentially heightens their risk of EM. Although Ahmed and Walker (1997) did not set out to examine the relationship between EM and its risk factors, their findings nevertheless provide valuable insights into the physical implications of poor health on older people. More than half of their participants, for example, reported that they were experiencing chronic health problems which were linked with difficulties in walking and performing household chores.

The intersection of poor health with other risk factors, however, could provide a deep insight into understanding the increasing risk of EM. Poor health does not just lead to physical dependency, its implications are manifold. This was highlighted by Grewal *et al.* (2004), whose study was not specific to EM but who nevertheless found that their participants from ethnic minority groups reported that long-term sickness was the main cause of their early retirement and consequently their socio-economic reliance on only the state pension.

Overall, these findings suggest that the characteristics of physical and mental health among South Asians could increase their dependency on others, and this might include their reliance for care. I shall therefore consider this risk factor next.

3.8.5 The burden and stress of caregiving

Despite being contested, caregiving stress remains a widely studied risk factor of EM in the general western literature. In this review, however, only two studies (Chokkanathan 2014, Bowes *et al.* 2012) were found to have looked at this variable, potentially suggesting a sensitivity attached to questioning the traditional norms of family caregiving in Asian families. Bowes *et al.* (2012) made only a passing reference to modern pressures on children's lives and its relationship with caregiving stress and EM.

As discussed in the previous chapter, common stereotypes in the literature are that Asian families 'look after their own' and consider family caregiving as their innate duty. I would

argue that these assumptions are problematic and the impact of stress on caregivers needs to be explored. I looked at studies which had been conducted with South Asian and specifically Pakistani caregivers to acquire information about their experiences of caregiving. Those studies reported that although the ideological commitments to caregiving (in other words, familism) were strong in South Asian participants, this did not translate into caregivers' willingness to provide care (Katbamna et al., 2004; Parveen et al., 2013). In a comparative study, Parveen *et al.* (2013) found a higher level of depression and anxiety among British South Asians compared with white British caregivers, as most Asian caregivers felt obliged rather than wanted to provide care, and had limited social support.

In the absence of formal sources of support, what a social network community can offer is a critical question, which I discuss next.

3.8.6 Social networks and feeling of loneliness

It was explained in the previous chapter that there is substantial evidence that social isolation is a risk factor for EM. The literature review identified studies which regarded the lack of social support as a potential indicator of EM among South Asian populations (Chokkanathan and Lee 2005, Bowes et al. 2012). In India, Chokkanathan and Lee (2005) found that urban migration, particularly among young people, was a major risk factor of social isolation for older people.

In terms of Pakistanis living in the UK, the stereotype exists that loneliness is uncommon and that community support is always there because Pakistanis live in multi-generational households (Ahmad and Walker, 1997). As was noted earlier, however, such close and extended kinship support networks are beginning to disappear with the rising societal changes which encourage nuclear families. As a result, social isolation is a growing issue among older Pakistanis. Bowes *et al.* (2012) reported that participants believed that fewer visits from their children was a form of interpersonal mistreatment.

Isolation is often regarded as living alone but I would argue that this perception is problematic. Recent research findings have suggested that large households are not necessarily a protective factor against older people's experiences of isolation and loneliness. In Canada, Ng and Northcott (2015) examined the relationship between self-reported loneliness and the living arrangements of South Asian seniors and found that 37.3% of the

respondents who lived in large household stated that they felt lonely. This finding shows that it is important to understand the quality of family and IG relationships rather than simply regarding living arrangements as a significant indicator of the perceived feelings of loneliness.

These findings are important because they focus on isolation in IG and family relationships, but most importantly they direct us to look at the issue from an intersectional aspect, given that migration and its associated negative impacts could increase the risk of social isolation among older people, and consequently their risk of mistreatment.

3.9 Theme 3: Reporting abuse and seeking support

Given that some risk indicators of EM have been identified as culture-specific, it was not surprising that the studies which focused on help-seeking reported that cultural norms, family obligations and religious beliefs influenced the preparedness of South Asian to consider using health and social care services (Bowes et al., 2012a; Chokkanathan et al., 2014). As stated in the previous chapter, older people from different cultural groups react and respond differently if they are faced with EM. It is therefore important to understand the help-seeking behaviour in this community if better services and support structure are to be developed.

In India, Chokkanathan (2014) interviewed six older people who had been physically abused by their family members but had not sought help. The study revealed some unique findings relevant to the religious beliefs of the participants, such as *karma*, self-blame and past sins, and “concern over not attaining salvation if one’s son did not perform funeral rites” (p.60), as barriers to reporting mistreatment. That study, however, had limitations, such as that it primarily reported the Hindu religious perspective, studied only one form of EM, and had a sample too small to generalize the findings. However, the findings were distinct from the general literature on EM and were relevant to the current study considering the influences of modernism, migration and acculturation on Pakistanis living in western countries.

In the UK, Bowes *et al.* (Bowes et al. 2012) conducted qualitative interviews with eighteen South Asians, seventeen white Europeans, twelve Chinese and eleven Afro-Caribbeans to inform their understanding of and actions taken in regard to EM. Comparing their findings with those of O’Keefe *et al.* (2007), Bowes *et al.* reported that 81% of their BME participants compared with 68% of the whites reported by O’Keefe *et al.* would do nothing about EM.

Bowes *et al.* reported that BME participants stated that complaining against their own blood would raise questions about individual loyalty to family and community.

The majority of the studies on ethnic communities, however, have focused on the cultural and religious barriers to seeking support. The access, availability and appropriateness of sources of support, whether it is formal or informal, are important channels of, as well as major barriers to, addressing EM. A qualitative study reported that lack of trust and low awareness of services were considered to be the main reasons why victims of EM did not seek support from the relevant services (Chokkanathan *et al.*, 2014). One of the major issues associated with trust was regarded as the fear among victims about whether the service providers would understand their situation or not, despite the fact both service provider and the service user use the same language.

Language differences, however, have been reported as a principal restricting factor for BME participants in reporting EM in the UK. Bowes *et al.* (2012) reported that their Chinese participants identified language deficiency as a major barrier to them in seeking support if they faced EM. Surprisingly, the UK Office for National Statistics (2012) reported that about 800,000 people who had migrated to England could not speak English well or at all, and that most of them were older people. These findings are relevant and important to the current study because literacy and linguistic proficiency, particularly among older Pakistani women, is limited.

The literature review clearly identifies different and distinct factors which might present barriers to reporting and seeking support in regard to EM, and a better understanding of Pakistani people in the UK context is required.

3.10 Conclusion

As identified above, there are many reasons why the current study is important. First, the review showed that there is dearth of empirical studies on EM from the perspective of older Pakistanis in general, and minority Pakistanis in western countries in particular. The need to enhance further the understanding of EM is also timely and particularly important as the first young Pakistanis to migrate to the UK are now becoming old and their numbers are expected to rise.

Second, it was also evident that the perspective on EM are culturally rooted, and therefore acts which have appear abusive in one culture might not hold same meaning in different contexts and different cultures.

Third, the risk factors for EM identified as varied and distinct in Asian communities, predominantly underpinned by their social, cultural and religious ideologies. It is therefore important to examine the values, beliefs, norms and customs which underpin the concept of 'abuse' and which are used to justify the mistreatment of older people in Pakistani communities.

Fourth, the literature review suggests that there are multiple barriers – cultural, social and religious –, which explain to the under-reporting of EM. However, little research exists to explain how sources of support, whether formal or informal, shape and influence the help-seeking trends in the community.

Fifth, the existing knowledge on EM focuses predominantly on the perspectives of older people and professionals, but the perspective of family caregivers and other relevant stakeholders is significant for better understanding EM; it is missing in the literature, a gap which the current study is designed to address.

Finally, the existing studies conducted on South Asian communities suggest methodological pitfalls in explaining EM. For example, the majority of studies in the literature are cross-sectional and report limitations associated with their research designs. A robust study with a qualitative methodology is needed to further enhance the understanding of EM in Pakistani communities, and the current study is planned to provide that.

This all suggests the need for a study which develops an understanding of EM within Pakistani communities.

The research/foreshadow questions which developed from these sensitizing concepts and emerged from the literature review and my own prior knowledge are:

- What do community members understand by the term 'EM'?
- What are the social, cultural and material factors which shape and maintain the practice of EM?
- What are the barriers which communities face to reporting EM?

- What are the strategies and coping mechanisms for dealing with EM?
- Based on the questions above, is it possible to construct a theory which could inform the understanding of EM among community-dwelling older people, young family caregivers and community stakeholders in the UK, and which can be used to improve both practice and research?

How these questions are addressed depends on the methodological choices made for this study and I shall discuss these in the next chapter.

Chapter 4

Methodology

4.1 Introduction

This chapter presents the methodology which guided this study. In this section, an outline and justification for the use of the qualitative research approach, the philosophical underpinning and assumption (the constructivist paradigm) and the strategy of inquiry (constructivist grounded theory) are provided. First, the rationale for selecting the qualitative approach will be presented, and then the process (see Table 4.1) which the qualitative researcher adopts to seek answers to a research inquiry will be discussed, in this case, the foreshadow questions which were developed from the literature review in Chapter 3. Table 4.1 shows the five phases which form the qualitative process: the researcher, the theoretical paradigm, the research strategies, the methods of data collection and analysis, and finally the evaluation of the study. An explanation will be given for adopting constructivist GT as the research strategy and for describing the application of GT principles in this study. However, the basic principles of GT (analytic coding, memo writing, theoretical sampling, theoretical saturation and constant comparison) will be discussed at the end of the chapter. Furthermore, I shall give an account of methods of data collection (interviewing and focus groups) which I used and the rationale for selecting each of the approaches. The researcher's role in qualitative research, the quality criteria used to judge the robustness of the study and the ethical issues involved will be discussed systematically throughout the phases of the qualitative research process. Before I begin to discuss the qualitative process, I shall first explain my initial engagement in this field.

4.2 Pre-protocol fieldwork

As described earlier, I carried out some piloting work to clarify a few of the research concerns. Not only did this affect the shaping of the research questions developed, it also had an influence on the methodological choices. Although this piloting work will be discussed in later sections of this chapter, I shall explain briefly here what it actually entailed. The pre-protocol fieldwork involved piloting and discussing the research documents (participants' information sheet and consent form), interview guides and issues around the recruitment of participants (for example, gender issues and access) and the selected population's

homogeneity/heterogeneity. The outcomes of this initial engagement with the research field are detailed and attached as Appendix 1.

As explained in different sections of the thesis, I selected three different categories of participants: stakeholders, older people and unpaid family caregivers. In the piloting phase, three interviews were conducted with participants from each category. The recruitment of the participants in the piloting phase was similar to the approaches taken during the actual recruitment process. The details on recruitment of participants are explained in section 4.8.2; Sample and Sampling. In brief, the stakeholders were identified via an internet search and personal contacts. In the piloting phase, I contacted one of the stakeholders who works for a local charity. I asked him if he wants to take part in the piloting phase of the study. Once agreed, he was interviewed. An older person interviewed was identified via personal contacts, she was aged 55 and was living with her daughter. During the fieldwork and discussion with stakeholders, an unpaid family caregiver was identified and contacted for a pilot interview. The unpaid caregiver was living with and looking after their parents aged over 60 years.

4.3 The Research Approaches: Why Qualitative?

Epistemologically, there are two major perspectives – positivism and interpretivism, both of which raise questions about what is acceptable knowledge on a particular subject (Bryman, 2008). The positivist view places emphasis on prediction, control of events and variability, and value-free knowledge (Rodwell and O'Connor, 1998). In contrast, the interpretivist view places emphasis on the subjective meaning of social action (Bryman, 2008). A key difference between these two perspectives is that the positivist approach predominately adopts quantitative research whilst the interpretivist approach uses qualitative techniques for understanding the nature of reality, so attention will now turn to these different approaches.

In both of these two broad approaches to research – qualitative and quantitative – researchers believe that they know 'something' (such as reality, truth or knowledge) about society which is worth telling others (Becker, 1996; Denzin and Lincoln, 2005). However, the approaches differ in their ways of exploring and explaining that 'something' or the nature of the reality or knowledge in terms of their epistemological positions; thus, the research styles and the processes vary but both are useful in their own ways.

The quantitative researcher sees reality or knowledge or truth as physical phenomena which can be observed, studied, captured, measured or quantified objectively (Bryman, 2008). They therefore use the quantitative approach for the purpose of isolating “cause and effect ... operationalizing theoretical relations ... [and] measuring and ... quantifying phenomena ... allowing generalization of the findings” (p.3) (Flick, 2002).

On the other hand, the qualitative researcher sees the reality or truth or knowledge as a social phenomenon which is socially constructed rather than a universal given contingent on its social and natural context (Draper, 2004). The researcher therefore uses the qualitative approach to gain a thick description of the phenomena of inquiry so that meaning, beliefs and behaviours can be described and explained within the context in which they occur.

The aim of this current study is to explore the meaning and interpretation of the mistreatment of elders and to further develop a theory. Since the meanings and experiences are expressed subjectively, a qualitative methodology was chosen because it offers a process of discovering social realities (unique interpretations) by making subjective experiences and meanings visible and true to participants’ own cultural and contextual ways of living them.

In addition, a qualitative approach to this study is appropriate for the following reasons.

1. The research problem requires detailed understanding and in-depth exploration because it is complex and under-studied. Furthermore, the study factors are not easily measurable through ‘how many’ questions.
- The current evidence suggests that EM is a hidden, sensitive, under-studied and under-reported phenomenon in ethnic minority communities. Furthermore, the review of the literature identified distinct views and characteristics of the populations of previous studies in relations to EM. So the research questions developed from the literature review, and most importantly from my early engagement with the field, predominately focus on ‘what’, ‘how’ and ‘why’ question. With this in mind, I believe that the use of an exploratory approach, that is, a qualitative approach, would be the most useful for forming a well-grounded picture of the situation.

2. The study population is potentially isolated and vulnerable. Their voices, their meanings and their interpretations need to be facilitated and explored more openly in a natural context.
 - Within the UK, in terms of research, there is evidence to indicate that ethnic communities are a marginalized (Ahmad and Walker, 1997), hard-to-reach group (O'Keeffe *et al.*, 2007), and their vulnerability to mistreatment is likely to increase (Bowes *et al.*, 2012). Furthermore, the current knowledge of EM was found to have western definitions and explanations; therefore, the perspective of ethnic communities, particularly Pakistanis, is invisible in the previous research. In this current study, I want to give a voice to the perspective of the participants to express themselves in their own natural context.
3. Partial and inadequate explanations exist for particular populations, and a new theory designed to capture the complexity of the problem is required.
 - The review of the EM literature suggested that Pakistanis are an under-researched group, and inadequate explanations exist about 'what' and 'how' various social, structural and contextual factors increase the vulnerability of EM in the community. Furthermore, the role of migration, modernism and a changing social process influencing the cultural norms of filial piety in Pakistani communities is missing in the literature. These are the important concepts which need adequate explanations in order to understand complex nature of EM in Pakistani communities living in the UK.

(Adapted from Creswell, 2013:47-48)

After justifying the selection of the qualitative approach for this study, I shall now explain how this approach places philosophy and theory into perspective in the research process.

4.4 Qualitative Research as a Process

Denzin and Lincoln (2005) stated that qualitative research is a process which is underpinned by three interconnected activities, ontology, epistemology and methodology. Behind these generic activities lies the personal biography of the researcher, who comes with set of ideas and questions about inquiry: knowledge, truth, reality. The process comprises five key elements which a researcher needs to follow in order to conduct a systematic and rigorous qualitative research study (*see* Table 4.1). I shall use this process as the basis for the structure

of the remaining sections of this chapter in order to outline the decisions which I made for the methodological aspects of the study.

Table 4. 1. Research Process (Denzin and Lincoln, 2005)

Phases of Qualitative Research	Key characteristics
Phase 1: Researcher	<p>History and research traditions</p> <p>Conceptions of self and other</p> <p>The ethics and politics of research</p>
Phase 2: Theoretical Paradigms and Perspectives	<p>Positivism, post-positivism</p> <p>Interpretivism, constructivism, hermeneutics</p> <p>Feminism(s)</p> <p>Racialized discourses</p> <p>Critical theory and Marxist models</p> <p>Cultural studies models</p> <p>Queer theory</p>
Phase 3: Research Strategies	<p>Case study</p> <p>Ethnography, participant observation, performance ethnography</p> <p>Phenomenology, ethno-methodology</p> <p>Grounded theory</p> <p>Life history, testimonials</p> <p>Action and applied research</p> <p>Clinical research</p>
Phase 4: Methods of Collection and Analysis	<p>Interviewing</p> <p>Observing</p> <p>Artifacts, documents and records</p> <p>Visual methods</p> <p>Auto-ethnography</p> <p>Data management methods</p> <p>Computer-assisted analysis</p> <p>Textual analysis</p> <p>Focus groups</p> <p>Applied ethnography</p>
Phase 5: The Art, Practices, and Politics of Interpretation and Evaluation	<p>Criteria for judging adequacy</p> <p>Practices and politics of interpretation</p> <p>Evaluation traditions</p> <p>Applied research</p>

4.5 Phase 1: The Researcher

In qualitative, constructivist research, the researcher is considered as an instrument of data collection (Rodwell and O'Connor 1998). However, researchers no longer engage in 'value-free' inquiry; they bring a personal biography into their research, such as their personal history, culture, and a view of themselves and others (Creswell, 2013; Denzin and Lincoln, 2005). Charmaz (2014) suggested that social reality is multiple, processual and socially co-constructed and noted that the researcher has position, power and privileges in those constructions. She also emphasised the idea that self can contribute to the ways in which the research encounter is constructed, so I felt that I needed to disclose my predetermination because it might influence the study.

In terms of positionality, I declare the following

4.5.1 Personal life and perspectives

I am British Pakistani who has lived in the UK since 2004. I have a wife and two children. My parents live in Pakistan but they visit us every other year. My father is 70 and my mother is 64. I constantly feel that I have been unable to look after my parents very well because they do not live here with us permanently. Therefore, when they visit us, I try to have as much quality time with them as possible by talking about different topics. In our discussions, we often end up comparing the living standards of older people here and back home in Pakistan. My Baba (Dad) always says that despite all of the facilities for older people here in the UK, his soul and mind find peace and rest with the relatives and friends with whom he grew up and with whom he spends his time.

I believe that these exchanges might have influenced the way in which I presented questions to the participants about the current caregiving ideologies within Pakistani communities. These points are detailed later in Chapter 8 when reflexivity is discussed.

IG relationships with my own children, on the other hand, have always been a major concern for me. Because my children were born in the UK, I fear that they might hold different views on various things which might not match my own perspectives as I was born and brought up in Pakistan. I assume that my own concerns about IG relationships might correspond with the views of the research participants, as older participants share a similar history and nativity.

On the other hand, I have been working as registered nurse for the last ten years in different health-care specialities across different environments: the NHS, community care and nursing homes. In nursing homes, I had opportunities to look after and to talk in detail with older people about the different concerns which they faced, including health and care. However, I rarely met anyone from a Pakistani community in nursing homes. When I was working as registered nurse in a hospital, I had many discussions with older people from ethnic minority groups and their families about their treatment in the community and in wider society. The major concerns which older people shared were about how to preserve their cultural and religious norms in the UK.

This might have influenced the way in which I presented questions to young participants who held different views on cultural values. These points are discussed in reflexivity section, Chapter 8.

4.5.2 Research approach: Data collection and analysis

Having discussed my personal perspectives and the influences which they might have on me and the knowledge gained from the literature review, I have clarified a few of my predeterminations and pre-conceptions about the topic. However, I have remained open-minded in designing the data collection instruments (interview guides) and remained open to participants' own perspectives. Furthermore, the interview guides were piloted to ascertain their credibility and usability in this study. This is further discussed later on in this chapter.

I shall also discuss in this chapter how I approached and presented myself to the participants, how they were recruited, the information and explanations which they received prior to taking part to study, the freedom and choice to which they were entitled as participants in an academic study, and the power and influence which they might have perceived I have.

I shall also explain any influences which I might have exerted on the data analysis of this study. GT principles such as constant comparison and memo writing were applied in order for me to evaluate my own preconceptions and the ways in which I avoided imposing them during the initial and the focusing coding and in later theory development. I also kept a reflexive journal in order to identify and reflect on my biases in the study.

After discussing my views and beliefs which might have had influenced the study, I shall now discuss my theoretical orientations which underpin the research.

4.6 Phase 2. Theoretical Paradigms/Perspectives

A research paradigm guides researchers on how to make decisions and conduct a study. Denzin and Lincoln (2005:22) described them as a “set of basic beliefs” whereas Annells (1996) views them as a “set of propositions that explain how the world is perceived” (p. 383). There are four main paradigms (metaphysics) of alternative inquiry (see Table 4.2). Each paradigm offers a different way of looking at social reality, so there is no objective ground for selecting a particular research paradigm. These paradigms are selected for their usefulness and are often directed by the ontological position of researcher. However, their usefulness depends predominantly on how they address the philosophical questions in terms of study objectives:

1. **Ontology** – what is the nature of reality?
2. **Epistemology** – what is relationship between inquirer and reality?
3. **Methodology** – how do we gain knowledge of it?

Table 4. 2. Basic Beliefs (Metaphysics) of Alternative Inquiry Paradigms (Denzin and Lincoln, 2005)

Item	Positivism	Post-positivism	Critical Theory	Constructivism
Ontology	Naïve realism – ‘real’ apprehendable	Critical realism – ‘real’ reality but only imperfectly and probabilistically apprehendable	Historical realism – virtual reality shaped by social, political, cultural, economic, ethnic and gender values, crystallized over time	Relativism – local and specific constructed and co-constructed realities
Epistemology	Dualist/objectivist; findings true	Modified dualist/objectivist; critical tradition/community; findings probably true	Transactional/subjectivist; value-mediated findings	Transactional/subjectivist; created findings
Methodology	Experimental / manipulative; verification of hypothesis; chiefly quantitative methods	Modified experimental /manipulative; critical multiplism; falsification of hypotheses; may include qualitative method	Dialogic/dialectical	Hermeneutical/dialectical

In the following paragraphs, I explain how and why the selected paradigms were considered useful to the ideas and questions which I have brought into this study.

The subject under study EM is a complex phenomenon and the literature review and importantly my own prior knowledge suggested that the views of older people, their families and care professionals are distinct but interwoven in numerous social structures (such as gender) and processes (such as migration). The nature of social reality would therefore probably be culture- and context-dependent; as a result, I wanted to take an ontological position which would acknowledge all these different perspectives (multiple realities) in equal value within their own local and specific contexts.

Beside the fact that the perspectives are varied and multiple, the literature also suggested that previous research and knowledge of EM in ethnic minorities is limited although distinct, so any new research would need to look for a complexity of views. As a result, the current study needs to take an epistemological position which develops relationships between researcher and participants in which shared meanings (social reality) are actively negotiated. Creswell (2013) believed that subjective meanings are not simply imprinted on individuals, so I wanted to take the epistemological position in which reality is co-created rather than objectively discovered in order to address questions raised by the literature review.

Meanings and interpretations can be different and can be negotiated, however, they cannot be measured in the true sense, so I believe that this study would benefit from taking a methodological position which enables participants to discuss and explore the meanings and interpretations which are important to their worldview. Furthermore, a methodological approach which is flexible and could encourage an ongoing dialogue with research participants would be useful for gaining a deeper understanding of EM in Pakistani communities in the UK.

Although a range of paradigms is open to qualitative researchers, it is important that the choice of paradigm is consistent with a researcher's own worldview and assumptions. After reviewing the paradigmatic assumptions of the four basic beliefs of inquiry (see Table 4.2), I felt as a researcher most closely aligned to the constructivist paradigm for addressing the research questions in a useful way.

Denzin and Lincoln (2011) described the constructivist paradigm as having:

- A relativist ontology in which realities exist in the form of multiple mental constructions, socially and experientially based, local and specific, dependent for their form and content on the individuals who hold them.
- A subjectivist epistemology in that inquirer and inquired are fused into a single entity so that the findings are literally the creation of the process of interaction between the two.
- A hermeneutic-dialectic methodology through which individual constructions are elicited hermeneutically first, and then compared and contrasted dialectically, with the aim of developing consensus on them.

As explained in the previous chapter, the aim of this study is to develop a theory which is formed from tentative suppositions which describe the relationships between EM and the study populations, in this case Pakistanis living in the UK. My initial understanding of the nature of reality in this case is based on the literature review and supplemented by my own prior knowledge, that the social reality of ethnic communities of EM is the product of their own consciousness, therefore it is distinct. However, as was explained in the literature review chapter, EM is a complex and little-studied phenomenon in Pakistani communities, therefore a subject-subject dualism, where an inspired inquirer and a marginalized population construct and negotiate their influences in the formation of the knowledge, here a resultant theory of EM, will be useful. I therefore believe that the constructivist paradigm best fits to answer the research questions and the three basic paradigmatic questions discussed above. I now consider the research strategy (Phase 3 of the research process) which best fits the selected constructivist paradigm.

4.7 Phase 3. Research Strategy

The third phase of the research process is concerned with research strategies and methodologies which provide theoretical justifications for selecting particular methods for collecting and analysing the empirical material. Denzin and Lincoln (2011) suggested various strategies (*see* Table 4.1) of qualitative research which can be used to investigate a research question, but the strategies which manifest the constructivist worldview are suggested to be

phenomenology and GT (Creswell, 2013). Both of these approaches have advantages and were analysed for their usefulness to the research objectives.

4.7.1 Phenomenology

Phenomenology evolved from philosophy with the goal of describing (Husserl's eidetic position) or interpreting (Heidegger's hermeneutic position) the human lived experience and consciousness (Creswell, 2013; Sokolowski, 2000). The adoption of phenomenology would answer/interpret/describe, 'what' are the experiences of older people of EM, and 'how' particular experiences of social structures can increase their vulnerability. However, the purpose of this current study is to explore the perspective on 'what' the research participants understand about EM rather than only describing their common experiences. Through this, the findings will enable us to understand the social, cultural and economic processes which are more likely to increase the vulnerability of older people to mistreatment.

A further purpose of this study is to generate an explanatory theory which might explain what interpretations exist of the actions and interactions of EM and 'how' and 'why' they are unique to the population of this study. In addition, the criticisms associated with the use of phenomenology such as the complex philosophical underpinnings (Holloway and Wheeler, 2013), the concepts of bracketing (Flood, 2010) and unsophisticated methods of data collection would not support this study in generating a theory, so that approach was not undertaken.

4.7.2 Grounded Theory

GT, on the other hand, goes beyond the description and generates explanatory theories inductively from the empirical data which explain basic social processes or interactions (Creswell, 2013). It is the most utilized methodological framework for qualitative inquiry, justified for its ability to "capture complexity, linking well to practice, supporting theorizing of new substantive areas, and enlivening mature theorizing" (p.95) (Locke, 2001).

The emergence of GT as research strategy in qualitative research was the result of the successful collaboration between Barney Glaser and Anselm Strauss (1965) in *Awareness of Dying*. A systematic analysis of this work shows that they articulated and concluded that theories can also be developed from research grounded in the data rather than only through the deductive approaches of testing and re-testing existing knowledge. They explained that

the purpose of GT is to develop and build substantive mid-range theories (Glaser and Strauss, 1965), with an emphasis on 'human agency', social and subjective meanings, interactions, and the context in the comprehension of a particular phenomenon.

In this current study, the goal was to develop a substantive mid-range theory for understanding the perspective of Pakistani communities in the UK towards EM.

The rationale for using the GT approach was that;

- EM is a complex phenomenon and therefore requires a systematic and rigorous methodology to cover its nature, and at the same time, the study participants are under-studied, so they need a flexible and open approach so that they can express their views openly without restrictions. GT is a structured, systematic yet flexible form of qualitative research which is useful for exploring experiences and basic social interactions and processes (Charmaz, 2014).
- Second, GT is useful when the purpose of research is to explain and clarify social structures and social processes and their consequences rather than exploring only individual experiences (Glaser and Strauss, 1967). As the literature review showed, EM is multi-etiological in nature, and for the participants in this study it could be the result of different social and psychological structures or social process; as a result, these factors might have consequences on the participants' interpretations of EM and their actions, such as seeking help.
- Addressing all these factors, the current study was designed to make changes to practice by widening awareness of distinct cultural barriers in reporting EM. Charmaz (2006) stated that GT is a rigorous method of knowledge generation which could help to inform and guide professionals and improve practice.
- In addition, the evidence to date suggests that there is no known study which has constructed a theory on this particular topic, which is another reason why a GT methodology was chosen.

There are many versions of GT methodology and all are concerned with developing explanatory theories, but there is a divergence of opinion in regard to whether GT underpins objectivist or constructivist assumptions (see Table 4.3).

Table 4. 3. Similarities and contrasts between Objectivist GT and Constructivist GT (Charmaz, 2014)

Objectivist Grounded Theory (OGT)	Constructivist Grounded theory (CGT)
<p>Foundational Assumptions</p> <ul style="list-style-type: none"> • Assumes an external reality • Assumes a discovery • Assumes that conceptualizations emerge from data analysis • Views representation of data as unproblematic • Assumes the neutrality, passivity and authority of the observer 	<p>Foundational Assumptions</p> <ul style="list-style-type: none"> • Assumes multiple realities • Assumes mutual constructions of data through interaction • Assumes that the researcher constructs categories • Views representation of data as problematic, relativistic, situational and partial • Assumes that the observer’s values, priorities, positions and actions affect his/her views
<p>Objectives</p> <ul style="list-style-type: none"> • Aims to achieve context-free generalization • Aims for slim and abstract conceptualizations which transcend historical and situational locations • Aims to create a theory which fits, works, has relevance and is modifiable 	<p>Objectives</p> <ul style="list-style-type: none"> • Views generalizations as partial, conditional and situated in time, space, position, action and interaction • Aims for an interpretative understanding of historically situated data • Specifies a range of variation • Aims to create a theory which has credibility, originality, resonance and usefulness
<p>Implications for data analysis</p> <ul style="list-style-type: none"> • Views data analysis as an objective process • Sees emergent categories as forming the analysis • Sees reflexivity as one possible data source • Gives priority to the researcher’s analytical categories and voice 	<p>Implications for data analysis</p> <ul style="list-style-type: none"> • Acknowledges subjectivities throughout data analysis • Views co-constructed data as setting the analytical direction • Engages in reflexivity throughout the research process • Seeks and (re)represents participants’ views and voices as integral to the analysis

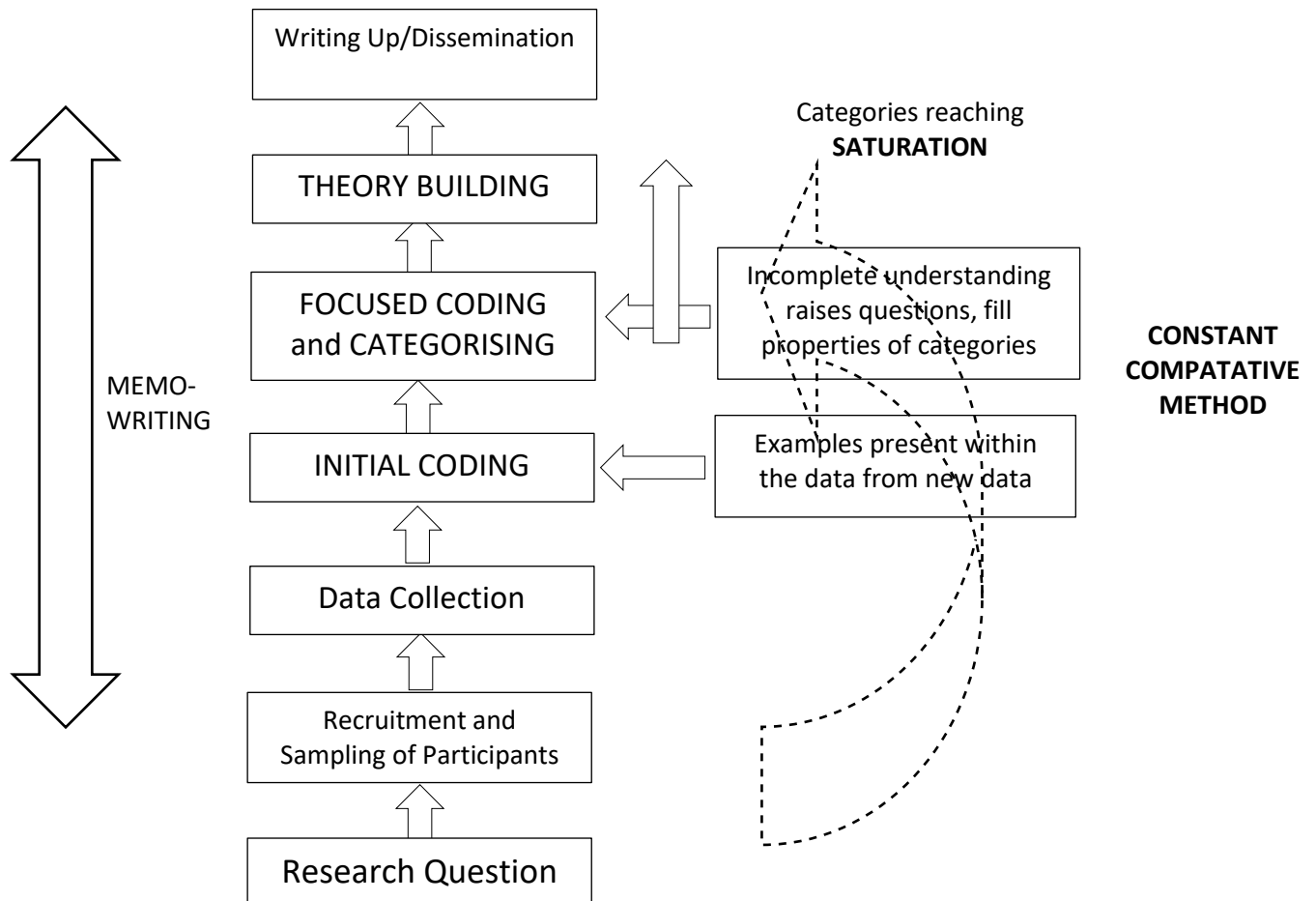
OGT is most commonly associated with Glaser’s GT or original GT (Glaser and Strauss, 1967; Glaser, 1998); it assumes an objective and external reality, and the researcher’s passivity and neutrality in the ‘discovery’ of the theory. It sees data as an objective fact which is discovered by the researcher who has no role in its creation. The objectivist version of GT could have been helpful in discovering the distinct perspective of the participants, but it would not be useful for bringing out hidden views, values and factors, as the role of the researcher is restricted. Furthermore, the fundamental principles of OGT (see Table 4.3) are a mismatch with the theoretical and philosophical underpinnings of this current study, the constructivist paradigms (Charmaz, 2014).

On the other hand, the constructivist version of GT acknowledges ‘subjectivity, relativity (multiple truths), and reflexivity in the construction of shared meanings through iterative/interactive processes’ (Charmaz, 2014). CGT emphasizes that although the knowledge is elicited hermeneutically through the interpretations, actions and interactions of individuals, agreement on such social constructions nevertheless depends on the dialectic consensus between the participant and the researcher, and the researcher has the principal role of shaping constructions from the data.

As the researcher in this current study, I am sensitive to both the ethnic culture of the participants and the existing literature on EM, so my role in the construction of the participants’ perspective can only be judged if I am using CGT. For this reason, CGT was selected in preference to OGT methodologies.

CGT, according to Charmaz (2014) is an inductive, comparative, emergent and open-ended approach which involves constant comparative analysis, memo writing, theoretical sampling and theoretical saturation (see Figure 4.1).

Figure 4. 1. A visual representation of GT (Charmaz, 2014)



As already explained, GT is a systematic approach to collecting and analysing qualitative data; so I now discuss the next phase of the qualitative research process, methods, and consider the application of the basic principles of CGT for collecting and analysing the data. Some of the basic principles of CGT such as coding, memo writing, theoretical sampling, theoretical saturation and constant comparison will be discussed after considering the methods of data collection.

4.8 Phase 4: Methods of Collecting and Analysing Empirical Materials

In this section, the application of GT principles and the process involved in obtaining and analysing the data are explained in detail. This includes an explanation of how the settings, the context, the sampling and recruitment, and the data collection and data analysis for the study took place.

4.8.1 Study Setting

The study was conducted in Sheffield, South Yorkshire, England, but other cities of South Yorkshire, for example, Rotherham where there are dense Pakistani communities, were also considered if the theoretical sampling and saturation could not be met in Sheffield.

Sheffield is the tenth most populous conurbation in the UK and the largest settlement in the metropolitan county of South Yorkshire in northern England. According to the 2011 Census, the total population of Sheffield was 552,698, of which 19.2% were from BME groups (UK Office for National Statistics, 2011). Pakistanis form about 20,000 (4%) of the residents, making them the largest minority ethnic population of Sheffield.

According to a Sheffield City Council report (2017), Pakistani communities live in overcrowded houses in Sheffield; for example, the average Pakistani house size by person is 4.1% compared to 2.4% in the city as a whole. The majority of the Pakistani population live in the most deprived areas of city, for example, Burngreave, Darnall and Firth Park. According to a Sheffield City Council report (2015) (Council, 2011) (Council, 2011) (Council, 2011) (Council, 2011) (Council, 2011) (Council, 2011), Burngreave, for example, is the second most deprived of the 28 wards in Sheffield with the highest crime rate in the city and lower life expectancy (74.7 years for men and 77.6 years for women, compared with 78.8 years for men and 82.5 years for women in the city as a whole).

Of Pakistan men, 72% are economically active in Sheffield compared with 36% of women. Looking after the family or home was one of the main reasons reported by one third of Pakistani women for being out of the labour market (Sheffield City Council, 2015). The three most common languages spoken in Pakistani households are English, Urdu and Punjabi. By religion, the majority of the Pakistani population in Sheffield are Muslim.

Sheffield as the study setting was selected for two major reasons. First, the demographic characteristics of Pakistani people living in Sheffield matched the nationwide figures of Pakistanis living in other cities. For example, in West Midlands, Yorkshire and the Humber and North West region has about 4.0% Pakistani, the same as in Sheffield. The second was a pragmatic reason; I live in Sheffield so feasibility and convenience of access, transportation and the time period available for PhD research were important considerations when I decided to conduct the study in Sheffield. In addition, I had been attending local events in Sheffield which were of relevance to the health and well-being of older people from ethnic communities. As a result of this, I had developed good links with community stakeholders and local charities involved in the well-being of older people. This had additional benefits in the recruitment of participants. Once the setting was decided, the next step was to select and recruit the participants.

4.8.2 Sampling and the Sample

For this study, both purposive and theoretical sampling were used to recruit the participants. The criteria for choosing purposive and theoretical sampling were based on the nature of the study design, the principal objectives of the research and the common use of sampling strategy in the literature addressing similar designs and objectives.

Purposive sampling is used to identify participants who fit the parameters of research questions (Bryman, 2008) and theoretical sampling involves recruiting participants with different experiences of the phenomenon being studied in order to explore diverse and multiple perspectives on social interactions (Creswell, 2013). The initial purposive sampling was used to establish inclusion criteria for the participants and the theoretical sampling was used to guide me where to go next (Charmaz, 2014) for developing and refining the categories in the emergent theory. Theoretical sampling and its uses in this study will be discussed later in this chapter (see page 83). Table 4.4 sets out the criteria used to select participants for the

study and the methods involved in obtaining the data from them. The study participants include as older people, family members and community stakeholders.

Table 4. 4. Participant selection and characteristics

Participants	Characteristics	Method
1) Stakeholders	Community or religious leaders or members of a charity organization working with or for Pakistani communities; aged eighteen or over; Ethnicity, any; Health, cognitively intact and able to consent	In-depth interview + consultation exercise
2) Older person	Pakistani, male or female; aged 55 or over; Health, cognitively intact and able to consent	In-depth interview + focus group discussion
3) Unpaid/Family caregiver	Pakistani; male or female: aged eighteen or over; Health, cognitively intact and able to consent; Relationship, partner/child or other family member living and looking after an older person aged 55 or over;	In-depth interview
<p><i>Note:</i> No formal assessment was undertaken to assess the cognition of participants. I used my own common sense and previous training and experience as a registered nurse to determine participants' mental capacity to consent to take part in the study.</p>		

In the context of this study, the age of 55 was chosen as the minimum age for the sample of older people as it was consistent with previous studies conducted with older people from this ethnic minority groups (Nagpaul, 1997; Ahmad and Walker, 1997). Furthermore, evidence suggested that most EM takes place in an older person's own home, and partner or children are more frequent perpetrators (Anetzberger, 2005; O'Keeffe *et al.*, 2007). Therefore, a decision to include family members was taken in order to explore their perspective on factors which might interact to cause EM and what stresses family members face while caring for or living with an older relative. The literature review also indicated that Pakistani communities prefer informal support over formal health and social services (Mir and Sheikh, 2010), so relevant stakeholders, particularly religious and community leaders, and people involved in charities which address or encounter issues relevant to the study questions were also recruited.

This study focused only on community recruitment. The nursing home sector was considered but later excluded for the following reasons:

1. As explained in a previous chapter, the numbers of older people from ethnic communities are limited in nursing homes (Mold *et al.*, 2005).
2. To the best of my knowledge and experience, I have not encountered older Pakistanis living in nursing homes.
3. Evidence also suggest that EM is more prevalent in communities than in nursing homes (Pillemer *et al.* 2015) which is partially explained by fact that number of studies conducted in long term institution (Erlingsson 2007).
4. For pragmatic reasons, because the studies which have been conducted with older people in nursing homes have acknowledged difficulties related to access and multiple gatekeepers (in private institutions, there are an owner or a company, managers and staff, and others involved, such as family); issues around identifying, accessing and interviewing victims and abusers; the DBS (disclosure and barring services) checks; ethical approval; revisiting consent and time issues (Bowes *et al.*, 2011; Erlingsson, 2007b).

In GT, determining an appropriate sample size is not straightforward; Morse (2000) suggested that it is impossible to predict what sample size will saturate a given theory. 'How many' is not exclusive to qualitative research (Baker *et al.*, 2012), but studies of ethnicity, ageing and EM which used GT have sampled in the range of 20-40 participants (Nagpaul, 1997; Dong *et al.*, 2011). For CGT, Charmaz (2014:214) suggested that if interview is the only source of data, a sample of 25 interviews is sufficient for a detailed analysis. In total, therefore, my aim for this study was to recruit about 20-25 participants for individual interviews. However, these numbers were speculative rather than definitive as the recruitment of participants in GT research mainly depends on the theoretical saturation of the data. Theoretical saturation will be discussed later in this chapter when the basic principles of GT are explored. The number of participants finally sampled is explained in the recruitment section which follows.

4.8.3 Recruitment

After completing pre-protocol fieldwork and obtaining clearance from the University's ethics committee, the recruitment of individuals and for focus groups was conducted over a period

of six months, following the purposive and subsequent theoretical sampling techniques. As mentioned above in the section on the sample, there were three different categories of research participant, so the recruitment process was ordered but flexible and took place at different stages as explained next.

1) Recruitment of relevant stakeholders

My intention was first to recruit the relevant stakeholders, who included community leaders, religious leaders and members of charities working for Pakistani communities (see Table 4.5). They were identified through key persons, internet searches, and personal contacts. Being representative of or working with Pakistani communities, they were deemed to be able to provide a general picture of the topic from their point of view so they were recruited first. In addition to their recruitment, the identification of stakeholders enabled me to design the interview guides for older people and unpaid family caregivers.

In order to increase the feasibility of this research study, I met with various gatekeepers and stakeholders before starting the study and built up a rapport and relationship with them. In our informal meetings, those who showed interest in taking part in the study were recruited first. A letter of invitation (see Appendix 6) was sent to members of charity organizations and to community and religious leaders who had not yet been contacted but were regarded as important for the context of the study, such as the Sheffield BME network and Ashiana. Ten days after sending the initial letter, a follow-up call was made to invite stakeholders who may not have had a chance to consider the invitation. Other gatekeepers were also identified and would have been contacted if theoretical sampling or theoretical saturation was not met.

In both the informal meetings and email invitations, an information sheet was given to potential participants and explained if necessary. In total, eight stakeholders were recruited and interviewed. Descriptions of these stakeholders are provided in Table 4.5.

Table 4. 5. Gatekeepers and stakeholders who facilitated the recruitment of older people and young family caregivers

Name	Functions	Study relevance
<i>Pakistan Community and Advice Association (PCAA)</i>	Offer services related to English and interpretation, employment and health.	The PCAA organizes a Muslim Elder Support Project (MESP) for Muslims age 50 and over, where older people meet invited health professionals to discuss their health issues. MESP meetings take place fortnightly. I met a key person who organizes them and she provided contact details and showed interest in the topic and helped with recruitment. She introduced me to all the people who attended the MESP and I had an opportunity to explain my study to them.
<i>Darnall Well-Being Group</i>	To deliver a combination of group activities, one-to-one support for healthy lifestyles and the management of long-term conditions, peer mentoring and volunteering as well as delivering local health campaigns, training and talks.	The Darnall Well-Being Group organizes healthy lifestyle activities for older people once a week. These include a brief talk by experts about health issues, physical activities and exercise led by a trained person, and a healthy lunch. The key person introduced me to all Pakistani older people attending the sessions, and I was able to explain my study to them.
<i>Roshni – Elder Muslim Group (male and female)</i>	Roshni has many projects including the Roshni advisory group, a carers project, a service for older women, a healthy living project and a children and young person’s project	Roshni runs the Muslim Elders project for older people (male and female) to address isolation and raise awareness of mental health issues such as dementia and depression. I met and interviewed two key person who organize these Muslim elder groups. They also helped me to recruit both males and females for the focus groups. I spent a few months attending the workshops and activities organized by Roshni to develop trust with older people.
<i>Age UK – Khalas Place</i>	To promote physical and social activities for older women from BME communities	Specifically aimed at older women from ethnic communities, Khalas Place is run by volunteers who arrange a variety of activities for older women, including swimming classes, days out, group activities, and health advice and information. They helped in the recruitment of participants for individual interviews.
<i>Yorkshire Muslim Academy (YMA)</i>	YMA is an open place for meeting and practising for many Muslims of Pakistani and Bangladeshi origin.	I met an Imam and a key person. They introduced me to people who attend the mosque/Academy. They helped with the recruitment of participants for individual interviews.
<i>Markazi Mosque and Islamic Centre (Darnall)</i>	This Jamia mosque is under Bangladeshi communities’ management, but many Muslims of other communities offer prayers there.	This centre runs two-hour sessions on issues relevant to older people on Thursdays. I met the Imam, who showed willingness to support the research. He helped with the recruitment of participants for individual interviews

2) Recruitment of older people (for focus group discussions and individual Interview)

Negotiating Access

Because the study involved three different categories of participant, I was involved in early engagement with many stakeholders such as community leaders, religious Imams, and members of charities working with older people and young family members. Table 4.5 gives an overview of a few of these stakeholders and their functions in relevance to this study. The study's aims and objectives, stakeholders' role and their participation, and importantly the key elements associated with the recruitment of older and young participants were discussed with the stakeholders. After receiving stakeholders' permission, these early engagements associated with the study and with recruitment were maintained with potential participants.

Some of the community gatekeepers and organizations, such as Firvale Community Hub (previously known as the Pakistan Community and Advice Association), Roshni, Darnall Well-Being and Age UK-Khalas Place, organize regular lunch clubs and health activities for older people at least twice a month. I was invited by three organizations – Firvale Community Hub, Darnall Well-Being and Roshni – to attend the lunch club sessions arranged for older people. I attended these sessions bi-monthly for three months. The gatekeepers helped me by passing on details about my research, including the information sheets, to potential participants.

This early engagement was considered important for several reasons: (1) the sensitive nature of the topic; (2) participants are a hard-to-reach group with limited engagement in research studies; and (3) the researcher's position as an outsider in a sense not part of their immediate community circle. The private and sensitive nature of EM has a wide range of implications around confidentiality and safety for older people. For example, discussing it might lead to an emotional response, or result in the stigmatization of the victim, or in IG or social conflicts and fears (McCosker et al., 2001). Furthermore, as the participants are a group which is hard to reach, gaining their trust, explaining the perceived risk and providing culturally appropriate information at a preliminary meeting were considered important. Some issues, however, were associated with access to participants, particularly to women, were linked to my gender identity. A stakeholder at PCAA shared older women's concern about being interviewed by a male researcher. A detailed discussion of this issue is given in Chapter 8 when I discuss the reflexivity on the study.

Early and prolonged engagement was also useful for developing trust and rapport with older people and for explaining to potential participants the research objectives and their involvement in the study. This also gave potential participants enough time to ask any question they had before considering their participation in the study. Older people interested in taking part in the study were contacted by the gatekeepers or by me. Older people were recruited second and they were recruited for focus group discussions and individual interviews.

Recruitment of older people for focus groups

The recruitment of older people for focus groups was facilitated by the charity Roshni which organizes the lunch clubs for older men and women under Muslim Elder Groups. Two focus group discussions with older people (male = 5 and female = 7) were conducted at Roshni's premises in order to explore the general awareness of the problem and to increase the recruitment of older people for the one-to-one, in-depth interviews. It was expected that the focus group discussions (FGDs) would help in identifying and building rapport with older people who might have been victims of EM or have some first-hand experience of it. It proved a useful strategy to recruit participants for the study. For the male focus group, initially eight participants agreed to take part but three could not attend due to health and personal issues. For the female focus group, ten participants initially agreed to attend but three could not attend.

Recruitment of older people for individual Interviews

The same approaches were used to recruit older people for individual interviews. The potential older participants for one-to-one, in-depth interview were identified through these informal meetings, focus groups and meetings with gatekeepers. Older people taking part in a focus group were eligible to participate in an individual in-depth interview. If potential interviewees showed an interest, the information sheet was discussed with them and any questions raised were answered, and a date, time and place for a formal individual interview were confirmed. Two female participants from the focus group agreed to take part in the later interviews. One male from the focus group showed interest in taking part in the study but when he was contacted, he was hospitalized, and his condition was deteriorating so he could not take part in an individual interview. In total, therefore eight older people were recruited

and later interviewed. The initial recruitment process began with purposive sampling, but later theoretical sampling was predominant, as soon as the concepts, relationships and gaps in the data began to emerge. Theoretical sampling and its application in the study will be discussed in the next section (see page 83). Descriptions of these eight participants are given in Table 4.6.

3) Recruitment of unpaid family caregivers

The unpaid family caregivers were recruited through the network sampling method by which potential participants were referred by gatekeepers or personal contacts. In total, six caregivers were recruited and interviewed. It was ensured that the unpaid family caregivers were not related to any of the older people identified and interviewed in the earlier stages of the study in order to prevent any risk related to the safeguarding or confidentiality of older people. I also contacted people involved in charities which work particularly with carers, such as the Sheffield Carers' Centre and the Carers' Trust but they declined to take part because of limited resources, staffing issues and the confidentiality of the caregivers with whom they had been working.

A brief descriptions of all the participants took part in an individual interview are given Table 4.6 and the detailed information about them is provided in Appendix 7.

Table 4. 6. Research participant took part in individual interviews

Pseudonym	Age and Gender	Country of birth	Education or Occupation	Living status - household	Other info relation to study
Category 1: Older people					
Hasan	73 years old; male	Pakistan	No formal education: Retired,	Lives with wife	Main carer for his wife; children lives separate
Khalid	62 years old; male	Pakistan	Primary School; Administrator	Lives with wife and two children	Other children live separate
Suhail	79 years old; male	Pakistan	Matric (GCSE) level; Retired	Lives with wife	Children lives separate
Nabeel	56 years old; male	Pakistan	Diploma; works in hospital	Lives with wife and children	
Janat	60 years old; female	Pakistan	No education: Housewife	Lives with a son	Divorced
Rahila	56 years old; female	Pakistan	No education: Housewife	Lives alone	Divorced
Zeenat	67 years old; female	Pakistan	No education: Housewife	Lives with grandson	Widow
Sabreen	56 years old; female	Pakistan	Diploma; works in hospital	Lives with husband and a son	
Category 2: Young people					
Usman	48 years old; male	UK	Bachelor; Self-employed	Lives alone	Main carer to his mum
Zohra	19 years old; female	UK	Diploma: works at store	Lives with mum	Main carer to her mum and also looks after her grand mum
Amina	25 years old; female	Pakistan	Bachelor: works in hospital	Lives with parents and siblings	Carer to mum and grandparents
Sadaf	43 years old; female	Pakistan but moved to the UK on first birthday	GCSE: Housewife	Lives with in-laws	Main carer to mother in law; carer to mum and dad in past
Muhammad	46 years old; male	UK	Bachelor: Self-employed	Lives with his own family	Carer to father and mother
Javeed	37 years old; male	Pakistan	Bachelor: works in healthcare	Lives with family	Main carer to father and mother
Category 3: Community Stakeholders					
Akash	58 years old; male	NA	Councillor; volunteer in different charities		Housing society in Sheffield
Mariam	Decline age; female	NA	Development worker		Charity
Zubair	34 years old; male	NA	Imam and teacher and also working for a local charity		
Waqar	Decline age; male	NA	Senior Imam		Mosque
Mubarak	27 years old; male	NA	Councillor		Member of different charity groups
Umar	44 years; male	NA	Executive member of a charity		Local charity
Arshad	49 years old; male	NA	Member of a charity		Runs Muslim Elder group
George	70 years old; male	NA	Councillor and member of different charity groups		

4.9 Data collection

'All is data' is a well-known dictum of Glaser (2002), but the quality, relevance and usefulness of data are important for ensuring the credibility, substantiality, richness and fit of a research study. Charmaz (2014) stated that choosing the right methods of data collection helps a researcher to answer the research questions with ingenuity and incisiveness. She said that *how* you collect research data affects *which* phenomenon you will see, because what sense we make out of data directs us to identify the social processes in the emergence and discovery. The data collection methods adopted in the study were selected to suit the objectives of the study and for their fit with the GT strategy selected; the methods used were interviews and FGDs.

4.9.1 Interviewing and FGDs

Individual in-depth interviews and FGDs are core and effective qualitative methods often used by researchers undertaking studies on EM in order to encourage participants' active construction of their social realities (Moon et al., 2002; Nagpaul, 1997). There are many advantages to conducting focus groups rather than other methods of data collection, such as synergism, stimulation, group dynamics, spontaneity and serendipity (Stewart and Shamdasani, 2014). Researchers who have used focus group methods for data collection have found it a useful approach for gathering rich and relevant data as it facilitates exploring participants' perspectives in a natural and socially contextualized environment (Morgan, 1996; Nagpaul, 1997). Similarly, one-to-one, in-depth interviews are an appropriate method for collecting detailed personal, historical and contextual accounts from participants. Also, through the individual interviews I wanted to establish a dialectical process to develop shared meaning with the participants (Denzin and Lincoln, 2011).

Because of the wide use of both methods in the existing literature on EM and their relevance to the study objectives, they both were deemed suitable for gathering in-depth, rich and relevant data about the perspective, meaning and beliefs which people hold about EM in Pakistani communities.

Only a few studies have used participant observation as a method of data collection on ethnicities (Bowes *et al.*, 2011), although observation studies have often been conducted in controlled environments such as institutions, for example, care homes. The observational method was considered for this current study but rejected because of the ethical issues and

time and resource-related challenges which it requires (Bryman, 2008; Starks and Trinidad, 2007).

4.9.2 Practical issues in data collection

Interview and focus group settings

As explained above, the FGDs and two interviews took place at the premises of Roshni. Roshni is local charity involved in organizing Muslim Elder Groups at a local community centre in Sheffield. It works with women, children and older people and organizes two separate bi-monthly sessions of two hours for both older men and women. The attendees listen to a talk from health-care professionals on different health issues and have an opportunity to ask questions. Participation in these sessions is free and participants are also offered a free lunch at the end.

The interviews were conducted in places agreed with the participants and consideration was given to the privacy, comfort and safety of both participant and interviewer. The participants were offered the option of a room at the University of Sheffield or in their own home. Those who opted for a university room were offered reimbursement of travel expenses up to a £10 limit. Only one person chose to be interviewed at the university and the majority preferred to be interviewed at their own homes. A significant number of participants also preferred to be interviewed at the premises of gatekeepers, and that was arranged with the gatekeepers in advance.

Interview and focus group guides

The individual, in-depth, semi-structured interviews and focus group discussions were conducted using flexible interview guides. A qualitative interview is considered to be a conversation with purpose and an interview guide is a vital instrument for directing the researcher to achieve this purpose. Charmaz (2014:62) recommended that new researchers should develop an interview guide in order to avoid asking awkward, poorly timed and intrusive questions which might hinder them in fulfilling their research objectives. I therefore remained mindful not to force interview data into preconceived categories (Charmaz, 2014:63) and kept the interview guide fluid and flexible in order to invite spontaneity. The interview guides were divided into three phases (Seidman, 2006) in order to collect rich and relevant data. The first phase focused on demographic data, the second phase was designed

to obtain individual understandings and experiences of EM, and the third phase was designed to elicit participants' reflections on the meaning of their experiences.

The interview guides were initially developed from the literature review, the research questions, sensitive concepts and the GT principles (see appendix 8, 9, 10). The final interview guides (see Appendices 11, 12, 13) were further refined after piloting and consultation with supervisors and gatekeepers. The piloting of the guides will be discussed next in this chapter. Considering the sensitive nature of the topic, the interview guides were structured in such a way that the first few questions were about the general background to the topic in order to build a rapport with the participants and make them feel comfortable.

Three interview guides were developed for the three samples of participant. The first guide (see Appendix 8) was developed for the interviews with stakeholders and consisted of questions about background data, perspective on EM, barriers and facilitators for reporting EM, and their role and services related to EM.

The second guide (see Appendix 9) was developed for the focus group discussions and comprised discussions around topics such as health issues and problems in later life, migration and adaptation in a new country, and the treatment of older people in a country other than their own country of origin.

The third guide (see Appendix 10) was developed for the interviews with older people and family caregivers. Some of the questions in this guide were specific to caregivers, such as the motivations, barriers and stresses associated with providing care to an older person. The questions in the guide comprised general background data, family dynamics, understanding of EM and actions taken, and coping strategies in the face of EM.

All three interview guides contained some probe questions to keep the conversation on topic, such as:

Can you tell me more about that?

Can you give me an example?

So are you saying ...?

Have you always felt this way?

What is significant about this to you?

How so?

How has your approach changed over time?

And what do you think of that approach?

Each focus group and interview guide were designed to complete the interview within one hour, which was appropriate given the sensitive nature of the topic and age of some participants. There was also the possibility that an interview with an older person might not generate enough data because of the sensitive and complex nature of the topic and the participant's age, so the option of having one or two short interviews was discussed at the outset of each interview. However, this option was not requested by any participant, despite my expectation. Considering the sensitive nature of the topic, I used different interviewing strategies and these will be discussed in the section on implementing the data collection.

Piloting and consultation for the interview guides

The interview guides were piloted in order to identify any ambiguities and to amend or exclude questions accordingly. Three pilot interviews were conducted; one with an older person, one with a family member and one with a stakeholder. Piloting the interview guides was useful for refining the questions. It was found that there were too many questions about demographic data in the guide for the individual interviews, which made them feel interrogative. So the demographic questions were limited in the revised guides (*see Appendix 11, 12, 13*). Also, the draft interview guides were found to be too lengthy, with an extensive list of questions, and that was deemed likely to restrict participants from providing new data. The revised guides therefore only contained the broader questions.

The initial interview guide for the focus groups contained questions seeking information about participants' background and demographic data. After consultation with supervisors and feedback from the ethics committee, this guide was also revised. As well as removing the background questions, ground rules were introduced in the FGD guide to address the issue of participant's confidentiality in accordance with the feedback from the ethics committee.

After the interview guides had been piloted, the recruitment and data collection took place simultaneously following the iterative logic of GT.

4.9.3 Implementing data collection

Similar to the recruitment of the participants, the data collection took place in stages. Semi-structured interviews were conducted with gatekeepers and stakeholders first, followed by focus group discussions and individual semi-structured interviews with older people, and then individual semi-structured interviews with unpaid family caregivers. However, data collection did not strictly move from gatekeepers to older people to family caregivers because of issues discussed above, such as theoretical sampling.

Participants were given the information sheet ahead of their interview and it was discussed with them before the start of the interview in order to give them an opportunity to reflect, recall and prepare what they wanted to say more clearly and freely. Next, each participant was given the consent form which contained information about their rights relevant to the study. Consent forms were available in both English and Urdu, explaining clearly participants' right to decline, withdraw from or participate in the study. A further discussion on consent is provided in the Ethics section.

A digital audio-recording device (Olympus LS-P1) was used to collect the data from both the focus group discussions and the individual interviews, with the permission of the participants. Glaser (1979) advised against using a recording device to take notes during data collection but in this case, taking fieldwork notes physically was considered impractical because of the time it would take, the possibility of diverting interviewees' attention and the fear of losing or missing valuable data (Charmaz, 2014:91). Recording the data freed me to focus on my research questions, to listen attentively to participants' answers, language and emotions, and to maintain fluidity in the conversation. Unlike the classic GT technique of only using field-notes, Charmaz (2014) recommended audio-taping to preserve tone and tempo, silences and statement, and flow of exchange between question and response. Other reasons for using this technique included audio-tapes' unlimited replayability, storage and accessibility, and easy transferability into transcribed texts for data analysis (Tessier, 2012).

In the interviews, the questions were softened for potentially disturbing issues considering sensitive nature of topic. For example, before asking about experiences or understanding of

mistreatment, the question was phrased as ‘What is the treatment of older people?’ And when participants were found to be developing an interest in the topic, further questions were asked and probed around EM. Phrases such as ‘Could I ask you?’ and ‘I don’t know if you wish to talk about this more in detail ...’ were used to elicit deeper discussions.

Another reason for narrowing down the questions was to keep the interviews open-ended and interactive but still direct and shaped. This was useful, particularly when participants digressed from the topic. For example, one participant went on from talking about EM to the religious conversion of a Hindu person and his relationship with a nurse.

During the interviews, a dialectical process was established in order to ensure that I was co-constructing a reality which was rigorously negotiated and mutually agreed. In situations when participants were struggling to understand a question or were cautious or circumspect about responding, strategies such as depersonalizing the questions, sharing personal views and giving references were used; that not only relaxed the participant, it also developed trust and rapport to allow the conversation to flow smoothly.

At the end of interviews, the participants were given the opportunity to add anything which they considered important or to ask any questions. The interviews were terminated when no new information was forthcoming, or when a participant looked tired and wanted to end the interview. Interviews were also sometimes stopped or paused at an interviewee’s request. For example, I was conducting one interview in a mosque and it was prayer time, so the interviewee requested that we pause until he had performed his prayer; the interview was restarted when his prayer was completed.

At the end of each interview, participants were given information about services and sources which they could contact if they had any concerns about EM. I shall discuss this in more detail when I discuss disclosure in the section on ethical considerations.

A similar approach was applied in the FGDs. Broader questions were asked in the focus groups and hypothetical statements about EM were discussed in order to depersonalize the issue and free the participants to discuss the problem more openly. To ensure their confidentiality, the older people were advised not to disclose their personal experiences of EM during the FGDs. Some ground rules were developed and were read out to the participants before the FGDs.

4.10 Data analysis

Data analysis in qualitative research is the systematic, iterative, comparative and interactive process of organizing, structuring, describing, condensing and evaluating a seemingly huge amount of data, predominantly textual, in order to understand the construction of social reality within its natural context (Richards, 2014).

A range of procedures and approaches are available for analysing data in qualitative research and the choice of methods primarily depends on the research objectives and the epistemological orientation of the researcher. The goal of the data analysis in this study was to adopt a 'bottom up' approach (Draper, 2004), widely used by GT researchers to provide an insight into the perspective of participants which is important to them, as well as to identify emergent themes and dimensions which fit, work and are relevant to developing a theory which is grounded in the data itself (Glaser, 1992).

In this current study, data were analysed using the CGT principles recommended by Charmaz (2014), in which analytic coding, memo writing, constant comparison, theoretical sampling and theoretical saturation are the basic principles for developing a theory.

Data were collected in both English and Urdu, so attention first had to be paid to translation and its related issues; how the basic principles of CGT were applied to all the transcribed data will be discussed later.

4.10.1 Translation, data analysis and related issues

It has been suggested that language can act as barrier in the access and provision of services (Parra-Cardona et al., 2007) so participants were recruited who were fluent in either English or Urdu in order that the perspectives of people who find language an issue in the context of the study topic could be included.

Both of the FGDs and five interviews were conducted in Urdu and later translated by me personally. One of the reasons I preferred to conduct and translate interviews was to eliminate the risk of bias in the construction of a theory. It has been argued that a professional translator not only transfers words from one language to another but becomes the producer of data in the process of constructing the perspective of a social world (Nurjannah et al., 2014).

Birbili (2000) suggested that a study which involves collecting data in one language and interpreting and analysing it in a different language poses challenges to its validity. In this case, however, concerns related to translation were minimal as the researcher-translator was me and I am fluent bilingual and had the advantage of sharing the broader culture of the research participants. In addition, because I shared the same ethnicity, language and culture as the participants, the meanings in their responses were less likely to lose technical and conceptual equivalence or lexical comparability in the process of translation and the interpretation of any emotional connotations (Halai, 2007). Furthermore, I analysed the transcripts using a line-by-line free translation in order to obtain precisely the meanings and interpretations which participants attached to their experiences and perceptions. Also, a bilingual expert cross-checked a sample of transcripts in order to ensure their accuracy.

Once all the data were translated, transcribed and accessible in English, the analysis was started. The computer-assisted qualitative data analysis software Quirkos was used for the analysis. Quirkos is simple and useful software for coding and analysing data. Although computer software programmes are useful for saving time, handling large amounts of data, and improving the validity and reliability of research, it has limitations in conceptualizing ideas and meaning, and critiquing and analysing the data (John and Johnson, 2000). For example, computer software programme enables all data to be explicit and fully examined without any assumptions and biases. However, these programmes are predominately focused on quantity or homogenisation of data than deriving meaning, context and integration. Therefore, Microsoft word, printed hard copies of transcriptions, pens, paper, colours and highlighters were also used to help with the analysis and keep myself engaged with the data.

4.10.2 Analyzing interview and focus group data

As already explained, the data analysis was undertaken on GT principles. In this section, the basic principles of GT and their application in this study are discussed.

4.11 Basic principles of GT and their application in data analysis

4.11.1 Constant comparison

Constant comparative analysis is the continual movement of a researcher between data, memos and concepts in order to authenticate that the theory is fully grounded in the data. Charmaz (2014:342) defined constant comparison as:

A method of analysis that generates successively more abstract concepts and theories through inductive process of comparing data with data, data with code, code with code, and code with categories, and categories with concept.

In order to raise the level of abstraction in the data analysis, I repeatedly read and compared each interview transcript and my own memos in order to identify the full range of complexities and diversities in the data. This helped me in fully comprehending which data or interpretations indicated a social process or interaction in each interviewee's perspective on EM. GT was also found useful for examining my own and each participant's assumptions because I was able to constantly compare the emerging themes and categories with my previous knowledge and experiences, the literature which I had reviewed, and any predeterminations which I had.

The analysis of each transcribed interview followed the constant comparison approach through the phases of data reduction, analytical distinction and data display. In the following sections, I shall describe how the constant comparison method was used for coding and analysing the data across the stages of the basic GT principles.

4.11.2 Coding

Coding is a pivotal descriptive and analytical process in GT in which the data collected are distilled to develop categories, concepts and social processes. Charmaz (2014:111) stated that "coding means naming segments of data with a label that simultaneously categorizes, summarizes, and accounts for each piece of data".

Using CGT approaches to coding, my intention was to distil data on the specific cultural and contextual meanings which people attach to key concepts; for example age, gender, abuse, family, culture, religion or other relevant concepts; and how the interpretations of these key concepts describe social relationships, interactions and processes.

In CGT, Charmaz (2014) suggested two levels of coding, initial and focused coding, to define what is happening in the data.

Initial coding is the preliminary stage of data analysis which is largely descriptive and close to the data. This is the process of breaking down and scanning, defining and labelling, comparing

and categorizing the data. This interactive process enables the researcher to see actions and understandings within the data.

In the analysis, the construction of initial codes began immediately after the first piece of data was collected, and these codes were primarily open, descriptive and provisional (see Table 4.7). By adopting open coding strategies, I was able to expose the thoughts, ideas and meanings contained in the text (Strauss and Corbin 1998:102), to assess whether the data were answering my research questions, and to examine 'What is this data a study of?' (Glaser, 1978:57). My initial codes were also provisional as after reviewing each interview again and again, the level of abstraction and conceptual analysis grew while I was coding the data.

Because the initial codes were drawn from face-to-face conversations, the participants' meanings, perspectives and actions were preserved, so my predetermination and prior knowledge had limited influence. Even so, I did use the sensitizing concepts to direct my initial coding because with such a large database, I was not sure where to start. I used sensitizing concepts as starting point for the analysis but sensitive concepts which corresponded with the codes were used to avoid distorting data integrity.

The initial codes were largely descriptive and provided an insight into concise actions, but when gerunds (Glaser 1978) were used, the processes were evident as well as actions in the data, for example, 'values are *changing*', 'relationships are *distancing*' and 'time is *moving*'.

A Gerund is a noun formed from a verb which refers to an action, process, or state. In English, gerunds end in '-ing', for example 'running' and 'thinking'.
(Collins English Dictionary)

Initial coding involves coding data word-by-word, line-by-line or incident by incident, largely depending on the size and significance of the data to theory construction. I chose to use line-by-line coding which involves coding or labelling each segment of data. The reason for using line-by-line coding was to stay close to the data. Line-by-line coding also gives the researcher an opportunity to compare, evaluate and adjust the data while assessing the 'fit and relevance' in the analysis. Line-by-line coding helps the researcher to remain open and see

otherwise undetected patterns and actions in respondents' everyday lives. This is clearly illustrated in the example shown in Table 4.7.

Table 4. 7. Initial codes

Mr Suhail (Pseudonym of participants) a 79-year-old male, was asked about the treatment of older people now and previously.	
Interview statement	Initial coding
<i>Day by day, you know, the conditions of human beings are changing. When I came to this country, people were different; those people (in old times) are not them (people nowadays). These people were loving and caring, all of them in here, we too as well, but now that love and affection are not there. In these days, if someone only says to you 'Hello' then this is also a big thing. That time is past. Today, the world has changed. This is not our time ... Those values are gone. Our values of respect for elders are over. You know, when we were young, even a distant relative used to love us, that 'Oh, he is Gafar's son'. It is not the norm now. Now even your own aunt will not bother about you. She does not. Things are changed.</i>	Noticing changes Recalling memories Differentiating changes Finding self-different; finding people different Indicating adoptability Comparing eras Fears values and respect are disappearing Relationships distancing Accepting changes

Labelling the data about people, actions and settings by line-by-line coding revealed participants' everyday lives; the next step was to extend and define what theoretical categories these specific data indicated. Categories began to emerge through this focused coding.

Focused Coding is used to synthesize, analyse and conceptualize the codes which were delineated from the raw data in the initial stage of coding. My intention in using focused coding was to develop categories and properties which would determine the adequacy and conceptual strength of the data through the constant comparison method (Charmaz 2014:140). The codes from the initial analysis which had greater analytical power, or were leading to the theoretical centrality, or were frequent or were telling, were named at this stage of data analysis.

In this process, each transcript was revisited and compared with the existing codes, concepts and categories to ensure corresponding adequacy and abstraction within the data. Comparing focused codes was also useful for identifying the frequency, emergence and gaps in the data. As the research involved gathering the perspectives of different categories of participant,

their words, thoughts and actions were recognized as explaining the same phenomenon differently. For instance, participants used different words such as ‘values’, ‘care’, ‘self-esteem’ and ‘love’ to describe ‘respecting’ older people. Similarly, it was also observed that the emphasis on respecting older people appeared more frequently in the comments of older people compared with stakeholders.

Constant comparison and revisiting the transcripts not only helped with identifying concepts and categories, it also led to collecting new data to develop the properties and dimensions of emerging categories. For example, in terms of the notion ‘respect’, I was not only interested in the frequency of the use of the term, but how it was perceived, distinctively and differently by different people. Further probing in subsequent interviews and comparison of the transcripts suggested that older people often defined respect as a longitudinal notion compared with the young people who saw it as a horizontal idea, indicating their belief in equality and reciprocity.

Table 4.8 shows the focused codes which I defined after comparing and examining the initial codes shown illustrated in the example in Table 4.7.

Table 4. 8. Focused coding

Mr Suhail, a 79-year-old male, was asked about the treatment of older people now and previously.		
<i>Interview statement</i>	<i>Initial coding</i>	<i>Focused coding</i>
<i>Day by day, you know, the conditions of human beings are changing. When I came to this country, people were different; those people (in old times) are not them (people nowadays). These people were loving and caring, all of them in here, we too as well, but now that love and affection are not there. In these days, if someone only says to you 'Hello' then this is also a big thing. That time is past. Today, the world has changed. This is not our time ... Those values are gone. Our values of respect for elders are over. You know, when we were young, even a distant relative used to love us that, 'Oh, he is Gafar's son'. It is not the norm now. Now even your own aunt will not bother about you. She does not. Things are changed.</i>	Noticing changes Recalling memories Differentiating changes Finding self-different; finding people different Indicating adoptability Comparing eras Fears values and respect are disappearing Relationships distancing Accepting changes	Times changing Norms changing

By analysing the data using focused coding, the categories and their properties began to develop, but the relationships between the concepts were not fully clear. I turned my attention to another GT principle which explains the relationships between concepts which emerge in the data; this starts with a core category.

4.11.3 Core category

Corbin and Strauss (2008) stated that concepts alone do not make a theory, it is the integration of these concepts into a central theme which holds an overall unifying explanatory scheme which eventually raises the findings to the level of a theory. A category which appears to have the greatest analytical power and the highest potential for linking all other categories together is called a 'core' or 'central category'. Corbin and Strauss (2008) put forward five criteria for choosing a central category:

1. It must be abstract;
2. It must appear frequently in the data;
3. It must be logical and consistent with the data;
4. It should be sufficiently abstract so that it can be used to do research in other substantive areas, leading to the development of a more general theory; and
5. It should grow in depth and explanatory power as each of the other categories is related to it through statements of relationship.

In order to identify a core category, Corbin and Strauss (2008) suggested writing thoughtful memos and using integrative diagramming to aid the integration of various concepts. I shall now describe this process.

4.11.4 Memo-writing

Memos are written records of analysis (Corbin and Strauss 2008) and memo writing is a key technique which helps the researcher to stop, focus, take codes and data apart, compare data, and define links within data (Charmaz, 2014:164). Memos are written records of the researcher's thinking processes which transform descriptive data into a theoretical account (Montgomery and Bailey, 2007).

Throughout the data collection and analysis phase, memo-writing helps the researcher to be continuously involved in the research process and to see what is happening within the data

and to identify how one might increase the level of abstraction of his/her ideas (Charmaz, 2014:7). By writing memos, I sought to define, label and justify each of my codes, to make comparisons within the data to identify relationships between the categories, and to keep a record of the progress. Memos are also written to enable a researcher to reflect, analyse and compare ideas emerging from data in order to construct theoretical categories. I started writing my field notes at the piloting stage of the study and continued until the end of data collection. Similarly, I begin writing my memos immediately after collecting the data and continued during the data analysis and writing phase of my study.

My initial memos were recorded in a methodological journal to document hunches, summarize interviews, redefine provisional codes and see developing links within the emerging categories. Field-notes, defined as a written record of observational data produced by field work (Montgomery and Bailey, 2007) were also made, interpreted and integrated into the memos to reflect on social constructions and interactions within the research context. Field-notes and memos were also used to log my reflexive observations, write brief descriptions of the interviews and plan what questions could be asked in the next interview and which type of participant needed to be recruited next. My memo on gender and family care (see Appendix 14), for example, was supplemented by my field-work notes. For example, when I asked participants in the FGDs what happens if older parents have only a daughter and no son to provide their future care, I observed that one participant took a long, deep breath to show pity and said *Allah ho Akbar* ('God is gracious'), suggesting that having no son in the family is a sad thing. Writing the field-notes and memo prompted me to ask the participants a wide range of questions on gender roles in family caregiving.

As the data analysis progressed, my memos were more analytical and abstract; I was questioning decisions concerning the concepts and the emerging themes and their links with each other, and more importantly raising focus codes into categories. My memo on 'Gender and perspective of EM' (see Appendix 15) is an example; my initial analysis on coding the data suggested that perspective on EM varies with gender, but it was memo writing which led me to think about the various factors which could cause this variation. I observed that women put more emphasis on the physical consequences of EM such as neglect and abandonment, whereas men accentuated the abstract impact of EM on their lives, such as loss of respect and worth. By writing the memos, I was able to develop a sub-category of gender as a risk

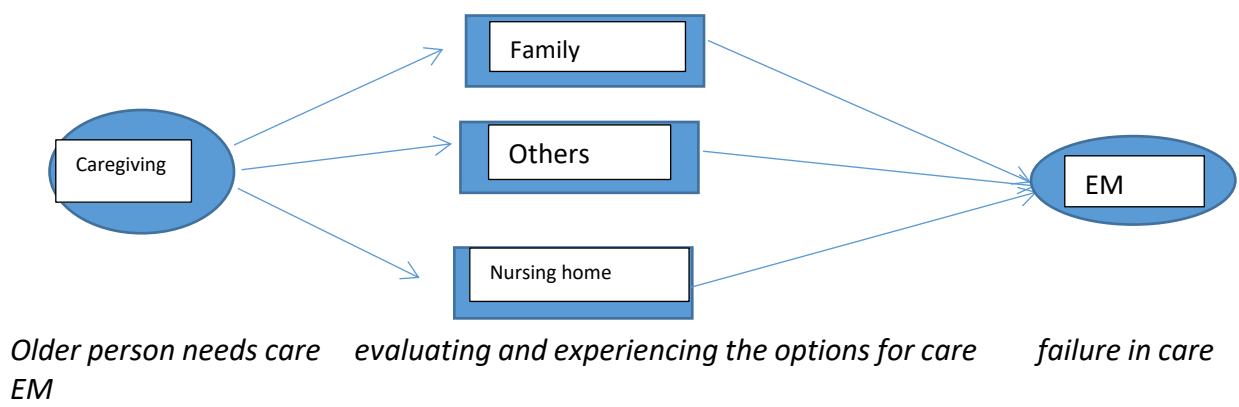
indicator of EM in Pakistani communities. As the analysis and memo writing progressed, I was able to develop and clarify the connection and relationships among different emerging concepts in the data.

All my memos were dated; they were short, integrative and spontaneous in order to capture all the nuances of the transcription produced through dialectic interactions between me and the participants. I also kept a reflexive diary to help in this.

4.11.5 Diagramming

Diagrams are visual devices which enable the researcher to see the relative power, scope and direction of the categories in the analysis and more importantly the connections and relationships within these categories (Corbin and Strauss, 2008:117; Charmaz, 2014:218). I used diagrams to clarify the positions and processes (Clarke, 2003) within emerging concepts to see the concrete image of my categories and ideas. In one of the diagrams which I drew, for instance, I wanted to examine the position and process within different dimensions of caregiving for older people in Pakistani communities (see Figure 4.2). As a person gets older, the family and the older person carefully engage in a decision-making process around the future care of the older person. The older person particularly evaluates the various available options and within these scenarios, when s/he see that the expected care is not being delivered, EM is subsequently perceived. This diagramming helped me to see that caregiving is a complex phenomenon and that all the available options of caregiving have the potential to increase vulnerability to EM under different circumstances.

Figure 4. 2. Caregiving and EM



Although diagramming is a rudimentary approach, it was useful in enabling me to see the complexity, clarity and connections between categories.

4.11.6 Theoretical sampling

Analytical coding, memo writing, and constant comparison helped the theoretical sampling, which involved the selection of participants in the light of emerging themes from the earlier stages of the data analysis. Whereas the earlier steps of analysis involved maximizing flexibility in order to identify more descriptive categories, this next step had a greater focus on the clarification and eventually the saturation of the existing categories. This will be discussed next.

As explained previously, the initial purposive sampling was undertaken in order to start selecting participants on broader characteristics, but theoretical sampling at this stage was used to guide what data to collect next (Charmaz, 2006; Glaser and Strauss, 1965). Theoretical sampling involves making conscious decisions about what question to ask in subsequent rounds of data collection, what type of participant to recruit, and which categories need developing.

To illustrate how theoretical sampling was applied in this study, two examples are given next. First, the use of theoretical sampling for the purpose of participant recruitment. Initial interviews with young family caregivers who were male and married suggested that the workload in the household, particularly in relation to caregiving, is gendered in Pakistani households. Therefore, the next participants to be recruited and interviewed were single females who were living with their parents. The analysis of their interviews demonstrated clearly that the workload in a Pakistani household is not only gendered but that the assigned responsibilities to females, who are married and living with their in-laws, can vary. This instigated the recruitment of a female who was married and living as daughter-in-law in the household. The analysis of her transcripts suggested that the household workload was not only gendered, but also asymmetrically allocated to daughters-in-law in Pakistani families.

Second is the use of theoretical sampling for the purpose of distilling and saturating the concepts. The descriptive analysis of the initial codes began to suggest that shame, respect, perception, disrespect and reputation are important concepts in the data related to reporting EM. Further analysis of these transcripts using focused coding clarified that the notion of

honour was a telling code explicating these initial codes. Writing a memo on this suggested that the notion of honour as a category within reporting EM was an intriguing category but it was thin and needed developing through more data. The existing data only presented the notion of honour in general; the role of gender and community in defining or sustaining honour was not found in the data. More relevant questions were therefore put to the participants about the issue of honour, specifically its position, possession and exertion in a relationship before reporting the EM.

The advantages of theoretical sampling were cumulative; it directed me to specific participants to gather and develop specific concepts, thereby saving time and resources. Theoretical sampling proved to be an important principle for deciding when data is saturated, the next step in a GT study.

4.11.7 Theoretical saturation

Theoretical saturation distinguishes GT from other methods of qualitative analysis in which rigour is acquired through multiple levels of confirmation or triangulation. Unlike other methods, GT uses theoretical saturation to determine a point in the analysis at which gathering new data no longer generates new theoretical insights and the central category is well developed in terms of properties, dimensions and variations (Charmaz, 2014:213). Theoretical saturation is often confused with repetition of same pattern; Glaser (2001:191) explained that

Theoretical saturation is the conceptualization of comparisons of these incidents which yield different properties of pattern, until no new properties of the pattern emerge. This yields the conceptual density that when integrated hypothesis makes up the body of the generated GT with theoretical completeness.

In this study, therefore, saturation was not just assessed on the number of interviews or participants recruited or on the repetition of some concepts, but on 'theoretical sufficiency' (Dey, 1999). In the context of this study, theoretical saturation/sufficiency was believed to have been reached when categories appeared well developed in regard to their properties and dimensions, the relationships between categories were established, and there were no

new properties found. Furthermore, the theoretical model developed for the study appeared well developed and clear when all the concepts were integrated. I also presented my data, the initial analytical work and my proposed theoretical model to my supervisors to confirm the adequacy of data collection and saturation.

Throughout the process of data collection and analysis, importance was also given to ensuring that the study was rigorous and ethically sound. This is the final process in qualitative research, and I shall discuss it next.

4.12 Phase 5: Evaluating Qualitative Research

4.12.1 Quality of study Criteria

Quality is a key concern when evaluating the credibility, authenticity, integrity, originality or transferability of studies. In quantitative research, validity and reliability are fundamental parameters for determining the accuracy, generalizability and replicability of the study (Bryman, 2008). However, these quantitative parameters cannot be addressed in the same manner in qualitative research (Denzin and Lincoln, 2011). Some commentators have argued that these concepts are irrelevant and underestimate qualitative research as good, valid and trustworthy. Others, however, have proposed various measures to address validity and reliability in qualitative research (Charmaz, 2014; Shenton, 2004).

Because this study used CGT as a research basis, the evaluating criteria suggested by Charmaz (2014) will be used. Charmaz (2014) proposed four key elements, credibility, originality, resonance and usefulness, for evaluating GT research.

Credibility

- Has your research achieved intimate familiarity with the settings or topic?
- Are the data sufficient to merit your claims? Consider the range, number, and depth of observations contained in the data
- Have you made systematic comparison between observations and between categories?
- Do the categories cover a wide range of empirical observations?
- Are there strong logical links between the gathered data and your argument and analysis?
- Has your research provided enough evidence for your claims to allow the reader to form an independent assessment – and agree with your claims?

Originality

- Are your categories fresh? Do they offer new insight?
- Does your analysis provide a new conceptual rendering of the data?
- What is the social and theoretical significance of this work?
- How does your GT challenge, extend, or refine current ideas, concepts, and practices?

Resonance

- Do the categories portray the fullness of the studied experience?
- Have you revealed both liminal and unstable taken-for-granted meanings?
- Have you drawn links between larger collectivities or institutions and individual lives, when the data so indicate?
- Does your GT make sense to your participants or people who share their circumstance?
Does your analysis offer them deeper insights about their lives and worlds?

Usefulness

- Does your analysis offer interpretations that people can use in their everyday worlds?
- Do your analytic categories suggest any generic processes?
- If so, have you examined these generic processes for tacit implications?
- Can the analysis spark further research in other substantive areas?
- How does your work contribute to knowledge? How does it contribute to making a better world?

This evaluation will also be revisited in Chapter 8 with my rationales for each of the questions raised by Charmaz (2014) in these criteria.

4.12.2 Ethical considerations

The Ethics and Governance Committee of the School of Nursing and Midwifery in the University of Sheffield approved the proposed conduct of the study in January 2017 (see Appendix 16).

The University of Sheffield's ethics policy (2012) states that:

... a research project focusing on any of the following subjects may expose participants to risks that may heighten their vulnerability: 'race', ethnicity, political opinions, religious beliefs, other beliefs of a spiritual nature, physical or mental health or condition, sexuality, abuse (child or adult), nudity and the body, conflict situations, and personal violence.

Because this study addresses a sensitive topic and raises a range of ethical issues, careful attention and planning were required in order to ensure that the study fully complied with the University of Sheffield's ethics policy and the Data Protection Act, 1998. Maintaining the dignity, privacy, well-being and rights of the participants was crucially important in the conduct of this research study. Strategies adopted to ensure integrity and ethical rigour in the study are discussed below.

4.12.3 Information sheet and informed consent

All the participants received an information sheet prior to their interviews. Because of the sensitive nature of the topic and issues of confidentiality, however, participants were asked if they wanted to take a copy of the information sheet home or wanted it reading out to them before the start of the interview.

In the information sheets (*see* Appendices 17, 18, 19) participants were informed that their participation was voluntary, confidential and anonymous. All of the information relevant to the scope of study, the interview guide, how data would be collected, and issues related to ethics including consent and confidentiality were explicitly declared on the information sheet. The information sheet was written in lay language so that participants could understand it well and could make an informed decision about whether to participate. The disclosure procedure was described in the information sheet and was discussed with the participants prior to their interviews. This will be discussed in greater detail below.

After the participants had agreed in principle to take part in the project, they were invited to sign the consent form. All of the participants were adults aged eighteen or above and had the capacity to consent. Their mental capacity was not measured with any standard scale or instrument; I used common sense and my previous nursing experience for evaluating the decision-making abilities of potential participants. The stakeholders also played a part in that they did not recommend a participant who did not have capacity to consent or who was particularly vulnerable. Consent was therefore informed and voluntary and the participants were aware that they had the right to withdraw any time without explanation or to refuse to answer any of the interview questions. It was also ensured that no participant, particularly older people who are deemed to be more vulnerable, would feel was obliged to take part in the study, and that no personal, social or cultural pressures were applied. The consent form was available in a language which the participants would understand, English and Urdu. Consent was obtained in writing. One copy of the consent form was given to the participant and other was retained for the record. The consent form is included in the Appendix 20.

4.12.4 Confidentiality and data protection

A detailed Data Management Plan (DMP) was developed for this study (*see* Appendix 21). The DMP was written using the DMP Online tool from the Digital Curation Centre, University of Sheffield. The DMP was also reviewed by Research Data Management (RDM) of the University of Sheffield and the feedback and comments provided by RDM were integrated into it. In the DMP, issues related to data collection, ethics and legal compliance, storage and backup, the selection and preservation of data, and data sharing were set out.

The participants were assured about realistic guarantees of confidentiality. They were informed that the interview transcripts and personal details would only be shared with the immediate research team.

All of the transcripts were anonymized and coded identifiers rather personal details such as names or addresses were attached to the transcripts of the interviews when storing the data in a password-protected computer. The raw data of the audio files of the FGDs and of individual interviews were destroyed after they had been transcribed and checked for accuracy. This is in line with the ethics application made for the study and also the general principles of ethics policy. Anonymised transcriptions and consent forms will be stored until

December 2021, as per the research ethics application. The physical movement of manual files (field-notes, consent forms and audio files) was kept to a minimum from the fieldwork site to the postgraduate research (PGR) students' office in the University in order to avoid damage, loss or theft. Manual files were locked in the PGR office cabinet, and I was the only key holder.

The data collection, storage, use, disclosure and destruction were all in compliance with the requirements of the Data Protection Act, 1998 and the ethics and governance policies of the University of Sheffield.

4.12.5 Disclosure and potential harm to participants

The risk of harm to participants by agreeing to participate in the study was low as the study was neither invasive nor interrogative. There were no interviews or focus groups which contained any actual known perpetrators or known victims of EM, neither was I actively seeking to investigate personal experiences of EM. There were, however, possibilities that people might want to talk about their personal experiences of EM or inquire about safeguarding adult support groups. At the stages of recruitment and data collection (interview and focus groups), attention was paid to minimise the potential risk to research participants. The participants were informed about how to contact the research team, if following their participation, they experienced stress, harm or have any other concerns about the research. They were also provided with contact details of the relevant organizations for support.

I understood very well that EM is a sensitive topic and that discussing experiences of EM, potential or actual, was likely to be psychologically distressing for all research participants. I therefore maintained sensitivity to the topic and to the participants' feelings and made sure that they were aware of the type of question that would be asked; I ensured that they understood that they did not have to answer any questions which they did not wish to answer and that they could pause or stop the interview at any time.

It was considered that there might be a risk of the escalation of mistreatment of older people by an abusive carer should they become aware of their victim's participation in the study. Therefore, all the information about every participant's recruitment for the study was kept confidential unless the participants themselves shared this information with someone else.

A detailed Risk Assessment Plan (RAP) was developed to ensure the appropriate protection and well-being of the participants (see Appendix 22). In brief, if a participant were to become distressed, the interview would be paused and the participant would be given a break and then asked whether he or she wanted to continue with the interview, reschedule it to another time or withdraw from the study. At the end of an interview with each research participant, I provided them with contact details of the research team and other support groups which could be of benefit to them if, following their participation, they experienced any stress or harm or had any other concerns about the research. The other support groups listed were Action on Elder Abuse, Age UK and Sheffield Safeguarding Adults.

On the information sheet, the limits to confidentiality were made clear to all participants.

There was plan of action in the case of any disclosure of abuse by a participant; this included:

- 1) Asking the participant if s/he could act for themselves to report the abuse and advising them and providing details about support groups which they could contact.
- 2) If a participant did not want to make a call to a service or support group him or herself but wanted the researcher to contact a support groups on their behalf, I would be able to do so. I would discuss the case with the supervisory team and with Sheffield Safeguarding Adults and/or the Action on Elder Abuse charity for advice, support, and recommended actions, and once agreed, I would complete a Safeguarding Adult Concern form (see Appendix 23) and send it to Sheffield Safeguarding Adults and/or Action on Elder Abuse. I devised a Safeguarding Adults Concern form which would be used to raise a participant's concern about their safeguarding to support groups (this form is attached). This form would be used for reporting abuse to or raising concerns with the relevant authorities. When the Safeguarding Adults Concern form had been sent, I would make a follow-up call if I had not heard anything from the authorities in ten working days. I would keep the participant (victim) up-to-date with the progress of his/her report or concerns.
- 3) If there were to be an immediate danger to any participant's life, immediate intervention would be taken which would include reporting the incident to the police and the safeguarding authorities.

Before starting data collection, the relevant organizations, for example, Action on Elder Abuse, Sheffield Safeguarding Adult Office, and Age UK, were contacted via email and telephone to inform about the conduct of study and potential for referral.

4.13 Conclusion:

This chapter presented the methodology which guided this study. In this study, a systematic and flexible version of grounded theory advocated by Charmaz (2014) was employed for the analysis of the data. The basic principles of CGT including analytic coding, constant comparison and theory sampling/saturation were explained, with example provided to illustrate how themes, key concepts, and properties were identified. Chapters 5 - 7 details the findings emerged from the analysis of data, and most importantly, the development of theory resulted from this analysis.

Preface to Findings

The last four chapters have focused on describing the rationale and the literature and explaining and justifying the methodology adopted in the conduct of this study. In these chapters, it was highlighted that the aim of the study is to develop a constructive grounded theory of EM among Pakistanis who are living in the UK. This aim was addressed by a series of research questions in these chapters:

- What do community members understand by the term ‘elder mistreatment’?
- What are the social, cultural and material factors which shape and maintain the practice of EM?
- What are the barriers which communities face to reporting EM?
- What are the strategies and coping mechanisms for dealing with EM?
- Based on the questions above, is it possible to construct a theory which could inform the understanding of EM among community-dwelling older people, young family caregivers and community stakeholders in the UK, and which can be used to improve both practice and research?

In the light of these aims and objectives, the findings which resulted from the collection and the analysis of the data will be presented and discussed in the next three chapters. The analysis of the data in these chapters draws on the findings from both the focus groups and the individual interviews conducted with community-dwelling older people, young family caregivers and relevant community leaders. As was explained in Chapter 4, there were no interviews or focus group discussions with actual known perpetrators or victims of EM, and neither was I actively seeking to investigate personal experiences of EM. However, as will be illustrated below, some of the participants had experienced EM and family members talked of being unintentionally involved in EM. The majority of the participants gave examples of the accounts of relatives or friends who had witnessed or been victims of EM.

Chapter 5 provides background and contextual information about past and current events and experiences in the lives of the first immigrant Pakistanis living in the UK. It further highlights the influences of family and community in shaping older people’s relationships and

future expectations. This chapter is not exclusively focused on EM but rather highlights the important social processes and structures which produce the conditions within which EM manifests itself. Chapter 6 is then exclusively focused on EM; the participants' perspectives are analysed to explain the understanding and the actions taken in the face of EM in Pakistani communities. This chapter highlights the participants' views and helps to explain the community's understanding of different types of EM, the risk factors of EM and the reporting and action-taking trends among Pakistanis living in the UK. The final findings chapter is a theory chapter: Chapter 7 brings together and interprets the findings presented in Chapters 5 and 6 with further analysis of the data to develop a resultant product, the GT of EM.

In participant's quotations and excerpts, the acronyms used to define their perspective category are as below:

EP = Elder Person

YP = Younger Person

SH = Stakeholder

FFG = Female Focus Group

MFG = Male Focus Group

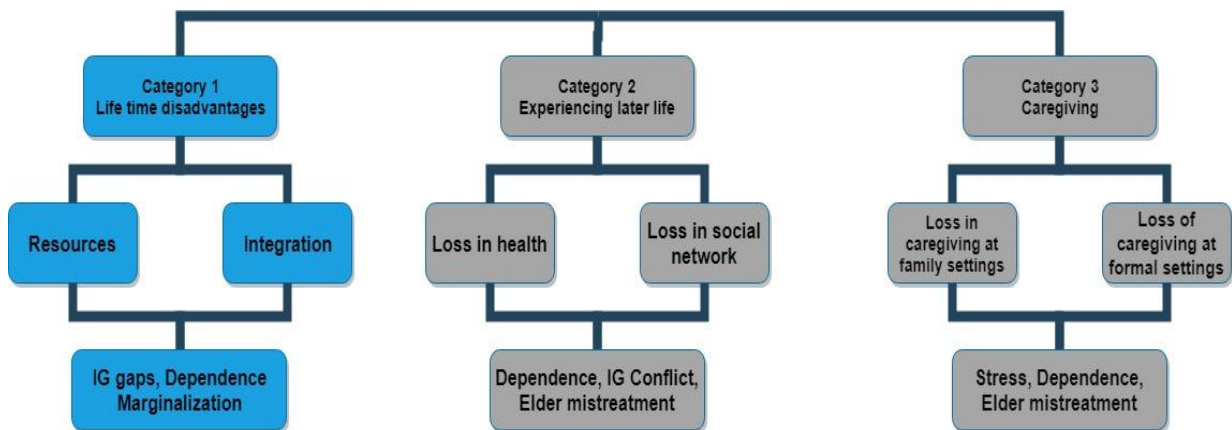
Chapter 5

Findings 1: Background and Context

5.1 Introduction

In this chapter, three principal categories emerged from the analysis of the data. The first category was *Lifetime disadvantages*; this explains the interplay between migration and the socio-demographic characteristics of the first Pakistani immigrants who moved to the UK in the 20th century. The second category was *Experiencing later life*, which stems from the current standing of elder Pakistanis to describe their perspectives and experiences of growing old in the UK. As well as outlining the different health problems in later life, the category explores communities' views about the mental, physical and social dependencies to which older people are either resigned or reluctant to acknowledge and personify. As will be shown, past events and the current state of older people are the key determinants of their IG relationships with their children and subsequently the expectation of their long-term *Caregiving*, the third category which emerged. This category predominantly comprises the factors which are relevant to the community in evaluating the future care of their older relatives, whether it is family or formal caregiving. Failures in family or formal caregiving have implications for the older person, as will be discussed in Chapter 6 and 7. Figure 5.1 provides illustration of these categories and their functions.

Figure 5. 1. Major categories and their functions.



5.2 Category 1: Lifetime disadvantages

In this category, the participants' views were analysed in order to understand their experiences and the implications of cultural, socio-economic and psychological changes, particularly in later life, following migration to the UK. As these experiences and the conditions in the UK shaped their IG relationships and family caregiving, how they were perceived by different participants is of significance. This category focuses on Pakistani immigrant biographies and provides the background to the lifetime events during their migration and settlement.

The initial analysis of the participants' narratives revealed the migration of Pakistanis as a combination of various push (such as to escape poverty in Pakistan) and pull factors (better services in the UK) which began in the mid-twentieth century. The first migratory cohort primarily consisted of young Pakistani men, with women joining next as dependents, when the decision to settle in the UK was made:

They had only one mind [plan] that we have come here [in the UK], for Rozy [Lit mean, earning]. One person went to prison [moved to the UK]; the others in back [in Pakistan] become happy... Okay, some people what they thought, now we have children as well, have a wife, everyone came, full family.

(Mr. Sikandar, MFG)

Despite the motives, migration brought challenges as well as opportunities for first generation Pakistanis living the UK and the outcomes were reported as wide-ranging and individual. The loss of a strong family and social network was discussed as one of the major negative outcomes which the first migrant Pakistanis continue to experience from moving to the UK. Although some Pakistanis migrated with relatives and friends to the UK, the social support has remained scattered and geographically distanced because of their migratory patterns. In the face of this fragmented family support system in the UK and the disrupted connections back home in Pakistan, many participants expressed their failure to access any social or family support, heightening their risk of acculturative stress. The excerpt below illustrates participants' feelings of being helplessness:

In Pakistan, our parents look after their parents and everybody else care about other. Now this country, off course you are not going to knock every other door for help. So these are the problems and tensions here.

(Ms. Farzana, FFG)

Not only this, family support was seen as a significant source of psychological and material support for migrant Pakistanis that they felt was missing from moving to the UK, as this participant explains:

You know in back home [Pakistan], someone like sister or other was always there to help you out with household work. You know because I was elder in the family, so my sisters ... used to come to me because ... I am alone, so a member of the family was coming for my help. So, it was good. This kind of support is not here; you have to do everything by yourself.

(Ms. Sabreen, EP)

The interplay between acculturation and psychological distress was a common finding, with many older participants stating that the lack of social support was one of the main reasons why they had failed to integrate into the new environment. As a result of the loss of family connections, participants explained that they did not expect to experience such an extent of being uprooted after migration:

That time I was disappointed because you come to a country and stay long and left everything behind. You promised your family that you would be back in five years, which never happened. Now we are just spare parts [neither here nor there].

(Mr. Hasan, EP)

The example above and other quotes illustrate that the significance of home and place was becoming clear to migrant. Some participants said that older people who had borne significant losses of social and family support find it difficult to overcome nostalgia for the motherland. The findings revealed that these experiences and feelings of being uncertain and unsettled are major factors shaping older people's relationships and beliefs about themselves and others. Not only this but also how these experiences are shaping the expectations and perception in relationships are of importance and have implication in the future interactions.

These points will be discussed further later in this chapter. However, because they are growing old with these moral dilemmas, one stakeholder commented that they are living longer with the same levels of grief and regret:

They still thinking or regretting in a way like if they would not have come or they were better off if they were back home [in Pakistan], so people mentally...same but since they can't go back now, it's too late.

(Mr. Umar, SH)

As the analysis progressed, it appeared that the loss in social support was tip of iceberg. Multiple challenges were emerging for migrant Pakistani while settling in the UK. Inequality and integration into the mainstream labour and social institutions, for example, were other challenges which the first migrant Pakistanis had experienced from moving to the UK. Lacking socio-economic skills and resources, older people reported failing to get equal rights, opportunities and treatment in their early years of their lives in the UK:

When I came to this country, I was 19, I think. Then in here I find many difficulties, like an uneducated person, having no English, no Pakistani education, so it was big problem so then I try to learn everything in night schools, as during day time working in British steel factory. I learnt about auto-mechanics, electricians, plumbing, and all these in night schools. To improve my life, I had to learn these things. I had to work hard to get jobs.

(Mr. Hasan, EP)

Mr Hasan was not alone in this; many participants told similar stories about living with hard conditions and facing multiple challenges after migrating to the UK. Poor and overcrowded housing, deprived neighbourhoods and poverty and deprivation were a shared part of their daily lives. Recalling old times, one participant described his past deprivation:

In our time, the houses you see, there were no bathrooms in them. There was special place [communal bathroom] where we used to go for bath. There was no bathroom in houses. This central heating and other, there were no such thing at that time.

(Mr. Suhail, EP)

As the examples above indicate, the migration was not well planned or thought through and the immigrants were unskilled, and as a result, it was believed that many migrant Pakistanis fell into poverty and continued to live with economic difficulties:

When they came over here [the UK], it was definitely a big shock for them that how they would have to live all in one house and work so hard, for so many years before they manage to get their own place, and things were very difficult for them. It was unbelievable.

(Mr. Usman, YP)

Poverty has implications for people's health and well-being. It was regarded as playing a key role in shaping older Pakistanis' position, status, relationships and well-being in the family. Therefore, the impact of lifelong marginalization on immigrant Pakistanis' health and social network is important and will be addressed in the following categories and chapters, and additional disadvantages which the immigrants experienced will be discussed.

Being an immigrant and unskilled has also been linked with the cumulative disadvantages which the first Pakistani immigrants continued to experience in their later life, one of which is integration – spatial (living together in a neighbourhood), structural (engagement with structures of society) and cultural (engagement with each other's values and norms) – into British society. One participant said that successful integration could have resulted in them acquiring socio-economic skills such as language and communications abilities, access to social resources, and opportunities for employment and housing; for the first Pakistanis, all these failed to materialize, primarily because of the host communities' unwelcoming attitudes. Although British society appreciated the services of the Pakistani residents, it was highlighted by the respondents that it did not give social recognition to the characteristics of their identities, such as their culture, religion and beliefs, as this next comment shows:

They [English] do value the service our community has provided, whether it be you know in the national health service, as doctors, or the providers of services...I believe there is element of racism ... [they] do not like you ...your cultural background, colour, religion.

(Mr. Khalid, EP)

Another elder participant expressed similar views about their early experiences of alienation and marginalization in the communities. She said that distancing was an implicit way in which the host white communities regarded Pakistani immigrants as racially and culturally inferior:

In the very beginning, English people used to hate us. When we were cooking, we like the aroma of food [and masala], but they [English] used to say that your food smells. When I first came to [Neighbourhood name], there was no Pakistani; it was just the next-door people and us. There were only three families, but now the whole Tinsley is full of Pakistanis. All [English] are gone from here. Rarely an English left. Because they used to hate us a lot.

(Ms. Zeenat, EP)

These experiences of marginalization and exclusion are important in shaping older people's views and practices and in developing their trust in services, relationships and the wider society. They also have implications for people's help- and support-seeking behaviour. These important points and their relevance to older Pakistanis' well-being and safeguarding are covered in the following chapters when the reporting and help-seeking trends of EM are explored.

Although marginalization by the white host communities was the central cause of the limited integration, as discussed above, the self-segregation, cultural and residential, adopted by the first Pakistanis was also considered as an alternative explanation for this. The findings on this aspect suggest that the fears of losing national identity, alienation from the native culture, socio-demographic behaviour and language were major concerns for the immigrant Pakistanis. In self-segregation, they found a sense of belonging and a feeling of safety and believed that they were preserving their culture and identity, as this excerpt illustrates:

They generally, kept eh with the people who, when they first moved over, the people who they knew then, who they used to work with, who they used to live with, they kept that friendship, and they stayed with them, eh you always go back to your original, base friends.

(Mr. Usman, YP)

Not all respondents held uniform views about the positive effects of self-segregation, particularly the generations who sought it. As a result, older people discussed experiencing the negative impact of this in both their IG relationships and wider social interactions. The second and subsequent generations born and brought up in the UK are highly inclined towards and acculturated with British culture and society in terms of sharing their spatial and cultural identities with them, and the young participants stated that this heightened the potential risk of IG gaps between older Pakistanis and their children:

Oh, I think that is where the problem were. They could not see, eh, they thought, may be thought, we were losing our identity by being adopting the way of life of the people in this country, but there is nothing wrong with that as long as you keep to your eh, morals because the people of the country have good morals.

(Mr. Usman, YP)

Not only the young participants but also a few older people acknowledged that self-segregation was widening the IG gaps:

Today's generation, the young generation is mixed up with each other. They have something from us and we have picked things from them. Old times were different...culture was also different. This is reason we were unable to mix with them.

(Ms. Zeenat, EP)

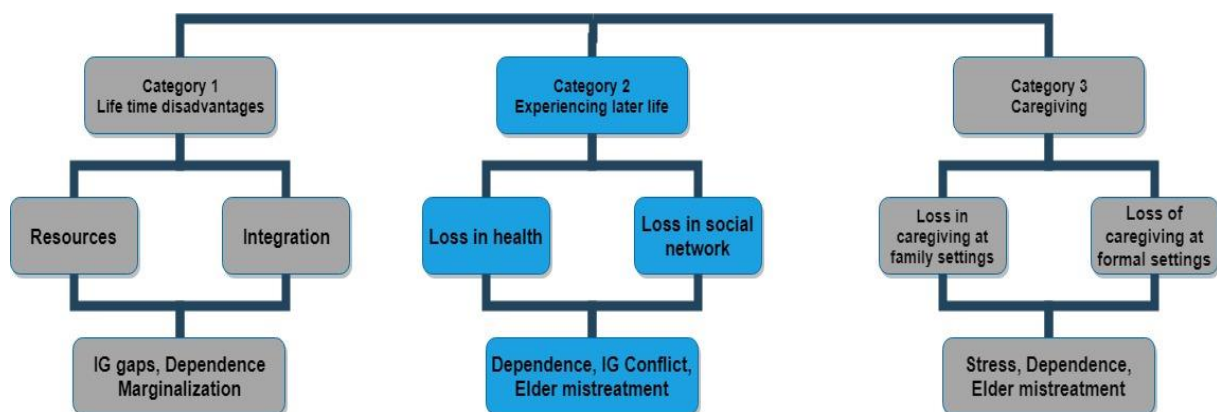
The first category provided a brief account of the opportunities and challenges first migrant Pakistanis experienced while settling in the UK. It highlighted that the lifetime disadvantages, such as marginalization, poor housing and poverty and the migratory losses for example, the loss of strong family network are linked with older people's current poor physical and mental health (see category 2 for details). It was also found that the understanding of society, the ways of living and the different attitudes toward relationships between old immigrant Pakistanis and their children are not necessarily uniform. How these different understandings and interactions shape, influence and maintain the present interactions and future IG relationships will have significant implications for older people. These points are important and will be discussed in chapter 6 and 7 when acculturation and elder mistreatment and,

more importantly action takins in mistreatment are covered. As the first migrants are ageing, how these disadvantages and other factors shape the current conditions and experiences of older people is of significance, and I shall discuss next their experience of later life.

5.3 Category 2: Experiencing later life

In this category, the participants gave their views on the current physical, economic and social state of the first wave of Pakistanis, now becoming old, and commented on how growing old as a migrant is experienced in the UK. As these perceptions and beliefs of later life and the current physical and social conditions of older people have a significant impact on their present and future caregiving and potential (mis)treatment, how these older Pakistanis experience their later life is of significance. This category further falls into two subcategories – losing health and losing a social network - both were believed to have implications on independent living and mobility of older people in later life (see Figure 5.1).

Figure: 5.1: Major categories and their functions.



As the analysis on this category progressed, it was clear that later life was predominantly perceived negatively by the participants who assumed that growing older was a combination of multiple social, physical and economic difficulties and challenges. The major prejudices attached to later life, such as that it would be a time of loneliness, ill health and suffering, were central points in our discussion and these prejudices were probably one of the reasons why many older participants expressed their reluctance to acknowledge themselves as an older person. As the comments below clearly show, accepting later life as an inevitable was primarily dependent on older peoples’ perception of body image and self-image, with many

participants associating body transformation in later life with self-worth. Being old, they saw themselves as less worthy and their life less meaningful, as the next comments show:

There is nothing special [in later life]. What could be our hobbies? Actual things happen when you are young. When youth is gone, everything is gone. In old age, everything is problem. You are old, you lose your teeth first, and then eyes, then hair turning grey then you colour them. This happens and that happens, pain happens, stomach-ache happens.

(Mr. Suhail, EP)

He [older person] thinks, wish he become young again, he wants to become young, but it is useless to cry over a spilled milk

(Mr. Sharjeel, MFG)

This denial or unwelcoming attitude toward later life, however, was believed to be linked with older peoples' present poor health conditions and age-related changes. In individual interviews with older participants, they were asked about their health status. The analysis of the findings revealed that older participants were suffering from at least one chronic health problem such as diabetes, arthritis and chronic heart disease (see Table 5.1). However, the age- and health-related challenges and dependences were established by the historical disadvantages and the traditional ways of older people's living, as this stakeholder explained:

Based on my experiences working within [charity name] I would probably say one of the problems that older people face obviously is ill health, its growing thing specially within the Asian community that unfortunately we are not, our diet, our lifestyle, its lack of exercise

(Ms Mariam, SH)

Table 5. 1. Health status of older participants

Ms Sabreen	Mr Suhail	Ms Zeenat	Mr Nabeel	Ms Janat	Ms Rahila	Mr Hasan	Mr Khalid
Diabetes		Diabetes	Back pain		Systematic Lupus	Diabetes	Not mentioned
Thyroid problem		Asthma	Gastric problems			Asthma	
Arthritis	Arthritis	Arthritis		Arthritis			
		High BP	High BP				
				Many problems not disclosed		Heart attack and multiple by-passes	

A number of participants saw the loss of physical strength (dependence) as linked with their current mental, psychological and economic well-being. The inability to perform everyday activities was believed to lead to stress and depression. Some elder participants expressed experiencing frustration at being unable to meet the social, physical and spiritual needs of their families and themselves, and feared that this would threaten their hierarchal status, particularly if it was linked with their financial contribution within the family:

I get quite a lot pain and that is quite distressing to me because I work and I am a father... I find it hard now to go to job or mosque or sit on the floor

(Mr. Nabeel, EP)

Of course, in old age, everything is restricted then. You cannot go anywhere, and you become dependent on other people. You have less money. Your health is not that good. I pray daily that God forbids from dependency and keeps away from complications of diabetes. God give good health and depart [die] in good health and should not suffer in disability.

(Ms. Sabreen; EP)

Not all looked at dependence exclusively in terms of material loss, as the examples above suggest. In becoming dependent, older people also anticipated losing their pride and dignity within the family, and this was believed to have psychological as well as material implications:

You know when I was young chap; I used to hear these elder people praying, "Oh, May God please keep us in good health". You see we do not want to be dependent on others... burden on our children...and lose your pride.

(Mr. Khalid, EP)

The comments above show that respect, authority and dignity are key determinants of older peoples' cultural identity. How dependence on others or on family members shapes their position and status in the relationship remains a critical question for them. Most interestingly, how this will influence their level of tolerance to abuse and their help-seeking emerged as an important part of my analysis. These points will be addressed later in Chapters 6 and 7. Here, the potential influences of dependence on other social processes will be discussed next.

The physical losses and consequent dependence did not just have implications for their mental health alone, but further extended to depriving older people of their social and family contacts. One of the participants used the example of his daughter living in London to explain this:

My daughter is in London. She asks dad 'come to visit us'. But, London. It is bit far. I get tired because I do not have same strength.

(Mr. Suhail, EP)

Not only this, but loss of physical health also had an impact on leisure and social life in later life; taking opportunities away from older people, as this excerpt illustrates:

I have been going to swimming classes. I cannot go now. It has been few years I got bad arthritis, I cannot walk much now. It hurts a lot in joints.

(Ms. Zeenat, EP)

Isolation and loneliness were major concerns of later life which appeared to have multiple causes in addition to physical impairment and the loss of strength. Being immigrants, Pakistan elders were believed to have a small social network in the UK, and any additional loss through

the death of family members or friends or by being abandoned by their children were regarded as daunting aspects of growing old in the UK. By becoming isolated, older people feared becoming vulnerable in society:

Of course, you have to face all sort of different things, your children leave you, and your family keeps the distance. So many people have issues [conflicts] in their families. These examples are very intimidating especially when you are old when you have no physical capacities.

(Mr. Sikandar, MFG)

Another elder participant also spoke about his reducing social support in the face of losing close friends in growing old:

My real friends are passed away. Majority of them. If anyone is alive, I know nothing about him, he might be somewhere, in his house.

(Mr. Suhail, EP)

The comments above highlight the important findings on isolation and loneliness. How vulnerable older Pakistanis cope, for example, particularly without family support, raises significant questions. Most importantly, how this fear or actual experience of being lonely and isolated affects older Pakistanis' social mobility or heightens their risk or fear of street abuse are critical; these findings will be discussed in detail in Chapter 6. Here, the potential implications of being alone and dependent for older Pakistanis and their family caregiver(s) will be further analysed next.

As the analysis progressed, it became clear that the loss of physical strength and social support were also linked with older people's adaptability to successful and active ageing. Suffering from overwhelming losses, increasing isolation and decreasing health, some older participants were struggling to find meaningful activities in later life; their resignation, reclusiveness and depression were internalized practices of living an inactive later life:

I am now used to isolation and loneliness. It is been 18, 19 years since my husband died. Then person becomes used to these things. It was very, very difficult in the beginning [to live like this].

(Ms. Zeenat, EP)

I find depressed when I am doing nothing when you do not know what to do tomorrow or when there is no planning at all. It is depressing.

(Mr. Hasan, EP)

Another explanation of inactive ageing was observed to be the result of some cultural and religious beliefs in later life. In Pakistani culture, later life is regarded as a time to retire from work and household duties, to transfer responsibilities to one's children and to rest. Similarly, religious coping was seen as the only strategy to address their physical, social and mental health problems in later life, as these participants explained:

Problems and illness come by Allah. When you are in trouble. Neither doctor nor anybody else helps, just Allah.

(Mr. Sharjeel, MFG)

I have some health problems, but I just carry on with my own normal life. What is Allah written in my fate will happen to me. My children are, Mashallah [thanks to Allah] good...to support [look after me].

(Mr. Hasan, EP)

In the younger participants' view, however, such traditional and religious beliefs were more likely to increase older Pakistanis' risk of dependency and a subsequent burden on family members. Young participants were found to expect that inactive ageing by their elders would have negative impact on their own lives:

When they are old they just say we are old, we are not gonna do anything and they just stay in the home or we got illness like say for example if they got like diabetes oh we are so ill we can't do anything [you do everything for us] . If they let them go out and don't maintain the health, that will just become a lot worse...dependent... and then they develop more health problems.

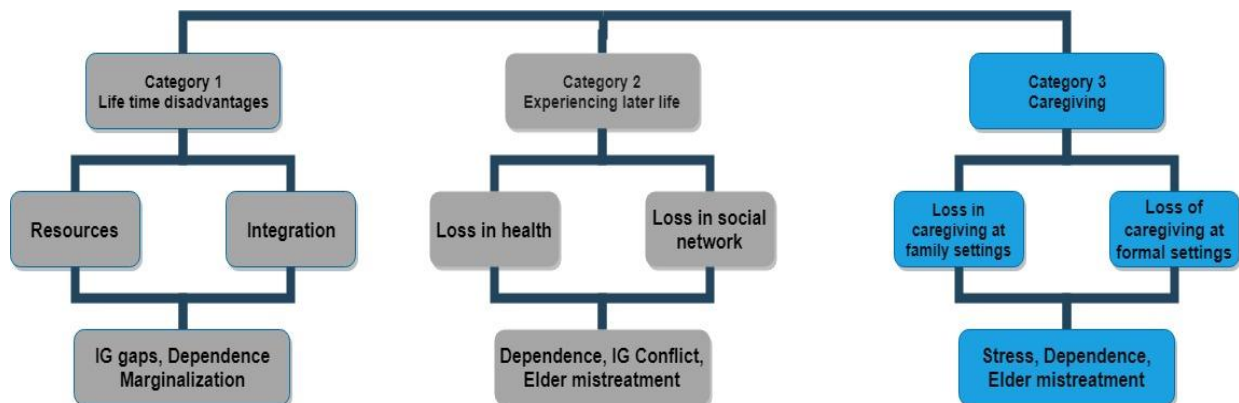
(Ms. Zohra, YP)

A number of older people who had experienced a reduction in their health anticipated that it would potentially increase their risk of dependence on others. In becoming dependent, IG relationships and support are important to them considering the migration-based losses. Most importantly, however, are the implications of the cultural and religious ways of this ‘passive living or active dependence or learned helplessness’ on older people’s expectations of relationships and the treatment in care? I shall therefore now turn to caregiving, an important aspect of the IG relationship.

5.4 Category 3: Caregiving and caregiving stress and EM

In caregiving, there are two sub-categories, losing care in family and formal caregiving settings (which means public care for private families) (see Figure 5.1). In family caregiving, different motivating as well as disabling factors were identified in terms of the implications and barriers which family members face when they provide care to an older person. Caregiving stress emerged as important, particularly in the light of conflicting expectations of caregiving. Such conditions served to heighten the potential risk of EM. In the discussions on caregiving stress, other sources of care, primarily nursing homes, were found to be a major topic of interest and also conflict.

Figure: 5.1: Major categories and their functions.



5.4.1 Sub-category 1: Losing care in family settings

Family-based care of an elder person was regarded as a highly complex phenomenon in Pakistani families, with many participants recognizing the greater influences of different social institutions (such as religions and culture), social context (such as migration and

acculturation) and social structures (such as family and community). As the caregiving conditions and perspectives play a key role in defining family relationships and family tensions, it is of significance to understand the practices and perspectives of participants on elder care in Pakistani families.

The initial analysis of the data suggested that the interpersonal relationships of older Pakistanis with their families, communities and wider British society are predominantly shaped by the core cultural values which the first Pakistani cohort immigrated with and were considered to believe strongly in (see Table 5.2)

Table 5. 2. Core Pakistani cultural values [identified from participants’ narratives]

Core Pakistani cultural values
<ul style="list-style-type: none"> • <i>An older person is considered as a wise person because of age and experience; therefore, consulted for decisions over issues inside the house or community. They hold the role of a wise person (Mr. Javeed, YP)</i> • <i>[older people] more like a library to us, they are the main source of knowledge and information (Ms. Amina)</i> • <i>... if they [young people] are 16 or 18 or even married, they are supposed to stay with their parents; this is not the case here [in the UK] (Ms Amina)</i> • <i>We’ve got up to three generation living in one household (Mr Akash, SH)</i> • <i>Grandfather or grandmother are very highly respected, they are seen as head of the household and no-body lifts an eye to them (Mr Akash)</i> • <i>Men are always like a kind of breadwinner; women can just take care of the household, the children, the food (Mr Mubarak, SH)</i> • <i>A joint family is a micro social security system (Mr Hasan, EP)</i>

As Table 5.2 shows, the fundamental principles of elder Pakistanis’ core cultural values can be recognized as collectivism, interdependence, familism and hierarchy. Within this, the family remains the central micro social welfare system in which the members pool their energy, incomes and resources for mutual goals. The elder person, on the other hand, takes the main position in the family, and this will be discussed next.

Living together was seen to hold special meaning for the immigrant Pakistanis in later life. The analysis of the findings showed that the majority of the older participants were living with their children or grandchildren and preferred to do so. There were number of reasons for this,

including declining health, loss of a partner/spouse, poor socio-economic status, cultural or individual values and an unwillingness to live alone. The older participants expressed satisfaction at living with family as such togetherness reflected their native upbringing, culture and migratory residential patterns. These preferences were raised many times:

We live in a big family, with children and grandchildren. We do not want to live alone. I have never lived alone; therefore, loneliness will be difficult.

(Ms. Farzana, FFG)

...but I think it is a good thing that at least one child should stay with parents so that they could be looked after as well.

(Mr. Hasan, EP)

These comments also clearly link the expectations of living together with family caregiving, and many older participants had strong expectations that their children will look after them if they need care in the future. Given that caregiving was regarded as the cultural and moral responsibility of the family, the elder participants simply saw it as a cyclic, natural and expected phenomenon, as their comments showed:

I have looked after my mum and dad; therefore, my children will also look after us. They are very good. This is our culture. This is what happens.

(Ms, Jameelia, FFG)

I was expected to look after my parents and that was expected thing to do as a son as well.

(Mr. Nabeel, EP)

Young people, on the other hand, wanted to evaluate the gains and losses (physical, financial, social, and career) involved in family caregiving, examining the role of culture, religion, social ideologies and structures in the context of elder persons' expectations. Young participants who were actively engaged in providing care to their parents gained satisfaction through fulfilling their filial responsibility and therefore viewed caregiving as a privilege and part of a natural life pattern. Their caregiving ideology was strongly affiliated with reciprocity, and many participants explained that the selfless love, unconditional care and hard work of their

parents in bringing them up were the core motivations inspiring them to pay off the debt in terms of future care, as the following comment illustrates:

Ehh ehh well, I think ehh it will be selfish of me not to do it really, considering everything that she has done for me, and when she was bringing me up...but what I am actually doing now is just repaying what she has done for me, so she is one up on me, do you know what I mean.

(Mr. Usman, YP)

Similar to role reciprocity, religion also emerged as an important driving factor, and caregivers gained strength and comfort from providing and managing their caregiving duties. A strong affiliation with religion was a significant determinant of their family caregiving, with many caregivers seeing immense reward in looking after an ageing parent in their religion, Islam. They regarded caregiving as equivalent to *Hajj* (the pilgrimage to Mecca); one of mandatory duties in Islam or the *Jihad* (the struggle to satisfy Allah with good deeds). In Islam, your parents' well-being comes next to the duties towards Allah, and one participant referred to a Qur'anic verse to make this clear:

Obviously, there is clear verses, the Quran fifteen-time mentions being dutiful to your parents...you have to look after to your parents, it is obligatory for you to do that. You haven't got the choice in that matter.

(Mr. Usman, YP)

Muhammad [prophet in Islam] said look after your parents, this is what your Jihad [Internal struggle to be better Muslim] is. You will get equal reward of Jihad in looking after your parents.

(Mr. Sharjeel, MFG)

By maintaining a strong affiliation with religion and a positive attitude towards filial piety, the caregivers said that they gained strength, developed patience, coped with stress, and derived meaning from their caregiving experiences. In answer to a question about whether he ever felt stressed in providing care to his disabled father over 25 years, Mr Muhammad, said this to explain his coping strategies in stressful situations:

To be honest, never, never thought of it, as being stressful. You always wish I spend more time with him, and I did more for him, that how I feel. It is the reward of looking after the parents, it's immense so even and to tolerate anything ehhe you know and gain patience from something like that is enormous.

(Mr. Muhammad, YP)

Like religion, the Pakistani culture also places emphasis on family caregiving; however, the provision of care was considered to depend on how the cultural values – familism, reciprocity and family loyalty – are transferred to the next generations. In situations where the caregiving role was religiously/culturally modelled over generations, the role became a natural part of the individual's life pattern as a cyclic and normative phenomenon, as this caregiver explained:

I felt that like, my parents loved them, because they are their parents then obviously, they are my grandparents as well, I should love them as well, so we used to be like, I was really attached to my grandmother, and I could not see her in pain.

(Ms. Amina, YP)

Nobody told us, you know but we just seen that, just role modelling. We see next door, your neighbours their grandad comes from other city they were actually touching their feet, talking to them ...looking after [them]...taking them to park...mosque.

(Mr. Javeed, YP)

Not all were said to have a cultural and religious upbringing such as described above. In contrast, role failure, described as a parent's failure to cascade or transmit these core cultural values and invest time and resources in children's upbringing was emphasised to have implications for older people in the family relationship and in caregiving. The participants discussed how not all older people enjoy taking care for granted. Children were believed to evaluate their parents' investment in their upbringing in order to calculate reciprocal treatment, as illustrated by the following comment.

Its mum and dad's fault. You know they say in Pakistan that first school is a mother; if mother teaches children good things then children will do good things. I have seen parents do not teach children and consequently, children do not care about parents.

(Ms. Zeenat, EP)

In role failure, however, the uncertainty of parents over which culture, British or Pakistani, to follow and promote in the UK was considered as one reason for parents' failure to transmit values to the next generations. This hesitation of parents about transmitting traditional values not only gave mixed and unclear messages, but it was realised by older people as a reason why children have been left uncertain about their role in meeting the demands of family caregiving. In the absence of value transmission, the participants claim that children have been learning different values from divergent socialization agents, school, peers and society, which might not conform to traditional Pakistani norms or values on caregiving.

I am trying to give them some of that believes and values that I had but it is difficult because they are out of house majority of the time, you know they are in school and in college with the host community and you know then the media... therefore, to expect that [caregiving] from my children would be extremely difficult.

(Mr. Nabeel, EP)

Many participants discussed multiple reasons for role failure, as was discussed in the previous category, such as lifelong disadvantages, unskilled migration, time-consuming and physically demanding work, and limited socio-economic resources (such as language proficiency, driving ability and modern education), as the following comment shows.

We, who did not teach them that [what are our culture] but again that times, parents themselves had little knowledge so what they could have taught to their children.

(Ms. Janat, EP)

However, the parents who were perceived to fail to invest in their children were indicated as being those who were already experiencing multiple disadvantages in status – poverty, overcrowding and discrimination, for example. As a result, participants claim that IG relationships and future care is a critical issue for them, as this participant explained:

Those who paid more attention to work, those who drove taxi all day and spend less time with children then this is their fault [they not having family care]

(Mr. Akbar, MFG)

The examples above clearly show that neglect in older parent's care is significantly linked with role failure. Whereas role modelling helps and guides children to improve their lives, make the right choices and develop better relationships, role failure was linked with a disturbed childhood. For children with disturbed parenting, how role failure shapes their attitude towards their IG relationships, older care and the treatment in the care are important issues and these will be discussed in Chapter 6.

As the participants' quotations were compared and categorised, another analytic code the *role reversion* emerged as an interesting finding in the context of role failure. Having different sources of knowledge and skills, the children are seen to be in the dominant position for accommodating and guiding their elders in modern ways of life, as the quotes below illustrates

They [young generations] have got more horizons of the knowledge that there are different means of, they have got exposure in the school, in the society, they are going out, they are watching telly, and they are educated in even different subjects which we were never. So, they are our guide now.

(Mr. Umar, SH)

If there is problem, children come and take me...all my children have cars, so no many problems.

(Ms. Zeenat, EP)

All they got ehh go to so many places to get treatment...because I have to look after my mum so much I cannot go out, the only place I go to is work and come back.

(Ms. Zohra, YP)

The comments above, however, also indicate the implications associated with role reversion for older parents, for being dependent, particularly in terms of their power and authority in their relationships and in the household. The findings showed that when the hierarchal role and the authority of the older person in family is threatened, they saw it as deeply hurtful and therefore a form of abuse. Role failure also raises questions about the social exchanges in relationships, and that will be discussed in next chapter.

As shown above, a number of young caregivers still adhered to cultural and familial expectations of caregiving. However, members of the younger generations were now seen to be evaluating the expectations of care before accepting the responsibility if it had implications for them. I consider these implications next.

Implications and barriers in family caregiving

Although the findings confirmed that many caregivers associated caregiving with filial duties and familism, it was also described as a life-changing and time-consuming responsibility. Young people wanted to evaluate and/or accept cumulative losses incurred against the motivational gains in providing care to a family member. Participants also mentioned different barriers which restrict young caregivers from providing effective care to older persons in families.

Social and personal implications and barriers

The impact on the social life of a caregiver formed the central feature of their evaluation. Half of the caregivers in the study mentioned feeling lonely, isolated and having no personal time. This included time to go on holiday, time to meet friends and time to engage in hobbies which they felt were important to them. The burden of caregiving increased for those who were the solo care provider and shared a house with a dependent elder. Drawing on her personal experience, a participant told how her mental and physical stress stemmed from being socially isolated by looking after her older mother:

If I ever go out probably like once in like a really blue moon and I will just go out like about an hour or two and even, then she is ringing me 'get home get home I am not well'.

(Ms. Zohra, YP)

For some caregivers, the responsibility was inherent in the relationship as there was no-one else to look after the older person and they felt obliged to provide care. Being women, the role was often asymmetrically distributed and auto-assigned to them because informal care is predominantly associated as a female activity in Pakistani culture.

Miss Sadaf, for example, began caregiving at a young age when her brother was severely ill with leukaemia. Then it was her father who was frail and ill. Currently, she is married and

provides care to her mother-in-law, as caregiving is associated with daughters-in-law in Pakistani culture. The cumulative losses were immense in caregiving; as Ms Sadaf said, it had taken away all the choices from her life, including the choice to study, work and live a social life, since she had no option but to provide care:

So, it's always been like that, when I got to that age where I should have thought about myself, my future, it is always been caring and you know elderly people, sick people and very close to me, yeah, you know. So yeah, I have lost out at that side, yeah definitely.

(Ms. Sadaf, YP)

As this example clearly shows, the care of an older person is gendered; but cross-gender care was seen as a sensitive issue and a major restrictive factor in Pakistani communities. The participants said that cross-gender care was more likely to affect the extensions and limitations of care, in that both the care receiver and the care provider had to be comfortable with it, as the next comment shows:

I would say also because you are male or female, if you are male it be harder for you to look after your mother and you just, you wouldn't feel comfortable, so you wouldn't do it.

(Ms. Zohra, YP)

This was also true in Mr Hasan's situation when his mother needed family care, but he felt helpless because he was male:

My mother had a stroke, so, we all decided that we will keep her in the house. She is my mother but then she is also a woman, so I can't do look after her. It is difficult but we could not find any women who can look after her in the home... we needed a woman who can change her clothes, give her wash.

(Mr. Hasan, EP)

The examples above suggest that providing care in stressful situation has potential implications for both care receiver and care provider. When care was involuntary or forced or family holds certain reservations, the compromises in the quality of care or neglect in care

were inevitable for older person. Similarly, stress in providing care has an impact on the physical and mental health of the care provider. Furthermore, as the loss in education associated with economic prosperity, how the role of caregiving influences on *material and economic resources* of care provider are of significance; therefore, this is considered next.

Financial and material resources and implications

For family caregivers, the financial and individual implications of providing care at home were key determinants in deciding elder parents' care. The caregivers who talked about bearing a significant negative outcome from caregiving reported that caregiving, on the one hand, drove them into financial instability and on the other hand, the role continued to load them with a financial burden. Anything which could happen to a family member receiving care had implications for the caregiver in terms of taking time off work, being unable meet financial needs or completely losing a job. In addition, transport costs, maintaining a vehicle or even keeping up-to-date with bills were significant factors which a caregiver evaluates while providing care to a loved one. However, many caregivers had to accept the losses (career and financial) as the caregiving role demanded it, as the comments below illustrate:

My father in law had a stroke for twelve years. I used to look after him, that is why I was unable to take classes and before that, my children were too young. Then I become free and work for a charter accountant for two days.

(Ms. Jameela, FFG)

I suppose it gets a lot really tiring because I have to go to work to be able to afford what I am wanting, and you know to pay my bills like for phone, eh my car, and also take my mum to appointment and keep her going.

(Ms. Zohra, YP)

Given that family structure and family function are going through rapid changes, the size of the house was a significant determinant in deciding the caregiving responsibilities. The small-sized houses were agreed to be a barrier, particularly if an older person has severe physical health problems and needs extra space.

They [children] complain that the house is small and they [old parents] are crying in pain and coughing or things like that and we get disturbed. So, it is a problem [to look after parents in small sized houses].

(Mr. Waqar, SH)

The above example also shows that managing and providing appropriate care in small-sized houses is significant concern given that community already lives in overcrowded house and face poverty. This will have implication on older people's quality of care and risk of neglect. This is covered next in chapter 6.

The analysis of the findings also captured many other barriers associated with modern pressures in children's lives which could affect the family caregiving. Economic mobility described as working long hours and working away from home was considered a major disruptive factor for family togetherness, and consequently for caregiving. Comparing his mobile, self-employed life with that of other young people, Mr Muhammad illustrated this:

I can imagine we are living in the much more global world, these generations in terms of their jobs and jobs security, might need to travel more, so they are out of the house more, and lifestyle is such that you spend less time at home, that has an impact.

(Mr. Muhammad, YP)

Financial pressures were also linked with a rise in dual-career families which were thought to have implications for family caregiving. The analysis of the narratives indicated that the participation of females in economic activity has significantly increased in the UK among people from Pakistani communities compared with the first-generation Pakistani women. In dual-career families, the female role is shifted beyond the household, so the household chores which were assigned to women in traditional and familial norms are now changing, and this is changing the caregiving dynamics, as the comment below illustrates:

I have got respect for them, but you know in this country you are financially really struggling, working, your wife working and you working and so I don't have time, my wife has no time.

(Mr. Javeed, YP)

Not only the multiple roles but also the stress associated with each role were also stated to be significant barriers to assuring elder family care. The participants discussed how work-related stresses and liabilities, household work, care for the children and other personal commitments and goals often pose challenges for caregivers to meet the care needs of older people. When the caregiving role conflicts with personal goals, it was considered to put the caregiver into a state of ambivalence because they constantly evaluate to balance the needs of their older parents, their own families and the demands of the wider society, so they are under constant psychological pressure, as the following comment shows:

I think there are immense pressure in modern day life because our children have to work and when they are working, they are under so many stresses. There is lots of youngsters in our community who still adhere to the old values of looking after your parents, but you see they can't look after us 24/7.

(Mr. Khalid, EP)

The example above infers that external and internal stresses of modern ways of living, for example, economic mobility or dual career families has potential implication for older people for living togetherness and the quality of relationship, consequently the family caregiving. These points are further discussed in detail in chapter 7. In these situations, however, the role of *human resources* for support are essential, therefore, this is now considered next.

Support systems

The majority of the participants agreed that a strong family and community support system is an advantage in looking after and providing better treatment for an older person. However, due to migration losses and patterns, caregivers mentioned experiencing frustration and stress over failing to access and take advantage of the fragile and fragmented social support, as this participant showed:

I haven't got no family here, my family is in Luton, Accrington, and Slough, so mine are all scattered. So, my support group is my friends you know but obviously, they can't take home three children, do your chores and help out in that sense.

(Ms. Sadaf, YP)

The limited social network moved the analysis toward the use of formal support in Pakistani communities. In family caregiving situations, the use of formal support was often discussed in terms of accessibility, awareness and acceptability. The initial analysis revealed that the caregiving responsibility was given to outside sources rather than a family member for a few young people. The caregiver who strongly believed in filial piety tended not to use external services for support. The use of external support was regarded as a family failure to meet the filial needs of an elder member. Additionally, external support was regarded as breaching family privacy:

Because the people coming out into your home which is difficult...people need to be sympathetic to our means which are different from the English patients and their culture and outlook.

(Mr. Nabeel, EP)

Knowledge and awareness between communities and service providers was another barrier to providing effective care for an older person. One stakeholder stated that on the one hand, external services have limited knowledge of cultural, religious, language and other sensitivities, whilst on the other hand, the family's awareness of the services, their outreach and facilities is also limited:

What the council or governments level of knowledge and understanding is of the BME community if I am honest with you, there is certainly a massive gap.

(Mr. Zubair, SH)

As a result, one participant believed that the stereotypes in both parties are common in terms of caregiving and care receiving. For example, participant discussed that Pakistani views services as insensitive to their need and hold negative attitude toward them. This is ultimately widening the gaps between services and families in need, and subsequently the use of services for support.

They [service providers] have the misconception in their mind, so they will be treating them for their myths, based on the myths, that okay you know if someone is from Pakistan, okay he will be like that does not matter how well educated that person is.

(Mr. Umar, SH)

As the analysis progressed, it became clear that the negative implications and barriers are not only significant factors determining the care, but also the stress associated with providing care to older person in the family. It was argued that when caregiving responsibilities are forced and or asymmetrically assigned without appropriate support, it increases caregiving stress. Furthermore, the family caregiver experiences social, physical and psychological stresses where caregiving responsibilities are strongly linked with social, material and financial implications. The issue of caregiving stress and its implications for older people, particularly in the quality of care and treatment, will be explored next.

Caregiving stress and EM

In line with the barriers and implications associated with caregiving, the analysis of the findings aggregated the different carer- and elder-related factors which were seen as more likely to be the sources of tension in stressful situations, which potentially heightens or help to explain the risk of EM. EM will be discussed in greater detail in Chapter 6, but because caregiving stress was found to be linked with EM, it was considered sensible to discuss this aspect of it here, rather than repeating some content again in Chapter 6.

Participants perceived the caregivers' age, experience and their knowledge of an older person's mental and physical health to be significant source of their stress. Some of the youngest caregivers acknowledged that their inability to understand and handle the provocative, manipulative and challenging behaviours of their older grandparents who suffer from dementia or other mental-health problems was a major cause of them experiencing excessive stress, which heightened the risk of them mistreating them, often unintentionally:

...if my grandmother is not listening to me, I quite get annoyed so I am just like can you listen and then she still will. She will ask the same question about six times, and I am like are you gonna get into your head.... I wouldn't say that is abuse but it's kind of been horrible to her because I don't, I am not understanding how she, what she is going through.

(Ms. Zohra, YP).

The youngest caregivers were also found to assume that this pressure is self-imposed because of their inexperience and lack of knowledge of the availability of support resources.

Inexperienced and with no support, the youngest caregivers also reported being the victims of mistreatment by the older people in their care and consequently lived with psychological stress from caregiving, as this caregiver described:

They kind of be irritable, they are kind of like fight with you...I was like become upset because I love someone, and they are like shouting at me, it hurts you obviously.

(Ms. Amina, YP)

Not only the age but also the personality of the caregiver, particularly in terms of the traits associated with mental health, were also described as being linked with an increasing risk of EM in Pakistani communities. The participants discussed the abilities of caregivers to cope with the workload, to control their temper in frustrating situations, the ways to address their differences with their elders, and how to access a dependable support network in case of need and agreed that they are fundamental skills and assets, the inability of which results in stress and subsequently the mistreatment of an older person, as these participants reported:

I think, everybody has good and bad days, so there could be something that you know you have a bad day and said something, it can just trigger you off and you could just snap. I mean it happened with me in the past.

(Mr. Usman, YP)

Looking after a person is one of the biggest things... I suppose people get frustrated and then, then begin with abuse, may be some people don't know that they actually, like abusing the person, the person who is abused might not even know that they are being abused.

(Ms. Zohra, YP)

On the other hand, the risk of EM stemming from the stress of caregiving was believed to increase if the elder person is highly demanding, has no set routine or is suffering from physical or mental dependences and needs help with the basic activities of life such as toileting and personal hygiene. In these situations, victim blaming was a major explanation of EM, as the comment below suggests:

The clash between my mother in law because she does not have like routine ... and to be honest when I get angry my tone changes and my husband always say me 'you are

right but don't say in that tone, so I think the elderly can take anything as abuse can't they?

(Ms. Sadaf, YP)

Mistreatment can also be applied to avoid the responsibilities of caregiving, particularly when additional burdens of personal families increase. Young people were believed to indulge in subtle forms of abuse to make their older parents think that they do not need care, as sending older parents to a care home or asking them to leave home are culturally inappropriate:

They try to irritate them, like not giving them food, trying to do stuff they don't like, or like pushing them from stairs, and say like oh I did not do it, or say oh it was by mistake.

(Ms. Amina, YP)

It became clear that the young caregivers adhered to cultural, religious and filial roles when care of an older person was expected. However, if family caregiving was taxing or exceeded the caregiver's resources, financial, social or material, it was perceived as stressful and distressing, potentially heightening their risk of mistreating an older person. As family care is the desired and expected phenomenon, the perspectives which the respondents held on alternative sources of long-term care, such as a nursing home, will be explored next.

5.4.2 Sub-category 2: Losing care in formal settings - public care for private families such as nursing homes

On the question of nursing homes participants said:

"I would prefer to die sitting here than going to nursing home" (Mr Suhail, EP)

"For me, there is no option [than nursing home], if I have a stroke" (Mr Hasan, EP)

"Allah forbids from such bad time. Allah save me from such dependency, I always pray this" (Ms Janat, EP)

The findings showed that the participants hold strong opinions on nursing homes, particularly the first generations which arrived in the UK. The narratives of participants' personal

experiences, witness accounts, and frames of reference indicated that the community goes through a process of explaining, evaluating and accepting whether to choose a nursing home for the future care of their elders. The participants also reported enlisting a variety of cultural, social, religious and personal factors which were key determinants in making decisions about using formal sources of caregiving.

One of the predominant reasons why elder members of the community would be reluctant to accept a nursing home as the place of their future care was explained as their fear of a new environment. The participants suggested a number of factors which could be possible reasons for older people's limited familiarity with and knowledge of nursing homes, such as:

- the lower life expectancy of Pakistani people meant that they never needed to plan long-term formal care; *"You know our age (life), it finishes in 60s or 80s. Therefore, no one is gone to nursing home. They gone (died) to Allah. Our die young, not seen our people in very old age". (Ms. Almas, FFG)*
- the limited acculturation of elder migratory Pakistanis with the wider structures of their new society because of their insufficient integration;
- the lifestyle in formal care, such as residential segregation and interdependence on community sources for support; and
- the absence of a care-home sector in Pakistan.

Well, the very first generation, they would not think about it [nursing homes] you know, the majority of them, it was not even in the culture, [on reasons] I think it is because we don't have these ehh sort of care homes... because a) there is no need for them and b) it is in our culture, its imbedded in our culture, to look after our elders so you know when they become older we look after them and we see it as our duty and our responsibility.

(Mr. Akash, SH)

Some participants also looked at nursing homes from religious, social and cultural points of view. They contended that it is the obligatory responsibility of the family to look after an older person at home, just as the previous generations had demonstrated:

I as a Muslim and Muslim community in general feel that their children have a responsibility to look after their parents because they looked after them when they were young and when their parents are vulnerable.

(Mr. Khalid, EP)

As explained earlier, older people are assumed to be an integral part of the family in the core cultural values of the Pakistani community, so the older participants evaluated placement in a nursing home as a most disrespectful and immoral act:

Our mind (mind-set) is same as it is in Pakistan that sending in a nursing home will result in insult for ourselves.

(Mr. Rizwan, MFG)

I think the children are the shameless, immoral as to send their parents to the nursing homes instead of looking after them.

(Mr. Sharjeel, MFG)

Nursing home placement was also considered as a most hurtful act because it was believed to threaten the cyclic and expected social exchange in caregiving, potentially diluting cultural values:

My father lived here, 13 years he lived with me. I used to look after him. I did all the care. You can get anything than but your mum and dad [so do not lose or distance from them].

(Ms. Zeenat, EP)

In addition to the moral and social obligations, others saw going into a nursing home as losing their individual autonomy and the companionship which they enjoy in living with the family. Elder participants stated feeling pride over being looked after by their children or their partners, and those who maintained patriarchal ideologies feared losing this pride and their hierarchical control if family care cannot be provided, as this statement shows:

I would prefer to die sitting here than going to nursing home. ...Person (older) gets a shock that I, one who used to command in the house, what happens now, that no one bothers about me. When I ask for tea, nobody gives it to me.

(Mr. Suhail, EP)

In this quotation, the participant clearly displays a sense of insecurity and fear of losing his own intrinsic worth by going into a nursing home.

On the other hand, the analysis of the findings also revealed various enabling factors which participants believed that the community members, particularly the younger generations, would evaluate for opting for a nursing home if family care cannot be provided. They discussed the modern pressures on children, the workload, caregiving stress, the physical and mental health of an older person, acculturation, attitude and the lack of family support as key determinants of accepting nursing-home care for older people:

Third fourth generation living in this country now have much busier lifestyle...some of the cases women are working...children, schools...the attitude have changed as well over the year...now it is becoming quite normal to place them (elder) in a are home or nursing home.

(Mr. Akash, SH)

The younger participants also foresaw the mistreatment and neglect of an older person in the enforced culture-driven care of a severely dependent and mentally ill person at home. Unlike the older generations, one participant suggested that young people now weigh and accept the option of nursing-home placement for an older person if voluntary care is stressful and leads to EM:

Yes, it is fine to look after elderly or religious or cultural, you know, way but the reality is a reality, sometimes the elderly need more, specialist care which the family can't always provide and sometimes it is a danger to elderly if there is neglect in that voluntary care that is provided.

(Mr. Muhammad, YP)

However, family pressure was described as forcing some caregivers to adhere to family caregiving. Given that the caregiving role is traditionally associated with women, women were found to accept this morally or by force, as this participant explained:

To be honest with you, I personally think they will be better off but their children won't allow it even though they won't be there helping practically but they will intervene with same with my father in law, when hospice was offered.

(Ms. Sadaf, YP)

These pressures are therefore likely to impose a dilemma on young people when they are faced with nursing-home choices for their older relatives. On the one hand, young people have received direct teaching from their parents on the core cultural values of elder veneration, and they will probably be acknowledging parent care as their responsibility. On the other hand, they face overwhelming responsibilities in their personal lives including job, work stress, child care and lifestyle. This ambivalence is likely to increase their uncertainty over the choices of a nursing home:

...obviously a lot of that culture is about how other people perceive, yes. It is perception. ...so, they will be in dichotomy, where you know, internally within the community, they don't want to be seen sending elderly family into the care but the care is provision, so really I think this growing issue.

(Mr. Muhammad, YP)

Although cultural, familial and community pressures were given as major reasons for young people being uncertain about placing their elders in nursing homes, the data captured many other factors associated with the uncertainties and the barriers in regard to nursing homes for Pakistanis, and I shall consider these next.

Barriers to nursing home care

As the analysis progressed, a number of barriers associated with the health and social care of older Pakistanis, the workforce and the environment of a nursing home emerged in the data. There was a broad consensus among the participants over the barriers which they discussed in the light of their personal experiences, witness accounts and frames of reference to explain the feasibility and the challenges of nursing homes for Pakistani communities.

Some participants thought that the structural design of general nursing homes fails to acknowledge diversity in its environment. Because Muslims offer prayers five times a day, the

participants emphasized the importance of prayer and *wazo* (ablution) facilities which general nursing homes lack, thus potentially neglecting the spiritual and religious needs of older Pakistanis, as this participant described through the example of his neighbour:

...my parents been known that one of their age fellows went to a nursing home...she was used to you know pray five times a day, so she could not perform pray in nursing home because can't make Wazo [ablution]...and nursing home don't provide these things...so she can't wash her feet to make Wazo.

(Mr. Javeed, YP)

Others emphasised a strong relationship between the care home staff's knowledge – cultural, religious and language – and older people's experience of physical and spiritual neglect. As discussed earlier, the language barrier is a major issue for the first-generation Pakistanis, so gaps in communication and understanding between older people and the staff was feared to leave Pakistani elders failing to make their needs known and thus potentially heightening their risk of neglect. Furthermore, Muslims only eat *halal* food (food permissible in Islam) so their dietary preferences and staff's knowledge about their diet were regarded by the participants as a major concern which could lead to older Pakistanis being marginalized in nursing homes:

...in care homes where their religious needs are been put to one side, because it is the belief of care staff involved that it really doesn't matter you know what I mean so they been eating food, that they not be eating (Halaal).

(Mr. Waqar, SH)

Fears of marginalization and alienation were also regarded as inevitable as the numbers of Pakistanis are already limited in nursing homes, as this participant explained:

I think it is very difficult you know if you are one or two Pakistani members of the Pakistani community living amongst say you know eighty, ninety, hundred white elderly people

(Mr. Akash, SH)

In addition, privacy, dignity and modesty were seen as important aspects, particularly for older women, in the consideration of a nursing home for future care. As explained above, gender-sensitive care and body exposure hold an important place in Pakistan culture. For the first-generation women who have lived their whole lives as dependent housewives within the boundaries of their houses, the exposure to a different environment, let alone different men, was feared as a daunting prospect to contemplate. Mr Waqar emphasized that the feeling of embarrassment at being naked in later life is a true fear which the community would evaluate as a major barrier.

I have visited few people in nursing homes and they said that modesty! modesty is thing you know, which comes as a barrier between the staff and that person, because you know staff they have to pay their own duties, they have to clean them, they have to wash and everything but at the same time the person you know either woman or man is feeling embarrassed you know and shamed that he is once old, cloths are taken off and you know everything so he feels very embarrassed so that's one reason.

(Mr. Waqar, SH)

A key feature of these findings is the mistreatment, neglect and abuse of older Pakistanis in nursing homes. The participants shared personal experiences, witness accounts and frames of reference to detail the poor quality of care and service provision in nursing homes for older Pakistanis. One participant described how his mother had received a poor quality of care and experienced mistreatment in a nursing home:

In nursing home, you do not get clean environment. I saw my mother, they got her in a chair...made to sit long and with bad posture...my mother had no good treatment that what some time scares me.

(Mr. Hasan, EP)

Similar examples and accounts were given by many other participants. For example, an older participant was shocked to observe the poor quality of care and neglect of her relatives and others in a nursing home when she paid them a visit. She was upset when describing the incident. The sub-standard care in that nursing home was her major reason for opting out of nursing home care.

One of our relatives was admitted in a nursing home, and I went there I saw ... nobody was giving them water, nobody listens to them and their nappies were dirty, wet in urine. They (residents) were dependent, but there is no good care in nursing homes.

(Ms. Zeenat, EP)

Ms Zeenat's image of a nursing home was not hers alone; Javeed and other participants shared a similar view, as their comments demonstrate:

You know when older people talk to each other, in the UK, they pass on information that once you are thrown in a nursing home, you are just there waiting to die, that they think.

(Mr. Javeed, YP)

The widespread narrative in the community, supported by witness accounts, confirms that nursing homes are major sources of physical, social and psychological abuse and neglect for Pakistanis.

5.5 Conclusion

The migration experiences and perspectives of first-generation Pakistanis in the UK are not identical for everyone and they are constantly changing. In brief, however, the early deprivation and marginalization of immigrant Pakistanis is linked with their poor health and social and economic dependence on others in later life. This was seen to have implications for their active life, their present and future care and treatment and their relationships with family members and others. Furthermore, because caregiving as well as familial trends are changing, their impact on older people's psychological, social and cultural ways of living is of significance. It was argued in the chapter that care in the family is no longer taken for granted in Pakistani communities, particularly if it is associated with material, social and financial implication for the care provider. Besides this, the risk of neglect and mistreatment of older Pakistani in nursing homes is more likely if care home provider lack cultural, lingual and religious sensitive services. How these recent changes and past events shape the perception and understanding of older people towards EM and actions taken in regard to it are important questions, and they will be discussed in the next chapter.

Chapter 6

Findings 2: Elder Mistreatment

6.1 Introduction

The aim of this study was to explore the understanding of and actions taken to address EM amongst a particular group of community-dwelling older people, family caregivers and the relevant community stakeholders. Three principal categories emerged from the analysis of the data on the participants' understanding of EM. The first was the **Perception and understanding of EM**. This category describes the forms of EM which the participants and community understood to be prevalent. The second was the **Risk factors and the understanding of risks**; this describes the complexity and the aetiological nature of EM in the community and the conditions which contribute to its manifestation. As well as explaining multiple social, material and cultural risk factors, this category explains the intersection of and relationship between these factors which can circumvent the conditions which are potentially linked with EM. The third category, **Taking Actions**, outlines the strategies which the community uses to access help and address EM issues. In this category, the participants suggested that the community should and does exercise a prescriptive process by which people determine what help is needed and address and even prevent the risk of EM.

6.2 Category 1: Perception and Understanding of EM

The first category identified from the data explains the basic understanding of the Pakistani community and the forms of EM which were described. Analysis of the findings revealed a range of perceptions of EM which differed across age, gender and education level. It is also the case that the ways in which the participants talked about EM were influenced by the data collection method. Within the focus groups, for example, the participants were more cautious about sharing their personal and family issues compared with the individual interviews, and the young and educated participants often recognized EM and its subtypes in academic or policy terminology, "*emotionally abusing them [elders], physically abused them, neglect*" (Ms. Zohra, YP), compared with the older participants. "*Children swear at older parents, starve their parents ... they leave parents on their own*" (Ms. Rahila, EP). The influences of interview

settings, gender and education on the data collection are discussed in detail later in this chapter.

The comparative and systematic analysis of all the narratives of male and female participants of all categories – elder, young and stakeholders – identified six principal forms of EM: psychological abuse, financial abuse, societal/street abuse, physical abuse, sexual abuse and neglect (*see* Table 6.1). Psychological abuse, which included verbal abuse, emotional abuse and disrespect, was considered to be the most deeply felt and significantly prevalent form of EM in the community. Psychological abuse was predominantly discussed in terms of disrespect and is therefore classed here as a distinct type of psychological mistreatment.

Table 6. 1. The forms of EM identified

Different types of EM						
	<i>Disrespect</i>	<i>Financial</i>	<i>Physical</i>	<i>Societal/Street</i>	<i>Neglect</i>	<i>Sexual</i>
Definitions	Failure to provide the respect ascribed in the cultural and religious scripts to an elder was defined as disrespect	The imbalance of material and non-material social exchange between two generations	An act leading to visible harm to elder person	Act of resentment, aggression, detachment, and othering in the community	Failure of family to meet the basic needs of an elder person; intentionally or unintentionally	Was not discussed
Major behaviours	<ul style="list-style-type: none"> • Sending older (grand)/parents to a nursing home • Not responding/silent abuse • Not giving due respect, time and space (position) • Not involving in family decision makings or honouring decisions • Abandonment or expulsion of parents • Language/verbal – being assertive, rude and aggressive 	<ul style="list-style-type: none"> • Defrauding, transfer of property, and exploitation of household resources • Religious and cultural division and exploitation of resources (forced transactions) • ...taking money without consent 	<ul style="list-style-type: none"> • Hitting, punching, beating, spiting • Pushing from stairs • smacking • Controlling and restraining (of women) freedom, choice, social mobility 	<ul style="list-style-type: none"> • Teasing, insulting, shouting, or using bad language directed at older Pakistanis – such as calling them ‘Paki’ or ‘Budha’ often by own generations • Harassment, intimidating behaviours, alienation, bullying and devaluing by others (stranger/natives) • Institutional racism/discrimination against Pakistanis • Islamophobia • Othering by own cohort (older Pakistanis of same age) 	<ul style="list-style-type: none"> • Not feeding or feeding at right time • Leave them wet, dirty in urine or faeces. • Deprivation of social/family contacts • Deprivation from access of services (medical or social care or treatment) • Not providing care or care at home 	

6.2.1 Disrespect

Failure to provide the respect ascribed in the cultural and religious scripts to an older person was defined as disrespect; a major and frequently cited type of EM considered in Pakistani communities. Disrespect as a sub-category was underpinned by three main properties – failure to respect personhood, failure to honour and the linguistic aspect of EM.

First, lack of respect was predominantly perceived as a failure of children to give value to an older person in terms of time, space and attention. As a result, the feelings of diminishing *personhood* – having the role, rights, status, agency or past – were believed to be growing fears among the ageing population of the community, as the following comment illustrates:

Here [in the UK] parents think they are not valued...just sitting in the corner and whenever decision they make in house, they [family] don't bother about [consulting] older people or spend time with ...they get ignore, they feel

(Mr. Javeed, YP).

This comment indicates that the involvement and inclusion of older people in family decisions and interactions has a positive impact on their psychological and mental well-being. Abandonment, on the other hand, which many older people described as children moving out of their parents' home, sending parents to a nursing home or failing to engage with older parents, was considered as the most hurtful and disrespectful act. Silent treatment by children was raised by one older participant as occurring when:

Children do not like sitting with parent, they leave parents alone inside the room, you keep calling the children again and again, but they do not come to you. It does not feel good that if you call someone and they do not come.

(Ms. Rahila, EP)

Desertion of an older parent by his or her children was not only considered mistreatment because of the loss of companionship, but was also deemed to be a most hurtful act. It was viewed as the manifestation of a failure of promised and expected IG exchange in relationships:

It hurts, mother and father that they worked too hard in bringing him up, fed him and now he is leaving.

(Mr. Akbar, MFG)

In this extract, the participant clearly emphasised that children have responsibilities towards their parents in exactly the same way as the parents have been demonstrating throughout their lives. The analysis of the data on this sub-category of disrespect suggests that EM is therefore partly an IG phenomenon. When expectations are mismatched between generations, it is perceived by older people as mistreatment, as this participant explained:

A lot of elder abuse and mistreatment is very psychological. It could be something like very hurtful words or disagreement or an argument or something that is blown up within the family that cause a long, long lasting effect on the older person

(Ms. Marriam, SH)

Although many participants defined the notion of disrespect from a cultural and social perspective, the language used in communication was another important way of framing the notion of EM. Some participants complained, “*In each house, speaking English is common*” (Mr. Sharjeel, MFG) as a subtle form of elder disrespect and others focused on the interpretation and perception of the language spoken at home. Because the notion of respect was argued to be symbolic and therefore cannot be categorically defined, the interpretation of it among the participants varied. Given that Pakistani culture places emphasis on longitudinal communication between parents and children, some participants argued that older parents interpret culturally inappropriate terminologies and their dialectic disposition differently, as disrespect possibly, as this participant explained:

Young children here [in the UK] they say to grandma or grandad 'shut up', 'shut up'. Shut up may be a common word in this country and if somebody is born here and become elder, they will not get offended but ... they [older people born in Pakistan] really, really get you know disappointed, sad, low mood and devalued.

(Mr. Javeed, YP)

Others, however, disagreed over the intention, outcomes and interpretations of disrespect among both the young and the old generations. One young participant clarified that because the temporal, spatial and referential interpretation and meaning are distinguished, disrespect is therefore a contextual phenomenon:

I don't think the respect has decreased. I think may be less tolerant, less tolerant ehh in the sense that if you know that the younger generations are more educated okay so in that case, they are more vocal, so they would say more, they are more assertive.

(Mr. Muhammad, YP)

The perception of disrespect was often dependent on the culture, language, time and context in which it takes place. Differences in any of these concepts between old and young generations were one of the main reasons for the (mis)interpretation of disrespect. The mismatch, whether it is in interpretations or in transactions, is deemed to be the key determinant of EM in Pakistani communities. Like interpretations, how financial transactions take place is of importance in understanding financial abuse in Pakistani communities, and this will be considered next.

6.2.2 Financial abuse

Financial abuse was another common type of EM which was assumed to be growing with changing times and cultural patterns. Although the participants often described it as being perpetuated by children towards parents, the conflict between partners over financial issues also existed. Monetary division was also found to be a significant risk indicator within the cultural and religious interpretations of the community.

The most significant factor which the respondents claimed to be responsible for causing financial abuse was *the imbalance of material and non-material social exchange* between two generations, with a recognition that both generations hold different approaches to the material aspects of family life. As the children had been the main recipients of their parents' investment, they were regarded by ageing parents as a source of security in their old age, so older people hold strong expectations of this exchange. In many cases of financial abuse, however, the participants stated that parents' material investments over their lives such as money, house and cars frequently fail to be exchanged for the non-material care which they had hoped for:

Financially obviously ... they [elder] have sacrificed their whole, all life in upbringing of this young generations ... so if they have built the houses, the car, bungalows, everything ... so hard-earned money and they [children] just eating in golden plates...and they [elder] are not given even due respect.

(Mr. Umar, SH)

Defrauding, transfer of property and the exploitation of household resources were common examples given by many participants of the experiences and accounts of family members and friends who had been taken advantage of. The participants mentioned duty and trust in relationships as a significant predictor of financial abuse. Describing the experience of a friend, one participant explained that financial abuse is a result of the decline in the duty of care and the increase in materialism, individualism and selfishness among children:

They [elder parents] wrote down [transfer deeds of house]; they thought that they have only one son, he will look after us. Within few months, he comes, and said 'get out'; this is our house, go to hell. Never mind looking after but kicked out of the house. There are various cases of these types.

(Mr. Sharjeel, MFG)

The risks associated with trust in IG relationships, on the other hand, were described as increasing 'behind closed doors', when children are dependent on their parents and when there is no capable guardian at home and older people are isolated. The participants considered that unauthorised or improper exploitation of older people's resources is inevitable when an individual in a position of trust commits it. The dominant ideology viewed as providing a camouflage for these activities was familism. There was a recognition that the family is a private institution immune to external scrutiny, and one participant gave the example of her friend's brother who had exploited her helpless mother:

One of my friend's older brother...would not look after her [mum] but would take money off her, whatever money she was getting paid. I do not know if it is common or not common, but I suppose you do not know what is going on behind closed doors right.

(Ms. Zohra, YP)

As well as too much trust, the lack of trust was also given as a leading risk of financial exploitation in Pakistani families. In this circumstance, the division of an older parent's inheritance was emphasized as being one of the fundamental and distinctive causes of financial abuse which was particularly common in joint and traditional families. The participants spoke of forced transactions, unequal wealth distribution, asset transfers and

deprivation of wealth as common occurrences when there are widening disagreements between family members. As the next extract shows, parents feel that they are losing their right to choose or consent to how their wealth is used in the later stages of their life if children have little trust in their parents:

People have talked, that they have got no money and now my child ... they have got it. I wanted to divide it [money] for different purposes ...to give it to charity... nursing home, or for any other way, but you know children at home they got all of it and used and so yes, there are examples of these abuses.

(Mr. Waqar, SH)

On the other hand, the *monetary utilization* in the household was considered to be the dominant factor creating conflict between older partners – “... *husbands not taking care of their wives ... not giving them enough to run the household ... so [they] clash*” (Mr. Khalid, EP). Compounding this issue was the dependency of relatives back in Pakistan on one or both older partners, which led to them sending funds abroad without their partner’s knowledge, which became a major cause of conflict between older partners, as many financially dependent women in the UK are also expected to support dependent families in Pakistan. Taking money for this without a partner’s consent was stated to be a major cause of interpersonal conflict, as this participant explained:

You know these women, they want to help their brothers and sister back in Pakistan therefore, they save and hide the money [from husbands], this is why [conflict happens].

(Mr. Sikandar, MFG)

Trust, duty and consent emerged as strong but subjective sources of objective and material losses for older people in Pakistani communities. With abuse being multifaceted, however, the subjective exchange often led to physical aggression, and this will be discussed next.

6.2.3 Physical abuse

Physical abuse was understood as an act leading to visible harm to an older person such as “*hitting, punching, beating, spitting, I think it is still abuse*” (Ms. Zohra, YP), or inflicting harm by creating situations which cause older people to suffer physically. There was consensus that child-to-parent physical abuse is rare, with a recognition that the young generations still

adhere to the cultural and religious norms of respecting elders in the community “... *that this system [of elder veneration] is still intact, and ... they [the young] will always show respect if older person comes*” (Mr. Arshad, SH). Physical abuse between elder partners, on the other hand, was perceived as more likely to have a native origin as the normalization of violence is common within families in Pakistan, as this participant explained:

I think this happens, no offence to anybody, I think this beating [domestic violence], physical abuse happens more in Pakistan. I do not think it happens as much over here. It is very rare in the UK.

(Ms. Mariam, SH)

In terms of child-to-parent assault, the cultural context and expectations were important factors in shaping the perception of physical abuse. The next comment makes it clear that it is not just the actual physical aggression against older people which shapes their perception of EM, but the fact that it is an expression of religious disobedience and the lack of respect for the culture which is seen as mistreatment. A comparative analysis of comments revealing views of smacking as forming the perception of physical abuse suggests that such acts of abuse hold contrary meanings when they are aimed at young and at old people. One participant explained that parent-to-child smacking contains cultural and contextual meanings and thus it is not a form of abuse:

Smacking... is not abuse...grandad or grandma slapping the young child you know that not abuse.... like giving punishment...for something, they did naughty things.

(Mr. Javeed, YP)

However, the act of smacking was seen as immoral and unacceptable if it occurs the other way around, suggesting that the position of older people is unilateral, possibly hierarchal, as this next participant explained when he was asked about smacking older parent:

[Participant taking a deep breath and in shock said] Nooooo, no no, it is unacceptable as a Muslim as a human being, you know, smacking you dad, that is immoral and that is unacceptable.

(Mr. Khalid, EP)

It was not only acts of commission which were regarded as EM, but omission in care and treatment were also discussed as important factors in describing EM. This *lack of action* also causes harm, and this is considered next.

6.2.4 Neglect

Neglect was believed to represent the failure of the family to meet the basic needs of an older person, and it was understood as both intentional – in Mr. Nabeel’s view: *“When you don’t feed them [elders], you don’t get them clothes, you leave them wet, dirty, damp toilets”*, and unintentional, linked to inadequate resources to acknowledge or meet the needs of an older person: *“when they need you and you don’t go to look after them and have basically just been too busy or had no time”* (Ms. Zohra, YP).

One of major risks of neglect was understood as the dependency of an older person often being coupled with or triggered by the attitude of both the care receiver and the care provider towards the demands of the older person. When the expectations of the different generations are different, the participants believed older people often fail to have their basic needs met by their family, as this participant explained:

Because when you are elderly, and you are dependent on them then you are, you know, for example if ...you want food at certain times, you will be told no we will have food that time ...that to me is abuse to a degree as well.

(Mr. Khalid, EP)

In this example, the participant clearly suggested a strong relationship between dependency and deprivation. The question of deprivation was not limited to the dietary needs of the older person but also extended to deprivation of social contacts. When IG conflict exists, the use of power and control in relationships was considered to be a major source of active neglect and deprivation, as the next comment shows:

If they [elder] want to watch TV and you are not allowing that and if they want to see their friend and they enjoy that okay, and you are not allowing that...neglecting them.

(Mr Nabeel, EP)

Depriving older people of access to the appropriate care and treatment when they need it was also seen as another form of active neglect. Within this, however, the intention and

awareness of families towards the available resources of care appeared to play a key role. Because seeking help and support is culturally and religiously rooted in Pakistani communities, the participants implied that the mistreatment and neglect of older people is inevitable if the family members hold strong opinion on, and decline medical care, as this excerpt shows:

If an elderly lady ... gentlemen wanted to get to see the doctor. They [family] may not want to take her to the doctors because they may think oh we will just leave it to God. God would kind of do all the work and we read Quran, and drink Zum Zum [elixir] water. So basically, mistreatment by not giving her access to certain services like that, so the stuff that may inflict on them.

(Mr. Mubarak, SH)

Similarly, as discussed in a previous chapter, the cultural norms of family caregiving describe it as an expected and obligatory duty of the children within the family, but when this care is involuntary or forced, it was considered to result in no compassion from or satisfaction for the caregiver, thus increasing the risk of neglect in care, as this participant explained:

If somebody does not want to look after their parents and then you are forcing them somehow culturally, physically or isolating them or society pressure to look after them then they are not going to do that job, again, so they will neglect their parents.

(Mr. Nabeel, EP)

From this and other examples and interpretations, it seems that EM is an IG or/and a familial issue contained within the family home. However, as the analysis progressed, the data began to show older Pakistanis' experiences of being unsafe outside the boundaries of their own homes. The treatment of older people in the street and in the wider society will therefore be considered next.

6.2.5 Society/street Abuse

At the macro-level, the mistreatment of older Pakistanis was seen as a growing issue and the population was considered to be experiencing it on daily basis. One of the interesting findings which emerged was that the most likely perpetrators of the abuse of older Pakistanis were acknowledged to their own descendant generations, suggesting that street abuse is an IG

issue. Failure to integrate, as discussed in Chapter 5, was re-emphasised as major source of this widening IG difference. In the face of growing IG gaps, the participants discussed the rise in the resentment, detachment and 'othering' among young British-born Pakistanis toward the older generations. Drawing from personal experience, one participant describes street abuse as teasing, insulting, shouting or using bad language directed at older Pakistanis:

I was walking on street. A Pakistan boy looking at me, said 'oh Paki' [an offensive term refers to a person from Pakistan] and I said in shock - Allah-u-Akbar [God is most great]. I thought he would be Pakistani, rather giving respect called me Paki. Yesterday, honest to God, two girls wearing scarf were passing by, they said 'Budha' [derogatory word used to refer to an old man] this is what I heard, God forgive, Budha [old man].

(Mr. Sharjeel, MFG)

Next to their successors, *othering* emerged as racial discrimination being another form of societal abuse. Many of the participants linked societal abuse with their Pakistani social identities such as ethnicity, age and religion. Perceived acts of racism in society were described as various social constructs and behaviours such as harassment, intimidating behaviour, alienation, bullying and devaluing, as this participant explained:

If they [older Pakistanis] do something which contradicts their English culture or the environment where we live they [English people] always say something, some funny words, or they will say oh look at him you know he is illiterate or what you call nonsense, or these kind of the things, they will treat him [Pakistani] like he is an idiot or does not know anything, so

(Mr. Umar, SH)

It became clear that the risk of marginalization increased when the intersections between and among the multiple socially disadvantaged identities of the Pakistanis were compounded. Being Muslim and Pakistani, for example, heightens the community's risk of Islamophobia-related attacks, but age was considered to increase older people's vulnerability, particularly the traditional older Pakistanis. Given that Pakistanis are more inclined towards spiritual issues and religion in later life, they experienced disproportionate levels of street abuse

simply because of their visibility and traditional characteristics, as this Muslim Imam explained:

Sometimes... the attitude of people is very rude with Pakistani people... got beard on their face have cap on their head...wearing white cloths, long cloths ... the appearance yeah, so ...

(Mr. Waqar, SH)

‘When in Rome, do as the Romans do’, but Mr Suhail associated these acts of discrimination against older Pakistanis as a result of their own lack of acculturation and assimilation into British society. Mr Suhail was born in Pakistan but migrated to the UK as a boy. He was a liberal person and believed in authentic integration as the main source of successful relocation and settlement in the UK. He regarded strong affiliations with Pakistani culture and segregation from UK culture as leading the entire elder Pakistani population to experience generalized marginalization and racism in society, thus heightening the resentment toward the traditional older people, as this next comment shows:

Many people have come here before me, died too, understand? But they have not changed, have not acculturated. They bloody Pakistani still wearing long shirts [Jubba], have left long beard, dirt fixed on beard, or curry, this is not the way to live. Whose insult is this?

(Mr. Suhail, EP)

This attitude of ‘othering’ from children to society is now more likely to devalue and isolate those older Pakistanis who are religiously inclined and derive pride from their religious and native identity. The risk of societal abuse and isolation is therefore more likely to be high for such older people in their streets from their own communities. There is another form of abuse which the community does not either admit experiencing or speak about, sexual abuse, and this is discussed next.

6.2.6 Sexual abuse

No participant, either in a focus group or an individual interview, mentioned anything which either referred to or implied sexual abuse, probably suggesting taboos associated with talking about sex in the community. The first category of participants in the interviews were

stakeholders who were recruited to help with designing the interview guide and to direct the framing of appropriate research questions (see Chapter 4). In all of the stakeholder interviews when no-one had spoken of or implied anything which indicated sexual abuse, direct questions to the final stakeholder (Ms. Mariam) elicited an explanation for this silence:

Interviewer: have you had or heard any cases of sexual abuse?

Ms. Mariam: No really no, I have not heard of people within the older community, that's very far and few between but nothing of sort of have come a line like that I am aware of, no

Interviewer: what could be reasons...

Ms. Mariam: it is not in culture to even obviously first of all talk about something like that but obviously now a day you know times is moving, people mind set, attitude is changing, however we dealing with the older generations, so again they are still stuck in a bit mind block, they still stuck bit of era, a bit of phase, so would they talk about something like that if they suffered any abuse like that in their older age, no.

Sexual abuse was noted to be an unacknowledged and taboo subject which is particularly linked with age, with the recognition that the cultural and religious upbringing of the older generations prohibited talking publicly about sex. In this conversation as well, raising the term 'sexual abuse' was seen as such an indiscretion that even a young stakeholder found it difficult to talk about it. She was unwilling to utter the word 'sexual' and instead made references such as '*talk about something like that*', '*that's a big taboo*', and '*any abuse like that*'. Given this understandable refusal to discuss such a sensitive issue, it is not possible here to explore more deeply what is clearly a form of abuse which exists, but which is still beyond reach in terms of any analysis or any greater exposure.

In summary, the participants discussed multiple types of EM in this category and some of them have been widely researched among indigenous (White) populations. However, it is clear that the behaviours and interpretations that fall under each form of EM varied and were often cultural and contextual. This perception of EM types is important in describing the understanding of the risk of EM in the community, and most important identifying the practices that justify and maintain the risk of EM; therefore, the understanding of risk factors is considered next.

6.3 Category 2: Risk factors and the understanding of risks

The participants discussed different conditions which could potentially make older people vulnerable to mistreatment in the community or explain why this is so. These risk factors emerged as diverse and developing on personal, interpersonal and society levels. The individual characteristics of the potential victims and the perpetrators were the central focus of the discussion alongside the cultural, social and religious factors explaining the risk of the mistreatment of older people in Pakistanis communities.

6.3.1 Gender

Interviewer: In gender, who is more likely to face elder mistreatment?

Mr. Arshad: [a brief laugh], I mean one of; one of my question would be who will live longer? ...Women obviously.

As well as old age, the analysis of the data suggested various conditions which could explain women's risk of EM in Pakistani communities. The cumulative effects of being female with the other social disadvantages which they experience in Pakistani communities are considered next.

When it comes to gender, EM was no longer considered an age or an IG issue; many participants commented on it as a cultural and interpersonal phenomenon. As the male-dominant system operates in Pakistani communities, women were regarded as underprivileged and controlled, and thus at greater risk of dependence and poverty. By being socio-economically dependent, women saw themselves as trapped and subsequently accepting subordination. Drawing on her own experience, an older woman related her longstanding poverty, illiteracy and poor socio-economic skills to patriarchal control:

My father used to say if no one else's daughter from the community is going to school then why should mine go. What people in the village [in Pakistan] will say that he [my father] has sent his daughter to school? [Interviewer: Is there any regret that you should have attended school?] Yes of course. That day, my daughter said that Mom! How much do you struggle with communication, and going out? What if you were educated, but it was not my wish [to abstain from school]. Now I just live as told.

(Ms. Janat, EP)

Others gave patriarchy as the main cause of women living in isolation, loneliness and agoraphobia. Older women referred to the restrictions on their social mobility which deprived many of them of opportunities to integrate into the wider community as well as to build the trust and confidence to interact with others. It was not clear, however, whether these restrictions were applied to control women or to save them from racial attacks, but because it isolated them, they spoke of feeling vulnerable and afraid:

He [my husband] did not allow. I was afraid. I was scared to go out as well. Therefore, I did not know much about outside world, about the community outside. Life went like this. I just stayed inside the house.

(Ms. Rahila, EP)

This social and physical entrapment not only increases woman's risk of isolation and loneliness, but the participants said that it also affects their mental health, thus heightening the risk of them retaliating in conflict relationships or situations. Explaining the status of women in Pathan/Pashtun [an ethnic Pakistani group] communities, one participant suggested that the prolonged confinement of women from birth to death is valued in Pushtan norms. However, the use of, and the extent of, these norms in the UK can be sources of intra-gender and IG conflict, because the status of women in the UK is different:

They [women] cannot go out...stay inside until got married and when she married then husband used to keep them inside... so, yes [this] mentally affecting them...and problems with the husband, problem with your children because you are bored, you fed up, you sick of, because you don't know what you are talking about

(Mr. Hasan, EP)

The notion of 'cot to coffin', on the other hand, was reported to be a strong patriarchal and cultural teaching rendering women vulnerable to accepting confinement, violence and mistreatment. The participants spoke of how, in traditional Pakistani families, girls are taught from a young age that once they are married, their life and their roles shift to their in-law's house. Women are ingrained from birth with these cultural teachings. The participant spoke of how this process internalizes them as inferior, and consequently they accept their marginalization and mistreatment in relationships:

They accept and cope with that physical assault on daily basis and the mental torture, okay and it is all to do we just married you walking out, and you just stay there, and you only leave that house in a coffin.

(Mr. Nabeel, EP)

Interestingly, not everyone who participated in this study disparaged these traditions. Many of the older participants felt pride and spoke about the promotion of these practices and values as reflecting their own cultural upbringing, and consequently female subordination, as the next extract illustrates:

So, in our times, daughter was told by her father or mother that beta [daughter], the house where your Doli [cot where bride sit and taken to in law house] is going, your Janaza [Coffin] should only come from that house. See the difference. How big is the difference?

(Mr. Suhail, EP)

Not only Mr Suhail, but also Mr Sharjeel and many other older participants appreciated the widespread existence of these cultural norms, predominantly confirming male superiority and the subordination of women and the normalization of violence against them in traditional multi-generational Pakistani households, as the following comment shows:

I got my son married from Birmingham. Then the girls' mother came here after the marriage and told her daughter that Betti [daughter] you have now to live here as well die here [in husband house], never come to your parent's house if you get angry. You live and die here now. Never come to our house if you get angry.

(Mr. Sharjeel, MFG)

The social arrangements and agreements stemming from these cultural teachings, defined by participants as role expectations, family cohesion and family attachments, were also considered to be major reasons for women accepting their mistreatment. One participant suggested that because women, more than men, favour sustaining family cohesion and harmony in the household, they are more likely to tolerate violence if they are faced by it:

I have seen few women [been mistreated] bound to their houses. Women are emotionally attached with families and house...if you are kind of like old people...you follow those rules.

(Ms. Amina, YP)

Others saw the intersection of multiple disadvantaged social identities as increasing women's dependence and marginalization in their family relationships and in wider society, thus potentially enhancing their risk of mistreatment. Age, gender, ethnicity and socio-economic status were regarded as the key factors explaining the multiple penalties which older Pakistani women experience. The findings showed that older Pakistani women were more likely to live in an abusive situation when they lack the skills to defend themselves, for example, the confidence and courage to escape, driving and communication skills, and the right capacities, for instance, education, knowledge and awareness of support:

Definitely women, because they do not have enough really education, awareness, what to do if something happen that you know or what is your right in this country. So women are really more vulnerable.

(Mr. Javeed, YP)

As the patriarchal norms are widespread, women who outlive men were deemed to be at greater risk of experiencing ageism if alternative sources of support are inadequate in the later stages of their life. Neglect, mistreatment and premature mortality were regarded as multi-faceted and recurrent negative outcomes after the death of a male partner. In the extract below, a participant explained how her mother had experienced a lack of support, protection and dependency after the death of her spouse:

Like my mother, she had a stroke, but she was still able to walk with the help of stick, she was able to go bathroom, this was good help but when my father passed away then ... my mother...she was neglected ... when you become dependent on others then it becomes very difficult.

(Ms. Sabreen, EP)

When older women become dependent and unsupported, the risks of abuse and self-neglect are heightened. A widowed participant explained how the loss of her husband had reinforced the feeling of helplessness, so older women learn to tolerate self-neglect and EM by others:

Here are many women, who are alone, whose partners are died. I am talking about [neighbourhood name], I live here. There is nothing, you have to be tolerant, patient even if child say something.

(Ms. Zeenat, EP)

The findings suggest that older women are more vulnerable in Pakistanis communities often because of their age, gender, cultural norms and socioeconomic status. It is also becoming clear that the intersection of each these factors increase their risk to mistreatment. This is discussed later in chapter 7; where the resultant theory emerging from these concepts is covered. As the women are the main part of large household in Pakistani communities, how living arrangement in these household increase risk of older people abuse is of importance, therefore, this is considered next.

6.3.2 Large households and living arrangements

A typical large Pakistani household was defined as consisting of three generations – “*we live in big family, with children [this includes a daughter-in-law] and grandchildren*” (Ms. Farzana, FFG). Historically, the large household was the hallmark of the first migratory cohorts of Pakistani communities. In the face of acculturative stresses and cultural shock, as was discussed in Chapter 5, the analysis of data showed the benefits which the first migrants had from living in large households: they were economic, they provided protection and safety, they preserved religious and cultural identity, they assured feelings of belonging, supported habitual living and enhanced the *division of labour* – “*someone did the cleaning, another did the cooking or washing. I think it makes life easier*” (Ms. Sabreen, EP). In terms of elder care, a large household was also found to serve a valuable purpose as the next extract shows:

My sister, she is looking after her mother in law, she has walking difficulties, she needs to be held to walk even food she eats needs to be liquified to some extent ehh so going to the bathroom, she needs support, ... because her children helped her out and husband helped, ... when you have extended family then it becomes easier.

(Mr. Muhammad, YP)

Despite all the advantages, the comparative analysis of the narratives suggested that these benefits are overrated or exceptional, therefore, those *“joint families do not exist now”* (Mr Suhail, EM). The participants offered a number of reasons for this, such as the lifestyle of young people and changing family functions, the size and conditions of the household and the growing individualism which does not support the *division of labour*: *“Sometimes a large household caused a problem, like children fighting with each other about daily chores, like ‘I did this thing’ and ‘now you go and do the cooking’ and things like that”* (Ms. Zeenat, EP). Privacy and overcrowding were also recognized as an equally important subtle cause of IG conflict, potentially heightening the risk of EM.

‘Your household and your grave’ should be separate. Living in large household you are putting so pressure on each other, you are in each other’s store and this leave to conflict and people are realising now.

(Mr. Khalid, EP)

“Not everybody realises this” (Ms Mariam, SH), and this was identified as a fundamental cause of conflict in large households which was predominately directed at an older person. Because the traditional-thinking first generation of Pakistani immigrants only saw the benefits of large households, they were identified as overvaluing them and therefore tending to force living-together, thus potentially heightening the IG gaps and conflict if young people were to hold contradictory ideologies – individualism and independence – on life-style preferences:

The older person has the expectation that this daughter in law, this son and they should live with them as their duty to do so, because they done the same thing, so there is the problem [conflict].

(Ms Mariam, SH)

Given that Pakistani culture and religion both strongly emphasise family togetherness, multi-generational living was considered to be a complex issue in the UK for Pakistani people. Considering the rapid socio-cultural transformations in society, traditional parents were believed to be living in a state of dilemma in a large household. One participant explained

from his own experience how living with children had led to IG conflicts whereas living without them increased the risk of inter-partner conflict:

When my children got married, they said baba [daddy] we want a separate home. I said okay. My wife kept saying no, no they will live with us. I told her, listen this is their privacy, they have their own problems, so you do not interfere in their life, let them go. The thing is, many people say no we have only one son, we will live together. This actually disturbs the harmony of the house. This cause fights and arguments.

(Mr. Suhail, EP)

This example not only establishes the relationship between living together and IG and inter-partner conflicts, it draws further attention to parents' involvement in their children's lives. How this involvement shapes how children live has implications for older people. Speaking about her own experience of failing to find a compatible partner for her son, Ms Janat talked about living with guilt and conflict:

Sometimes conflicts are about children. When children are grown up, no matter they like it or not, we [parents] get them married... I got my son married from Pakistan...my daughter in law...cheat and quarrel...and not behaving... this also worries and cause problems.

(Ms. Janat, EP)

Another participant gave a similar example to emphasise the increasing risk of IG conflict if marriages which fail were forced on children by their parents:

What happens in relationships is that wife wants that their children marry in their relatives, and husband says in my relatives my children should marry. Beta [son], Beti [daughter] they want to marry someone of their choices. So, there happens a crash, if marriage does not work.

(Mr. Bilqis, MFG)

As was discussed in Chapter 5, family caregiving and a secure future within the family are important to older people, and this desire for security in old age is partly linked with the choice of a suitable daughter-in-law. So, the wish that their son(s) will marry someone who will meet these interests and provide assurances to their older in-laws are important issues

for them and lead to their undue (and often unwanted) involvement in their children's lives. This involvement, which is usually linked to a determination not to end up in a nursing home, inevitably shapes older people's interactions and relationships with their daughters-in-law.

Given that marriages between cousins and arranged marriage have long history in Pakistani culture, the willingness of traditional families to accept someone else – both from the wider family and from outside the immediate family or caste – was believed by some participants to be an individual act but the notion of *othering* was very much present. A daughter-in-law explained that the cause of conflict and the poor quality of her relationship with her mother-in-law were primarily because she was always considered an *outsider*:

Especially in our family, in my in-laws...because they all married first cousin and whereas me and my husband are not related at all so I was the first one...so, they sort of judge me ...if I do hundred and one good things and one thing that I get wrong they forget hundred ...she did this...so yeah because I think I am not blood so you know.

(Ms. Sadaf, YP)

Others saw the multi-generational household as a mini state, and the power and control over resources, people and position as the main cause of IG tensions, particularly between the mother-in-law and the daughter-in-law in these households. Not only the issue of accepting and adapting to the presence of an *outsider* but also failing to share love, authority and workload heightens the tension between what one participant called 'two queens in one palace' (Mr Usman, YP) as the next comment illustrates:

Comes along a daughter in law who is a lot younger, has different views, point in life, had different take, different way of managing the house, ...then shift of power change and with shift in power, it is very hard for older people to change with that...then there is going to be friction [conflict].

(Ms. Mariam, SH)

To complicate the situation, separation and divorce of children were perceived as shameful acts in the community. Both situations, therefore – whether the children chose to live in failed marriage or to divorce – were considered to have disproportionate implications for older people. If they decided to continue to live together, it was believed to have a significant

impact on the quality of the relationship between family members in a large household, whereas divorce was believed to result in family dishonour, guilt or community ostracism.

The stigma that attached to separation and divorce which are now common in our society, you know, that really common and I think as a Muslim you know we should get married once, and... you get ups and downs over the year... and there is physical abuse.

(Mr. Nabeel, EP)

Although large households are preferred for living among older generations, they were believed to be associated with implication for them in response to recent changes in the social norms, family structures and function. It was argued that mistreatment and IG conflict in large household are inevitable if cultural norms of living together are forced by older people. Overlapping with culture, religion was another distinctive factor which shaped the perspectives and beliefs of the participants about ways of life and was therefore assumed to be a dominant risk indicator of EM, and this will be discussed next.

6.3.3 Secularization of religion

Mistreatment of any person is lack of Islamic understanding as far as I am concern. A lot of people are following the Islamic faith but those that are the minority who disrespect their parents do so because of lack of understanding of Islam.

(Mr. Khalid, EP)

Most of the participants in the study were Muslim, so the narratives quoted here mainly refer to the religion of Islam. Most of the narratives also reflected the views of older participants or stakeholders, who emphasised that all transactions in life, moral, financial and social, should follow the scripts of the Qur'an and of Islam. The mistreatment of older people was therefore often associated with the lack of understanding of religion and its correct implementation – *“because clearly religion defines abuse in different way” (Mr Waqar, SH).*

Islam gives older people an advantageous place within the community and the family and heightens their position in relationships – *“The Qur'an mentions being dutiful to parents or*

*the care of parent is obligatory like Farz [a mandatory act to follow]" (Mr Muhammad, YP). Islam also determines right and wrong for all in their dealings with elders – "Don't say any harsh things to them [elders], don't speak to them in a loud voice" (Mr Javeed, YP), or "neglect of parents is major sin ... Shirk [Infidelity]" (Mr Arshad, SH), or "don't say 'uff' to them [elder parents], 'Uff' means don't make long sighs at them" (Mr Waqar, SH). So, a potential perpetrator is often analogous with the religious dichotomy of *good and evil*. Non-practising children were regarded as bad children or those who commit EM or disrespect their parents, as this older woman explained:*

Those [children] who know about Islam, they respect parents... if you misbehave with mother, Allah will not be happy and if you abuse parents then your Akharat [Day of judgement] will be ruined. Children has no knowledge [of Islam] will just continue swearing and shouting.

(Ms. Janat, EP)

The comparative analysis of the data, however, suggested that agreement over religious principles about what is right and wrong, and who is good or evil, was contested. The young participants' views on religion were secular compared with those of the older generations. In changing socio-cultural ideologies, the participants stated that the level of education and understanding of Arabic (the language of the Qur'an), and the growing sects and opinions in Islam have divided young and old people. It was suggested that older people could perceive any cultural or social opinion or practice which contradicts the religious doctrines on the status, position or care of the older person as EM:

Very strong cultural upbringing, views, and values. Like I said, lack of understanding of as Muslim rather than a Pakistani, how I meant to be treating anybody.

(Mr. Waqar, SH)

As none of the cultural and religious doctrines are objective, IG conflict occurs as result of subjective interpretations and individuals' own cultural and religious ways of living, as this comment explains:

It says in Quran that... If they [elder parents] mistreat you, then do not say anything [to them]. The biggest issue in Islam is that there are so many Firqas [divisions] in Islam; this division has caused so much disturbance.

(Mr. Suhail, EP)

Although Islam defines abuse and abusers specifically, the communities' and society's general understanding of the characteristics of people who carry out mistreatment is important, and this will be discussed next.

6.3.4 Characteristics of potential perpetrators

When asked who was more likely to be an EM perpetrator, the participants were more likely to identify younger members from within the family; *"Basically, it is grandchildren or children"* (Mr Javeed, YP) and *"daughter-in-law"* (Mr Suhail, EP). The participants shared personal experience and acts which they had witnessed describing the experiences of an older person suffering financial, physical and psychological abuse by being threatened, beaten or degraded by their children and family members.

Drug use, alcohol consumption and gambling were repeatedly given as the true characteristics of potential perpetrators inflicting financial abuse as well as other forms of abuse. Because women are culturally, religiously and emotionally regarded as subordinate and weak, they were considered to be both unlikely to challenge an abuser and prone to repeated abuse, particularly financial abuse. Many of the female participants gave examples of relatives who suffered multi-faceted abuse stemming from financial exploitation, clearly illustrating the direct link between potential perpetrators' characters mentioned above and the victimization of women:

Children today take drugs...alcohol. Allah forgives them. When they do not get money, then they steal from own house and outside. They do bad things, fighting, beating.

(Ms. Zeenat, EP)

I have a relative, her children are heavily involved in the drugs. They have destroyed their life, so he irritates her mum a lot for the money, sometimes beats her, agitates her because he need money. If dad passed away, and when mother is not working, lives on social benefits then how much a mother can give it to him. When she gives to him, he is happy, if do not then [he] starts beating because they need these (drugs) anyway.

(Ms. Janat, EP)

Others defended the perpetrator's position if sound explanations existed for the forced financial transactions. One participant argued that if the cost of exploitation is less than the benefits of the services to an older person, it cannot be labelled as abuse:

I suppose like someone is not working because they have to look after their parents, and they would want to go out and they need money ... I suppose you have to like take money of them even if they want to give it to you or not, you have, do you know what I mean, because that person is not working but not looking after that person I suppose that would be like an abuse to certain people.

(Ms. Zohra, YP)

This notion of measuring material and non-material exchange was suggested as a principal explanation for EM and most importantly for help-seeking trends, which will be discussed under category 3.

Many participants, however, also explained the relationship between the environmental influences and the 'cycle of causative characteristics' (see Figure 6.1) of the perpetrators. These influences were argued as "peer pressure" (Mr Sikandar, MFG), "bad company" (Ms Mariam, SH) and the "UK culture ... and lifestyle" (Mr Akash, SH). In many situations, it might not be the intent of children to misbehave or to abuse, but having different views and lifestyles was also not regarded as complying with the *treatment* which older Pakistanis expected from their relationships. The analysis of the data often suggested that the perception of EM depended on who is defining it and what and how they believe it comprises. To illustrate this, the following extract explains why the detachment of children from their own family institutions and its fundamental principles is the cause of disturbed family relationships:

Those who are less connected to the community, less connected to family values, they would probably be the kind of people that might you know do it [abuse their parents] ...because...less cultural norms...less tolerant.

(Mr. Muhammad, YP)

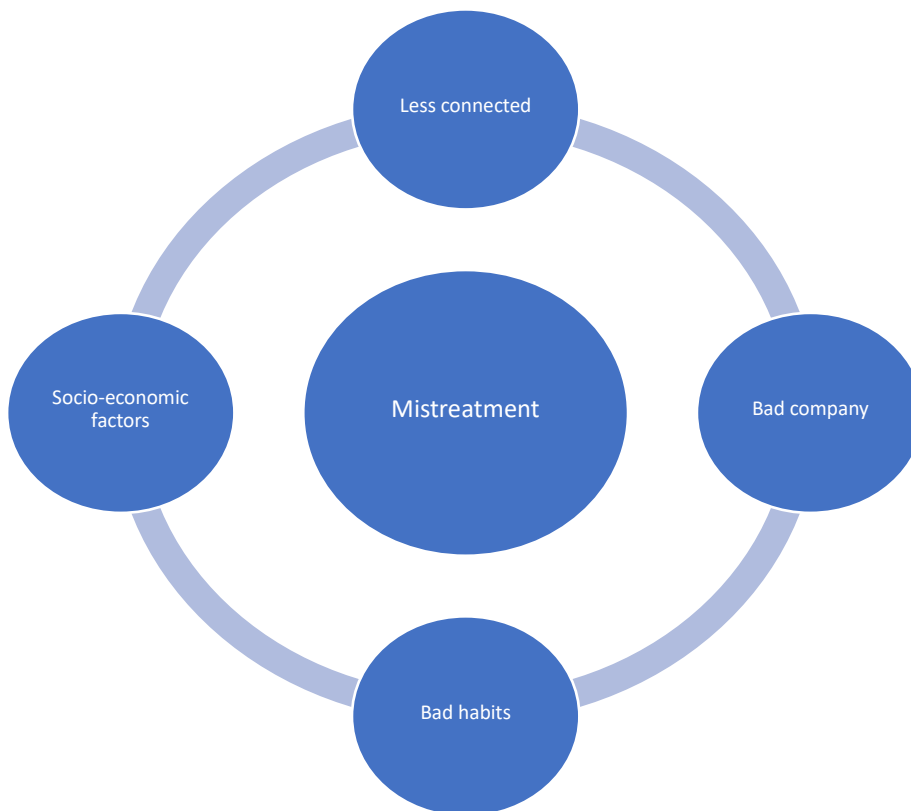
Others looked at the social and mental characteristics of perpetrators and their relationship with EM in the community. Considering mental illness as a growing issue in Pakistani

communities, the participants discussed the idea that young people who are living with stress, anxiety and depression are more likely to commit EM if they find difficulties in relationships or are unable to cope with their caregiving responsibilities, as the next excerpt shows:

I think, people who themselves got some sort of social problems ... may be the short-tempered people, people, you know, who cannot control their temper, violent people. These might do the sort of things [elder abuse].

(Mr. Usman, YP)

Figure 6. 1. The cycle of causative characteristics of potential perpetrators



The comparative analysis of the data identified varying characteristics of potential perpetrators as shown in Figure 6.1. It can be seen that children who are less connected with their families are considered more likely to gravitate towards bad company and consequently bad habits such as alcohol and drug abuse. As a result, they become socio-economically dependent on their families and potentially abuse their parents when their needs for cash to sustain their bad habits are unmet. The next question which arises is about the socio-

economic status of older people themselves, because this behaviour is likely to increase their vulnerability in family relationships and wider interactions; this issue will be discussed next.

6.3.5 Poverty and the socio-economic conditions of the household

The fact is, the conflict in the household only arise when there is poverty. When there is poverty, man and woman fight with each other.

(Mr. Suhail, EP)

In later life, Pakistanis were considered by the respondents to be more likely to be living in poverty. Lifetime disadvantages in employment and housing, the lack of pension protection, and limited socio-economic resources were all regarded as being linked with older people's dependence on their families. The participants drew parallels between the non-contributing status of older people and their worthlessness in the household, reinforcing the notion of ageism. The participants described the characteristics of vulnerable Pakistani elders as being powerless because they have retired with insufficient assets and therefore mainly rely on their children:

Now that they [elder] have reached the retirement age and they are now relying on the income from their children to support them, so that's where, the money is coming from now...they dependent.

(Mr. Usman, YP)

Yes Pakistani [older] they haven't got [pension] protection and by the time they get to retirement they not paid much to national insurance and they had no private pensions schemes to and ... would be relying on family.

(Mr. George, SH)

In a household with a dependent elder, on the other hand, the whole household income was also believed to be main predictive factor of IG tension. Comments on the intersection of disadvantaged social identities such as ethnicity and race increasing the risk of household poverty were evident in the data. Many participants argued that the historical marginalization

and discrimination persists today, breeding an environment of inequality, and as a result, young Pakistanis are trapped in low-pay jobs and long working hours. Young participants in the study regarded their economic instability as a principal cause of stress and depression, thus heightening intra-familial conflict:

Jobs we are doing actually, hardly we can buy one house, pay mortgage, and other utilities, and things are very expensive...affording car...fuel...we don't get really jobs that...deserve, so yeah poverty definitely cause conflicts.

(Mr. Javeed, YP)

The failure of successive governments to address systematic discrimination and poverty was also seen as a form of abuse at a wider level. As a matter of fact, “elder people in general face poverty” (Mr. Khalid, EP) and “have limited knowledge of benefits” (Mr. Zubair, SH), and initiatives taken at the national level were believed to be inadequate and thus merely confirming that the older people are a neglected element of the population. As this marginalization is strongly linked with poverty, older people who were deprived of economic incentives in the earlier stages of their life were considered to be at greater risk of suffering, as this comment explains:

People need to heat their houses and people you know wrap themselves with blankets and so many layers of cloths, elderly people in order to save on fuel. And the government give them [elder Pakistanis] very nominal amount that goes neither here nor there and yes this is one form of abuse.

(Mr. Khalid, EP)

The comparative analysis of the data, on the other hand, also revealed that it is not completely societal or systematic discrimination which is the main cause of poverty in Pakistani communities. The intersection between social, cultural and religious value and the attitude toward economic incentives were also found to play key roles: “My children, mashallah [God is great], don't like paying interest on their mortgage” (Mr. Hasan, EP). Speaking from personal experience, another participant suggested that the relationship between financial stress and the number of earners and dependents is often linked with patriarchal practices in the household:

My wife wanted to work, and I said to her oh no, no, no because I felt it was my duty and responsibility to earn and it was my wife's duty and responsibility to look after household... so we had tight budget whereas in English family you have the man and woman both working.

(Mr. Khalid, EP)

It seems that the socio-economic conditions of the household as a whole, as opposed to those of the individual family members, is a major factor causing the vulnerability of older people in Pakistani families. Furthermore, socio-cultural institutions play a major role in shaping these conditions in the household. If the cultural practices shape the household income, the next question is how they do so, and this will be discussed next.

6.3.6 Intergenerational violence and disciplining

The participants believed that violence is a cyclic and learned phenomenon, and that it occurs when the power balance allows it to occur. The participants gave a range of intersecting factors linked with the IG transmission of violence including culture, religion, and social and personal characteristics. In terms of culture, the participants pointed out that because the first male child is preferred in Pakistani communities, girls and other boys are neglected and discriminated against and therefore accrue negative feelings which often emerge when the power balance is shifted. One participant suggested that this unequal treatment and upbringing potentially renders older parent(s) vulnerable to IG neglect and violence:

The problem is that in our community parent have one favourite child and they spend everything on that child and neglect the other children. Do you know that? So, the other child becomes jealous. When the person becomes old, then that child neglects his parents. He remembers everything that his father did to him; therefore, older people are abused.

(Mr. Suhail, EP)

Furthermore, not only neglect and discrimination but also earlier abusive parenting was also seen as coming to a head when parents themselves are abused. Abusive parenting, however,

was largely synonymized with parental discipline, bearing in mind that Pakistani culture gives parents the right to control and discipline their children. The implications of abusive parenting were individual for both young children and older parents. Speaking from his personal experience, however, Mr Usman contended that the aggression modelled within the family institution rather provides children with a main script for violent behaviour:

Its [disciplining] quite common in Pakistani communities ... the parents discipline the children with by hitting them. I mean... I took a few beatings, yeah, and I do not think anybody should physically hit a child, because it is not the way to discipline them. It's just eh causes a backlash, just cause them to rebel.

(Mr. Usman, YP)

As the analysis progressed, the relationship between disciplining and violence began to clarify. There was an acknowledgement that “*violence is becoming so prevalent in our community*” (Mr Nabeel, EP) and that it was more likely “*because ours [Pakistani people] become aggressive very quickly*” (Ms Sabreen, EP). The participants believed that the increasing growth of intimate partner violence (IPV) in a community was more likely to be linked with IG violence, as children who grow up with IPV victims experience similar mental, physical and social trauma. Ms Janat described the impact of IPV on her children’s mental health and social isolation:

Yes, then my husband used to beat me, hit me and everything and my children were also watching it. It is true that if parents are fighting then children feel it bad and get influenced. It affects them mentally.

(Ms. Janat, EP)

The more likely effect on children, in the view of other participants, was the normalization of violence. If violence is accepted and cyclic, one participant commented that it potentially heightens the risk of older people being mistreated:

Younger person is seeing...what happened to my grandma and my mother... that they may think that's [mistreatment] completely normal, that's part of the culture and they may start to adopt certain behaviours, that they saw happening.

(Mr. Mubarak, SH)

The comparative analysis of the narratives suggested that traditional teachings on generational discipline and IG violence were still favoured by older participants. Having no control over their own children in being able to correct and discipline them according to their culture and religion was described as the most distressful feeling for older participants. A few of the older participants argued that today's excessive freedom and wide range of choices draw children into socially and culturally inappropriate behaviour, and as a result they fail to abide by 'parental obligations', so parental disciplining still exists. Issues associated with culture- and space-related upbringing were raised by many participants:

You see mother or father can only verbally say anything, they cannot beat them. So, it depends they [children] take notice of it or not.

(Mr. Akbar, MFG)

And they have no sense of responsibility, but only rights, that we have to live but taking no responsibility.

(Mr. Sikandar, MFG)

It is just that freedom. It is just misusing of the freedom, because police ehh parents cannot do anything that is why, do anything they [children] like.

(Mr. Rizwan, MFG)

I think, you should leave something to parental discipline. Parental disciplining is ok as long as it is not physical abuse. Smacking to a degree is okay to me.

(Mr. Khalid, EP).

There is fine line between parental discipline and child abuse, but both provide opportunities for violence. In addition to the home environment, the comments above also suggest that one of the key factors in EM is the failure of the education system. The role which education can play in preventing and in promoting EM is another important question, and this will be discussed next.

6.3.7 Education

In my view, it is not probable that a child who is educated will do this [elder abuse].

(Ms. Jameela, FFG)

It is not like those who are educated they do not do it; they also abuse as well.

(Ms. Bilqis, FFG)

Do not think education has anything to do with abuse.

(Ms. Farzana, FFG)

Education has recently been studied as a potential risk indicator of EM in the general literature (Skirbekk and James, 2014). The idea that having an education ensures a secure later life remains a heavily debated issue and the participants in this study were no different in their levels of acknowledgment of this fact. The community participants, however, emphasised several distinct reasons associated with education which could potentially increase the conditions which lead to EM, including co-education, secular education and the lack of religious education in the British education system. Many of the participants in the male focus group argued that the education system and education institutes in the UK fail to put any emphasis on traditional values such as elder veneration, elder care and familism, but predominantly focus on equality and children's rights, and as a result, older people are not respected in families or in society:

You know, this education system, the education system of this UK. In this from the beginning has coeducation, girlfriend, boyfriend thing starts from the beginning so our children get that influence and do not listen to parent.

(Mr. Akbar, MFG)

They [children] have become too much educated, there is too much knowledge and but no fear of Allah [God]. They do not know how to give respect to parents.

(Mr. Rizwan, MFG)

How can we teach children our culture, when a child from the age of three goes to school for eight, nine hours...that children goes to school and they only learn English and the law and rules of this country...their brain is already washed...they don't know about the culture back home in Pakistan...elder care...respect.

(Mr. Sikandar, MFG)

These comments show that the role played by modern education is significant in reducing IG interaction as well as widening knowledge gap between the generations. As a result, attitudes

and ways of looking at different aspects of life vary between young and old people. These differences are important for understanding the IG relationship and will be discussed in detail in Chapter 7.

Other participants saw education as a protective factor in EM regardless of whether it is religious or secular. One participant felt that education empowered children with knowledge about acceptable and unacceptable behaviour, thus ensuring fair treatment of the older generation:

Those who have got education either worldly education or religious education, they are looking after their parent's sort of very well, if there is no education, then may be obviously there may be a case of abuse.

(Mr. Waqar, SH)

Although education empowers people, how attitudes towards, and practice in education distancing and isolating the old generation from the young is critical. In addition, what are the social needs, social groups and social interactions of older ethnic communities and how they shape, evolve and influence older people's health and well-being, socialization, and safeguarding are important questions. Isolation and loneliness will therefore be considered next.

6.3.8 Isolation and loneliness

I cannot stay inside the house long, as I get depressed. I always want to talk to someone.

(Ms. Janat, EP)

You want to talk to someone and there is no one. Often the people are talking to themselves [a big laughter].

(Ms. Sabreen, EP)

The analysis showed that isolation (the objective fact of having few social contacts) and loneliness (the subjective feelings of distress at being isolated) are growing issues in the community, increasingly linked with depression, poor health, neglect and abuse. A number

of reasons associated with isolation and loneliness in later life were largely recognized as children living at a distance, limited health and physical abilities to visit others, the economic mobility of children in megacities, small houses, age and its associated limitations, changes in family structures, language barriers, and the British weather, particularly the cold winters, as the next extract shows:

Weather gives depression anxiety especially with older people. They can't walk themselves outside because it's raining, cold and if they go outside, how they gonna speak to anybody because here in this country for them they got communication barriers...people live next door to each other, but they don't talk.

(Mr. Javeed, YP)

The comparative analysis of the data, on the other hand, suggested that intersecting statuses play a role in increasing the risk of women living in isolation and loneliness. As was discussed in Chapter 5, many Pakistani women arrived in the UK as dependents with low socio-economic skills and language ability; they were believed to have developed only a minimal understanding of the UK culture and social system. Also, being migrants and controlled in their households, their social network was confined to their closed native-language groups. These intertwined factors were suggested by a stakeholder who worked with older Pakistani women to be the principal causes of driving women into linguistic isolation and wider segregation:

Integration issues is been very limited...people are clubbed together and hotspots they feel very comfortable within their own sort of communities...friends from outside the family or beyond that is not really something they did. So they are more isolated.

(Ms. Mariam; SH)

Vulnerability in society could also be inferred as another explanation of living in isolation and loneliness in the above example. As discussed earlier, street abuse is growing in the communities and participants spoke about the idea that marginalized groups such as women accept voluntary confinement, which protects them from street abuse but at the same time potentially heightens their social isolation and loneliness:

It is just the elderly people, vulnerable and the women in got touch recently, and she is in 80s and she was scared going outside because kids were throwing at stuff and things like that, she felt vulnerable.

(Mr. George, SH)

The comment by Ms Mariam quoted above also seems to suggest that Pakistani women have a strong and close familial support network. However, further analysis of data contradicted these assumptions. In response to questions about household conditions, many older participants mentioned living in large households and found them to a source of social and cultural sustenance, but they expressed concern that social interactions are disappearing under the influences of rapid social transformation and increasing technological advances, so the quality of relationships is often compromised and older people see themselves living in a crowd but nevertheless lonely themselves:

I think it [loneliness] is getting more and more common, yeah. [Interviewer: Even in joint families?] Even in joint families, yeah definitely because there is so much going on outside, we know people doing so much with their children with school, mosque, activities after school, jobs as well for all people working no one going to stays at home 24/7.

(Ms. Sadaf, YP)

Mr Muhammad had a similar view, suggesting that isolation is not a multi-generational but an IG issue:

They [young people] do not spare enough time at home. These young people are always out, you know. If they are spending time at home, then inside [home] they playing games, you know on their mobile phones, they don't interact that much [with older parents].

(Mr. Muhammad, YP)

This do not happen only in multi-generational households; the analysis of the data showed that older Pakistani women are left lonely and isolated even when living with their partners. As the woman's role is inside the home, their physical exploitation in terms of family and

household responsibilities was considered to be inevitable, preventing them from engaging in social contacts outside, as the next comment shows:

The men in the older age what will happen is they will retire from work, so they more regularly go to the mosque, which happens five times a day, they regularly meet up friend's house, where is an older lady she still going to be in the house, she still needs to do the house work.

(Ms. Mariam, SH)

Social infrastructures and social opportunities play a vital role in community cohesion and help people to develop social skills and make meaning of world around them (Perry and Blackaby, 2007). However, the participants believed that Pakistani women receive limited attention in both local and national social structures, which is now linked to their current marginalization and exclusion in society. The participants suggested that local infrastructures such as mosques, lunch clubs and other social networks are hardly inclusive as they are predominantly aimed at men because of the patriarchal history of Pakistani communities. On the other hand, opportunities on the wider level were regarded as gender- and culture-insensitive. A daughter spoke of her mother being lonely at home all the time as there were no local infrastructures in the area:

I don't think in this area specially there is nothing for them to get to, to have bit of like their social time, yeah or like get together with her, their friends and yeah you know to do activities basically or sort of, anything like that, even if there is like if it is not funded enough.

(Ms. Zohra, YP)

This was confirmed by a stakeholder who suggested that there are limited opportunities for Pakistanis at wider levels:

...to address that sort of social isolation, there are contributing factors. One of a factor is that we do not have or very little provisions out there.... where it is culturally conducive...there is pray facilities.

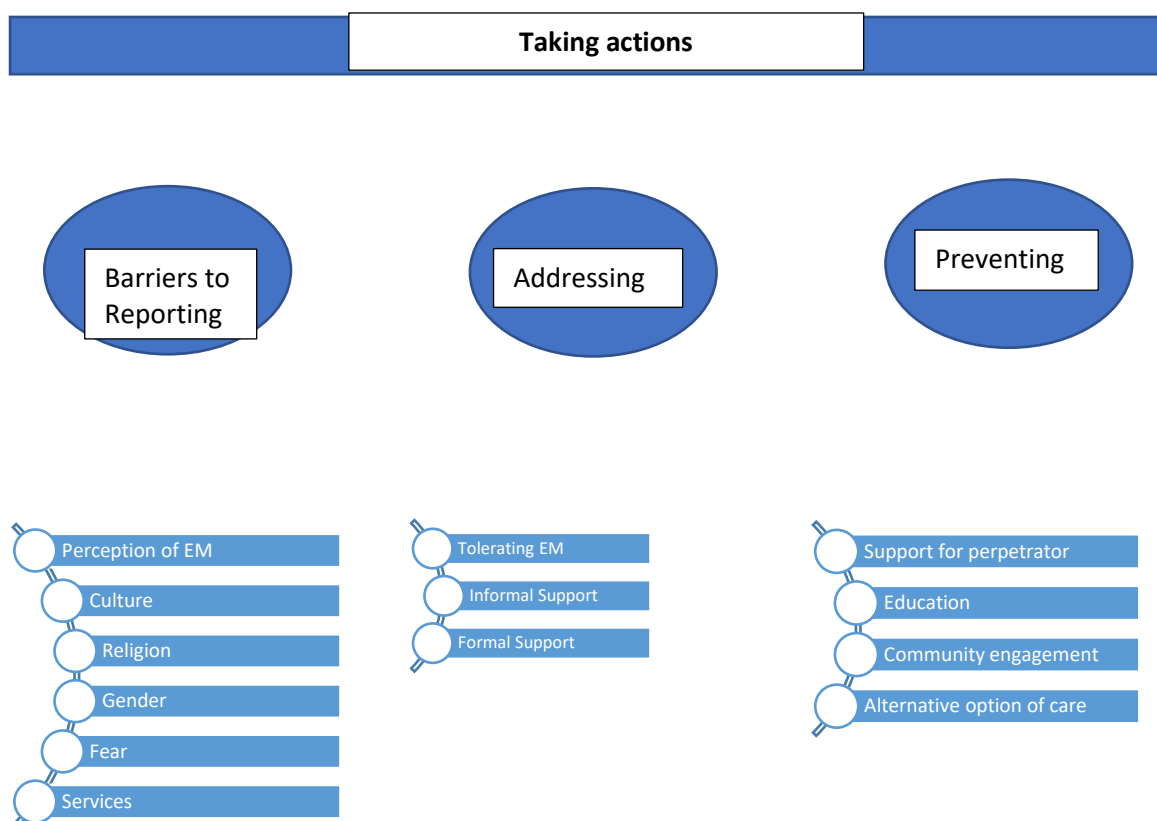
(Mr. Zubair, SH)

Isolation and loneliness seem to be a growing issue for older people in the community bearing in mind Pakistanis' small social networks, changing societal values and old age. In addition to the many other factors which increase the risk of EM, isolation and loneliness were also thought to increase the vulnerability of older people both inside and outside the home. The actions which the community can take to address EM are a key determinant of the extent to which Pakistanis can experience EM, and these will be discussed next.

6.4 Category 3: Taking actions

The views of the participants were explored about the actions which communities take to address EM. The analysis of the narratives and the codes which were produced identified the major themes in action-taking as reporting, addressing and preventing EM (see Figure 6.2). Reporting EM was frequently stated to be an action taken by communities, so this will be discussed next.

Figure 6. 2. Taking actions



6.4.1 Reporting EM

You know it's like licking the finger in the air, looking which way it's going to you know, it's very difficult, because when this [EM] happen in the families, very difficult to know anything.

(Mr. Muhammad, YP)

Reporting EM is one of the fundamental ways to measure the extent of it, identify the causes and design appropriate interventions. It is clear from the findings discussed above that EM was perceived by the participants as a complex phenomenon stemming from the interplay of multiple intertwined cultural, social and individual factors. Similarly, the analysis of the participants' personal experiences and perspectives and the accounts which they gave suggest that reporting EM involves a complex decision-making process. EM victims do not just tolerate abuse if it meets legitimate explanations, but the participants spoke of a variety of interwoven IG and wider social barriers which restrict older people from accessing formal support. To report or not to report was regarded as a moral, cultural and material dilemma for the victims of EM in the community. The barriers to reporting mistreatment were by and large related to the perception of EM, cultural barriers, gender, fear about reporting, and the role of social and health services. These aspects will be discussed separately next.

Perception of EM

I do not think that families abuse their elders you know no matter how bad or good they are we still have that respect. We might be very backward, traditional but I personally think, a lot of them have that respect

(Ms. Sadaf, YP)

I think White people do abuse and do report as well (Ms. Sabreen, EP),

Denial was one of the main reasons given by the community participants for EM being perceived as an outside problem which does not exist in the community. Another key determinant in under-reporting EM was the perception of the community of the different forms of mistreatment, whether the abuse is psychological, physical, financial or neglect. The normalization of some types of mistreatment, for example, an act which does not result in the loss of any substantial material or physical possessions, particularly for women, made it difficult to decide whether any action should be taken, as the extracts below illustrate:

These children say to you this and that...it is not new thing...common... but then what should you do, you can't turn house upside down [by reporting it]

(Ms. Farzana, FFG).

...never mind if they take him [husband]. He has beaten that's why police are taking him. If he has physically hit me then [only] they should take him

(Ms. Almas, FFG)

Many participants argued that conflict between mother-in-law and daughter-in-law is a normal and long-standing phenomenon of Asian culture and family life. They did not see that IG conflict between the two merits being regarded as EM, providing another rationale for under-reporting in the community:

In joint family, of course, daughter-in-law and mother-in-law tense relationship is always present, but such issue has not come to surface, like happened to be a big issue to report anyway

(Mr. Hasan, EP)

Internalized ageism was another reason; women who were dependent and controlled felt that reporting EM would not result in any substantial action-taking, and they perceived tolerating the abuse as the better option, as Ms Janat said, – “*Who listens to an old person?*”. These perceptions of EM are important and often believed to be cultural; therefore, how cultural interpretation impede reporting are considered next.

Cultural barriers

Interviewer: If it [EM] happen to you, what will you do?

Mr. Sharjeel (MFG): we will take poison and die. What else we will do

The participants recognized that cultural concepts such as stigma, familism and honour are major barriers to reporting EM in Pakistani communities, particularly among the older population given that their upbringing is culturally rooted and their acculturation limited. Comments such as *“It might be happening, but no-one mentions it”* (Mr. Hasan, EP), *“They don’t want the neighbours to know”* (Ms. Amina, YP) and *“Make sure that nobody knows about it”* (Ms. Zeenat, EP) were some of many frequently used acknowledgements of the sensitivity surrounding the phenomenon and the stigma associated with involving a third party in family affairs. Because the family is considered an inviolable and immune institution which is not open to scrutiny, the participants saw EM as a hidden issue in the community:

Ehhh I wouldn't say it's uncommon, but it's difficult to sort of gauge, but one thing I can say it is becoming more and more common, and I think majority of it is hidden, that's why it is difficult to gauge it.

(Mr. Akash, SH)

Stigma was not the only reason for keeping EM hidden. Honour similarly emerged as an integral part of the individual’s cultural identity in Pakistani families. *Izzat* and *gairat* were the two terms used interchangeably to describe honour (high respect). The participants referred to *perception* and *reputation* as the two central derivations of honour. Honour was defined as a property or a notion which lives in the collective minds of individuals, families and the community and which is interwoven into their culture, religion and history.

As honour is a collective asset, the participants questioned how EM will affect the whole family and the IG relationships. Family support or pressure and perception, as a result, were considered as key determinants to reporting or tolerating EM, as the next extracts show:

Well, I think they do not want to embarrass their family, the family honour, this concept you know exist in some of Pakistani communities, you know the family honour and Izat [lit. means respect].

(Mr. Khalid, EP)

I assume the family would play you down, and say listen, you should not have done that [reporting] ... people play, because, they do not want to bring shame to family.

(Mr. Mubarak, SH)

It is just out of respect really, so again it is culture. What people will think of you, like other people will start talking about you. It is more what other people will say because no matter what happens in an Asian person's home, they will not ever report it. Honestly, well I do not think that they will anyway. I suppose my family is like that as well, they just would not because they too worried about what other people will think

(Ms. Zohra, YP)

Not everyone discussed honour in abstract terms of reputation and face-saving, but they did comment on the physical repercussions associated with it. One participant said that people negotiate moral and material dilemmas when faced with EM in the community. On the one hand, they have family honour which is precious to them and relevant to others, and on the other, there are consequences which determine their own health and well-being. To tolerate or not to tolerate EM is major dilemma in the community when the notion of honour is involved, as this older participant said:

Your Giaret [family honour] stand against you. If you involve anyone else, it will worsen the situation. If nothing is happening, then just be silent or get caned [for speaking].

(Mr. Rizwan, MFG)

Not only family but also community honour and consequently community pressure were also highlighted as important restrictive factors, especially as the family clan and caste system are widely prevalent in every Pakistani community. The participants reported that Pakistanis are identified by their particular native groups of origin: *"Biraderi [the tribal network] exists ... and people still do recognize each other from that"* (Mr Muhammad, YP). Reporting EM has a

significant effect on the community's reputation and people's current allegiance with the clan system presents moral and social dilemmas for them, increasing the risk of tolerating EM:

you got your [Neighbourhood A name] Pakistan community, then you got your [Neighbourhood B name] Pakistani community, so each of them got their own communities with that, that kind of support each other [to solve the problems] ... so, they [victim] will jeopardise their own health and things, you know just because they don't want to put shame on rest of the family...community...so they would just keep the mouth shut.

(Mr. Mubarak, SH)

The notion of honour is also heavily gendered. Traditionalism and patriarchal ideologies reinforce male dominance in the community. Men are therefore recognized not only as the "spokesman of the family" (Mr Mubarak, SH), but also as the authority, the value and the power in the household. The desire to save manhood emerged as another interesting context for men in their toleration of EM, as these next extracts show:

He still has little bit of Gairet [self-honour], more than women. I am sorry to say. A man burns inside, only women goes to report.

(Mr. Sharjeel, MFG)

Men are very gentle...keep the dignity...women don't mind saying anything

(Mr. Arshad, SH).

Stigma, familism and honour are the key components of cultural identity which shape the perspective of the community in regard to seeking help, but culture is only one parameter and there are many other variables, including religion, so religion will be considered next.

Religion

The majority of Pakistanis follow Islam which seems to play a central role in shaping their perspectives on their health and well-being. In Islam, life and death are important and religiously embedded concepts in Pakistani communities. The place of death, according to some of the participants, is central to Muslims, and death at home is the most desired wish because it reassures the dying person of the feeling of belonging and comfort while

surrounded by family and friends. If reporting EM is correlated with institutionalization, it becomes a religious dilemma for traditional and religious elders, thus heightening their likelihood of tolerating EM, as this next extract shows:

They [elder] might be afraid that they [young children] will throw us [in a nursing home] ehh what so better not to contact anyone and then to die at home.

(Ms. Amina, YP)

In Islam, the life after death is shaped by the present life, and the participants agreed that having a family member reciting from the Qur'an and then dedicating this to the deceased person will bring rewards for him or her. Many, therefore, saw potential benefits in the hereafter of tolerating EM within the family:

How will this [reporting] affect my children or me [as individual] ... How will people remember me after this [reporting]? This is the reason it is good to be patient and tolerate it.

(Mr. Suhail, EP).

Furthermore, victim blaming was seen as another explanation, supported by religious scripture, for the fact that EM is under-reported in the community. It was noted that condoning EM through silence was a religious way of coping and taking action in the community, as the participants explained that human deeds are the results of their own actions, as this next comment shows:

What goes around, comes around, basically...there is Hadith [saying of prophets] says that you are to your parents to your children that happen to you... who does it [EM] will be punished severely, severely not only in this life but hereafter... what you sow so you reap.

(Mr. Arshad, SH)

Other participants also talked about rewards and about wisdom in forgiveness in Islam. Because young people are culturally and religiously considered naïve whereas the older people are regarded as enlightened, when children make a mistake, older people are supposed to forgive them. By doing nothing against their children, older people are prided for their sagacity, as this extract shows:

I will never do that [report abuse]. The reason of this is that whatever happens, you child is your child. Even if your child become your enemy, you tend to forgive him. This is what my parents and religion taught me.

(Mr. Suhail, EP)

Both culture and religion highlight multiple social, moral and material dilemmas which Pakistanis go through when deciding whether to seek help. At the individual level, however, the characteristics which influence reporting are also important, for example, gender, so this will be discussed next.

Gender

The participants gave a range of explanations for female toleration of EM. One was family togetherness. As reported above, women described a preference for living in multi-generational households and this requires them to maintain the collectivism and the interdependence in the relationships which exist within the family. Therefore, the desire not to disturb family harmony was perceived as the main motivation for older women to remain in a disturbed and abusive environment:

If they [elder women] have been abused they will majority of times accept it... they wouldn't retaliate, they wouldn't use any other forces of means to sort of help themselves, to get out of the situations [live separately] ...they just learnt to accept it.

(Mr. Mariam, SH)

Others looked to material variables, the intersection of which potentially heightens the likelihood of them tolerating their mistreatment. For example, if legal institutions are brought into family affairs, this will more likely result in the loss of people's sole source of support; many of the older women, one of whom was a widow and socio-economically dependent on her children, said that being dependent and unsupported meant that they would fear for their independent survival, as their comments clearly show:

If my children are providing care, then of course they have to spend money. So even if they exploit, it is fine but what will happen they neglect me.

(Ms. Sabreen, EP)

As discussed previously, women are a marginalized and dependent group within Pakistani communities, and their independent survival remains a significant fear for them in deciding whether to report EM. How fear influences help seeking will therefore be considered next.

Fear

Many comments made by participants in different categories reflected the perceived fears which they consider to be central in their decisions over seeking external help:

...if tell someone, it also intensifies the conflict. (Ms. Zeenat, EP)

...they [elder] must be feared... they might be kicked (Mr. Umar, SH)

...they [elder] could be threatened (Ms. Sadaf, YP)

One of the fundamental fears leading to enduring abuse was linked to the social and physical entrapments within which older people live and how their relationships are shaped by these entrapments, such as culture and the family: *“they got bonded with their own home ... and got cultural strength ... to bear anything but losing the home” (Mr. Umar, SH)*. Therefore, losing the family or ruining relationships with children and family members were important considerations for elders before reporting EM. In fact, as discussed previously, the family is considered a major source of support, particularly for marginalized and deprived groups of the community.

In the absence of family support, the fear of isolation and of failing to find appropriate lodging were mentioned as major causes of concern. It was also believed that the elder generations live with the pervasive fear of being institutionalized because they are highly dependent on their children and strongly attached to the idea of the family and home. Additionally, the alternative options outside the family such as a nursing home or sheltered care are already feared as inappropriate. Older participants noted the precarious balance which exists between tolerating and reporting EM, as this older person explained:

Psychological and verbal abuse is common, the physical mistreatment is rare but again as I said even if this happens what can you do...where will I go...now I am helpless, and I need my children whether they are mistreating me or not.

(Mr. Hasan, EP)

The decision on reporting was also linked with the power and control in a relationship, with a general understanding that the perpetrator of EM would be more likely to be stronger, younger and healthier. The participants cited the notion that older peoples' fear of retaliation and fear of developing animosity are inevitable, as the next extract shows:

Obviously, the person who has abused them must be stronger, younger and you know I believe when like my mum used to stay and still does that the older person becomes like a baby and they get scared, vulnerable and you know to report it.

(Ms. Sadaf, YP)

From above examples, it seems that it is the fear that restrict reporting, however, as the analysis progressed other factors begin to emerge, for example, the lack of hope, particularly outside the home. Service therefore are considered next.

Services

Although, there is “*this proliferation of these [social and health] services*” (Mr. Khalid, EP), how likely they are to be accessible, available and appropriate were noted as a significant concern in the reporting of EM. The reason “*a lot of it would go unreported*” (Mr. Akash, SH) was believed to be associated with the trust which a community places in these services. It was explained that the type of relationship (whether it is vertical or longitudinal), the depth of the stereotypes and the number of past negative experiences between services and older people are central questions. As a result, participants said that services are considered as a last resort in the community:

No, I do not think they trust it that much to be honest. I do not think that the Pakistani community necessarily give information out as easily and say this we need help so for example. They will I think it will always be a last resort. They will do everything to try and solve it themselves but if it comes to last resort they may then go to service.

(Mr. Mubarak, SH)

As well as trust, other participants mentioned the unwelcoming and insensitive attitude of service providers toward Pakistanis as a key restricting variable:

They [older Pakistanis] do not have communication skills and people [service providers] have no patience when you report them...they are very quick, so older people, they do

not really feel comfortable. They think they are not really listening, you know nicely and calmly...not like welcoming.

(Mr. Javeed, YP)

The excerpt above also shows that the gaps in understanding between migrant and native communities also act as a major factor in their limited integration and acculturation with each other, as discussed in Chapter 5. Others, however, also argued that it is not just the issue of trust, but that *“they [victims] don’t discuss the whole matter ... with them [services]”* (Mr Waqar, SH). Language was identified as a principal barrier to accessing services, and it was also regarded as a cause of concern in regard to disclosing sensitive information to the services. The language barrier was also seen as jeopardizing effective communication and accurate reporting. Furthermore, because older Pakistanis often rely on their children for translation and it is their children who are most likely to be the perpetrator, engaging with services was viewed as an effective way of distorting the facts through the fear of controlled translation:

And to get message across, and if you can’t communicate with someone, how can you tell them how you are feeling, or this is happening [elder mistreatment] ... you always be dependent [on your children for translation].

(Mr. Mubarak, SH)

Family member is always representing their views of the client [older person] which again from Asian culture and how they opening the background is not always right.

(Mr. Zubair, SH)

The analysis of the data on reporting EM showed many micro and macro variables which the participants viewed as hindering the community from seeking support. Because there are so many barriers to reporting, how the community addresses the issue of EM is an important question, and this is considered next.

6.4.2 Addressing EM

Reporting patterns defined the action-taking behaviour of the community toward EM. Sources of advice and regular interactions such as the mosque, friends and the Imam were regarded by the participants as major influences in shaping people's perceptions and decisions about taking action, with a general understanding that a significant level of trust predominantly lies in the informal and closed institutions of the community. For Muslims, the older participants believed, any solution which reflects elements of Islamic *Sharia* law is central to the way that they address EM, as the next extracts show:

I always say, 'wash your dirty lines among yourselves' and ... sometimes when a person who is familiar to you, ... may try and resolve them with knowledge of yours, you know your situation or go to, you know, Ulema or Imam [religious leader].

(Mr. Khalid, EP)

Imam can play pivotal role in this, not, I think we should always leave eh decision to the imam or, that he is the person, obviously, he is person of authority within the masjid but there are other people within the community who have certain roles to play. ...obviously certain things imam can talk from Sharia from the Islamic law which older person will not be aware of.

(Mr. Arshad, SH)

However, others regarded the role of the Imam as informal and unstructured. How the knowledge and advice of an Imam influences the safeguarding of EM victims was raised as an important question. So talking only to an Imam as the solution to addressing abuse unfortunately turns the problem back on itself and encourages under-reporting, as this statement by an Imam illustrates:

as an Imam, I try to tell them [elders] that you should be eh in the home, be good with them [children], you know because this is the time when you need something from them, they don't need to get something from you, so this is the time to be patient with them number one, I advise them.

(Mr. Waqar, SH)

Not everyone, however, was willing to accept an Imam's advice to tolerate abuse. Some participants also discussed the different ways in which community leaders handle the issue. Expelling perpetrators from the community, for example, was reported as an atypical and informal way of handling family issues, including EM:

One or two cases that I have heard of, who I actually know personally these people have been caught...and eventually the community has outcast them, expel them from, well you know, not expel them physically where they are thrown out of community but ostracized basically.

(Mr. Usman, YP)

Reporting and addressing EM are important concerns as well as interventions, particularly when the intersections of multiple cultural, religious and social variables are involved. As the analysis progressed, one of the major solutions to taking action over EM which emerged was preventing EM from happening altogether.

6.4.3 Preventing EM

A few suggestions were made by the participants for addressing and preventing EM. Education, awareness and training were some of the suggestions, along with introducing different platforms to empower the older people and arrange support for the perpetrators. Community engagement and sensitive interventions were also suggested as ways of reducing the risk of EM in the community.

Support for the perpetrator was believed to be a fundamental step in the prevention of EM, and it was the young caregivers who had experienced the tensions in caregiving settings who emphasised this the most. For Mr Usman, for example, behavioural issues such as losing one's temper and control were reported as major repercussions of EM, and education in "*the reasons why it (EM) is wrong*" for the perpetrator and support from informal sources such as family, community or the mosque in particular was considered important in terms of their acceptance and appropriateness compared with formal services:

...ehh people seems to change is when they start come to the Masjid... their behaviours changes and, they start learning why you shouldn't be losing your temper, why

shouldn't be getting angry, why should have respect, you know not harm other, anybody else.

(Mr. Usman, YP)

Similarly, caregiving stress (see page 119-121) was seen as a significant risk factor in EM, considering the demands of modern life and the level of family support. Respite support or some sort of help from services for a carer such as Ms Zohra were therefore considered to be a major relief and appropriate strategy for preventing EM, as long as the support is sensitive to cultural and religious beliefs:

for me that would be big thing like getting help for them, for example, ... whilst I am at work, I am nothing to worry about and then as soon as I am back from work, you know, I can take over.

(Ms. Zohra, YP)

As discussed previously, ageism was another factor considered to increase the vulnerability of the older population in the wider society, so promoting the status of elders through education in all pedagogical institutions, home, school and mosque, was thought to be a good start to preventing potential abuse, as this comment illustrates:

It [elder veneration] should be at home first, like the parents, teach them [children], also the school because most of things with children get influence from the schools. It could also be done like telling them from religious point of view that what your god wants you to do [respect your elders].

(Ms. Amina, YP)

Not only young people, but also educating society as a whole through public awareness programmes was also suggested as an important strategy in which religious and community leaders could play a significant role. The participants believed that programmes such as this could increase older people's knowledge about their rights and the appropriate routes to access support at the same time as providing information to potential perpetrators about the consequences of their actions:

It's worth investing into like a safeguarding seminar, events related to domestic violence that's not tailored necessarily for professionals but for public and again imam

is important, words of mouth or whatever it is for women, men as well, if you are one of the perpetrators its worth you coming to find out ... consequences.

(Mr. Zubair, SH)

Community engagement was also seen as one of the public awareness programmes for preventing EM in the community. The participants suggested that awareness is key source “for elderly people ... to know where to go, who to talk to” (Mr. Akash, SH), but how to articulate one’s needs would require sophisticated community skills and capacity. There would need to be high levels of engagement to enable collective actions to address the community’s needs:

I think the best way to tackle it would be, instead of outside sources coming, I think it be, the best way would be to empower them, so it be a case of empowering women, to support each other and also give each other the skills , so even like basically, learning to speak, the language, English.

(Mr. Mubarak, SH)

As discussed previously, trust in the services is a significant barrier to accessing caregiving support and reporting to services, so there is a need for agencies to build a rapport and ensure that the community will be treated fairly and equally, and the participants regarded this as an as important step, as this comment shows:

Because the more the Pakistani community realise these services are accessible, open to them, then they more likely they are to kind of use them ... the role that the services could be doing to actually engage with certain communities.

(Mr. Mubarak, SH)

Additionally, the language barrier was studied and regarded as a significant issue for older Pakistanis, particularly older women, because it could very likely restrict effective reporting of mistreatment. The services would need to work on improving and making more available interpretation and translation services for the community:

I also want to suggest that the interpreter must be with their background where this elderly people is from you know. If he is Gujrati then interpreter must from Gujrati community, this is help them understand older people problems.

(Mr. Waqar, SH)

Many other options which are culturally, linguistically and religiously acceptable about future care of the older people were also recommended for preventing EM. It was reported that the attachment of older people to the family home is culturally and emotionally rooted, so those options which attach an older person's existence to his/her own house and family matter most. Extending home support by services when needed to sustain support within familiar boundaries was believed to bring positive results by increasing the safety and satisfaction of older people and preventing their complaints:

They must have their own separate room that children must not be disturbed due to them, and that way and those expenditure which social services spend on them on nursing home that could be spend you know here at home in this way, I think we see a positive result, and then children will not abuse them.

(Mr. Waqar, SH)

Although family caregiving remains a prevalent, widely expected and virtuous duty, the stress in caregiving emerged as a growing risk indicator of EM considering recent changes associated with family structures. The participants saw many advantages in having a nursing home for the Pakistani or Muslim population. They believed that many barriers would be eliminated when the members of the community see 'a lot in common' in a care facility, such as cultural, linguistic, religious and social needs, so community and religious leaders as well service agencies need to work together on such projects:

Older woman get along with older woman because they share the same background where they came from, they have a lot in common and even that would help them get better because they are actually getting out and talking to people and getting know the world and getting to, you know, even socialising does a lot for the people you forget what's going on at home, or whatever is going on with you and you just talk to friends basically and friends are the people, sort of help you get through stuff.

(Ms. Zohra, YP)

6.5 Conclusion

In this chapter, it was argued that Pakistanis hold distinct view about EM and that these views are influenced by their culture, religion, and migratory experiences of settling in the UK. It was also found that community perceive types of EM from more abstract and social ways than they are broadly known in the wider literature. The chapter presented wide range of factors and conditions which community viewed increases the risk of older people of mistreatment at various individual and social levels. These factors are interlinked, and the intersection of them was considered central in heightening the risk of EM. Intersection will be discussed in chapter 7 in details. Furthermore, how community perceive EM often determines their action takings, with a general understanding that it is often a complex but prescriptive process which can be encapsulated by the acronym TIP (Tolerating, Informally addressing and Preventing). Because EM was considered to be a private family issue, with the notions of honour and shame attached to it, *tolerating* abuse was the most righteous and emphasized advice which almost half of the older participants and stakeholder were able to think of. Even if it was considered that EM should be exposed, it was often expected to be resolved *informally* within the existing community institutions. Because social and cultural norms are changing as the first migrant Pakistanis age, alternative *preventive* options were the major priority of the community.

The next chapter further explore and explains these processes and other key concepts that are interlinked and in doing so present the resultant theory of EM developed from the analysis of the data.

Chapter 7

A Grounded Theory of EM among Pakistanis

7.1 Introduction

In the previous two findings chapters, a wide range of background and contextual factors shaping the lives of immigrant Pakistanis growing old in the UK were presented. In Chapter 5, I discussed the life-long disadvantages which the Pakistani immigrant cohort experienced from living in the UK and how these experiences shape their current position in family relationships and further wider interactions, including their future care. What members of this community mean by EM and how they might respond to it were discussed in the preceding chapter and it became clear what the social, material, cultural and ecological conditions are that increase the risk or help to explain the risk of EM in the community and, most importantly, the relationships between these conditions. This chapter will explore these social, material, cultural and ecological conditions. Before moving onto this, I would like to note that the findings in this chapter are supported with new data (quotations) which are consistent with the results of preceding chapters and in doing so additionally confirm the validity of the study and resultant theory.

My intention in this thesis is to generate, as far as is possible, a mid-range substantive GT of EM in Pakistani communities living in the UK so that the findings can be used to improve our knowledge of this phenomenon. This aim was implicit in the research/foreshadow questions which were developed from the sensitizing concepts discussed in Chapter 3. In Chapter 4, I explained my choice of the constructivist version of GT to address the research questions and I gave a number of reasons for this choice of methodology (*see page 54-57*). GT research is essentially concerned with establishing the relationship between the abstract concepts and categories which can explain or predict a phenomenon, and thereby provide a guide to action (Hallberg, 2006; Charmaz, 2014). In this chapter, the primary focus will be on explaining the identified core category and sub-categories informing the resulting theory, and their interactions and relationships with the findings of previous studies which have highlighted the theoretical and thematic concepts. In this chapter, however, the types of EM and reporting trends in EM discussed in the chapter six will not exclusively be covered. These will be considered and integrated in the light of core and sub-categories of the resultant theory.

Strauss and Corbin (1998) stated that a core category constitutes the central phenomenon of a research study. They defined a core category as a category which appears to have the greatest analytical power and the highest potential for linking all other sub-categories (or basic social processes) together. Constructivist grounded theorist, Charmaz (2014), however, contend that one single category could restrict researchers' abilities to theorize complex phenomenon and that collapsing multiple wide ranges of processes into one category would be oversimplifying. The purpose of a core category is to determine and delimit the theoretical framework (Hallberg, 2006). Corbin and Strauss (2008) furthermore suggested that the function of a core category is to unify and condense all the products of a study into a few words to explain what 'this research is all about'. It is this purpose which the core category identified in this current study will address.

7.2 'Living in the Margins': the key to understanding the etiological nature of EM in Pakistani communities

As has already been discussed in the previous chapters, the first immigrant Pakistanis begin to experience disadvantages from the outset of their migration when communities moved and decided to settle in the UK. They not only began to lose part of their native identity and an active voice in society, there were also life-long disadvantages which were to have a cumulative effect on their later life. Because they were pushed to the edge of society, their health and well-being became a critical issue. As they grow older, it has also become noticeable in the study data that they are beginning to experience a different level and type of marginalization which is specific to them and exists within their own family systems. Although this marginalization is not predominantly material, it is nevertheless extremely hurtful and emotionally damaging as it questions older people's position, status and respect in the family and in society which is regarded as their due in their culture and their religion. Although the participants discussed, implicitly or indirectly, the ways in which this marginalization leads to a number of conditions which can explain the possibility of EM, they were not fully aware of the implications of making such an assertion or of suggesting the dynamic relationships between the factors of EM and the marginalization of the UK's Pakistani population. 'Living in the margins' is therefore identified as the core category of the

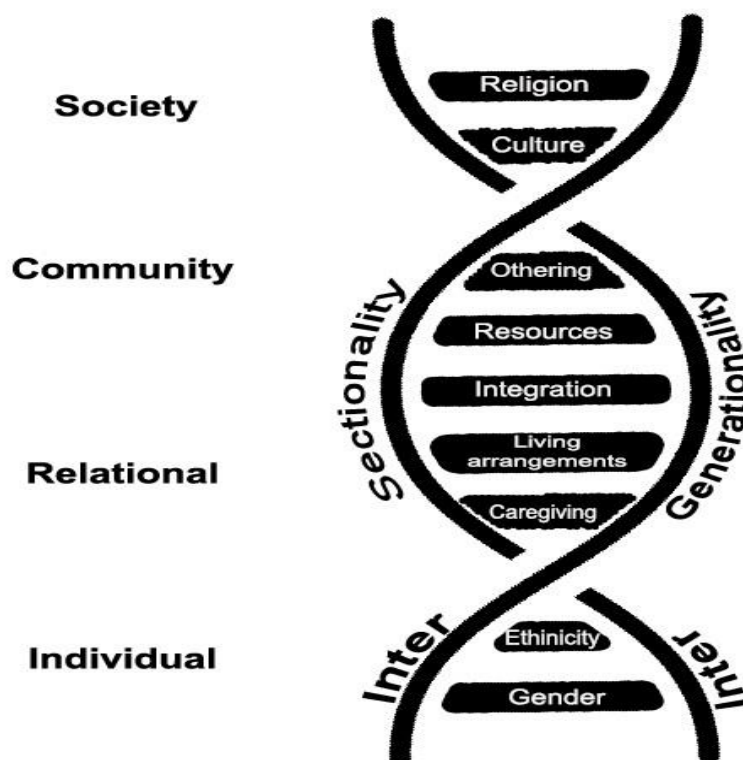
theory which has emerged from this research and can be defined in the context of this study as follows:

An exclusion, covert as well as overt, of an older person from intergenerational and wider social relationships and interactions which results in a perceived harm, both psychological and material.

As can be seen from this definition, there are two key properties (here sub-categories) of the core category of 'living in the margins' which create the conditions which potentially heighten the risk of older people suffering mistreatment: intersectionality (IS) and intergenerationality (IG).

Figure 7.1 shows the dynamic and reciprocal relationship between the key sub-categories of living in the margins – the IS and IG – and the various key concepts and sub-processes informing the resulting theory.

Figure 7. 1. IS and IG Double Helix diagram of EM



The two principal sub-categories will be discussed in greater detail later in this chapter, but the key messages underpinning this theory will be considered next.

7.2.1 Theory statement

This theory accounts for the intergenerational and intersectional factors which increase the likelihood of elder mistreatment in the Pakistani communities living in the UK.

7.2.2 Theoretical underpinnings – material, cultural and ecological

- The theory asserts that EM can occur in several contexts – individual, relational, community and societal. It supports the ecological nature of the factors and discourages single etiological explanations of EM in the migrant Pakistani communities.
- The theory also emphasises that EM is potentially the result of the dynamic relationship between IS and IG social processes. The theory also highlights the importance of understanding cultural factors such as the expectations implicit in IG relationships and wider social interactions. For example, it suggests that an incongruity in IG and or IS relationships and interactions widen the gaps in understanding and can render older people vulnerable to mistreatment.
- Based on the analysis of the findings, the theory also states that EM is not only an IG phenomenon but could occur between partners in addition to the fact that the risk of EM by strangers is an inevitable and growing issue in the immigrant society.
- The data and consequently the theory support the argument that the actions taken to address EM in the Pakistani community could be determined by the TIP (Tolerating - Informally addressing - and Preventing) process, as was discussed in previous chapters.

To understand fully the core category and subsequently the theory of living in the margins, I shall now turn to discuss its sub-categories. First, the key processes and the dynamic relationships involved in IS will be illustrated and discussed, and then the sub-category of IG will be similarly illustrated and discussed.

7.3 Subcategory 1: Intersectionality

The term 'intersectionality' was coined in 1989 by the black feminist scholar Kimberlé Crenshaw in order to identify the impact of multiple interlocking systems of power on people with disadvantaged social identities. It has also been defined in the Merriam Webster dictionary as "the complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, or intersect especially in the experiences of marginalized individuals or groups" (www.merriam-webster.com, accessed 20 September, 2018). This is the main understanding of IS that is used in this thesis.

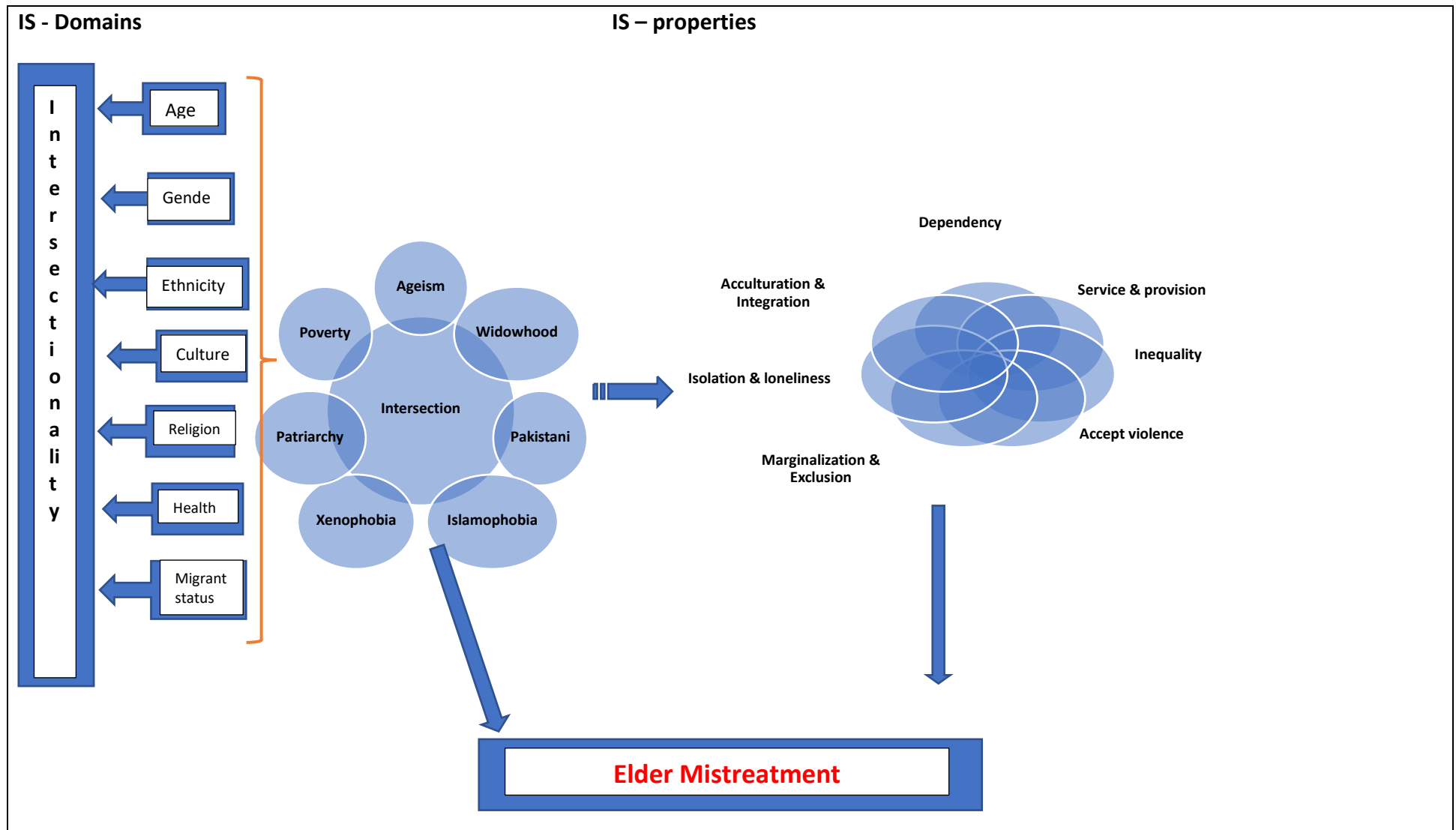
As was shown in the preceding two chapters, EM is a complex and multi-etiological phenomenon in Pakistani communities living in the UK. It was also shown how many independent conditions and factors can potentially increase the risk or help explain the risk of older people experiencing mistreatment in families and in wider social settings. However, there was also a clear indication that the overlap of these conditions and factors could have a cumulative effect in the form of double discrimination or multiple jeopardies.

It is therefore important to understand the intersection of the social identities, characteristics and risk indicators which help to explain the risk of EM in the community (see Figure 7.2). The major properties of the sub-category of intersectionality were considered to be multiple disadvantageous social identities or characteristics, and these include but are not limited to age, health, gender, ethnicity, religion, culture, migrant status and class which were assumed to be co-existing and intersecting with each other in a distinct way.

In figure 7.3, the key domains such as age, gender, ethnicity, culture, religion, health and migrant status and their properties form the important part of the main sub sections of intersectionality, for example, Being old, Being Female and Being Pakistani. These domains and their properties are explained within the subsections of Intersectionality. Furthermore, these domains and their properties are also explained in chapter 5 and chapter 6. I have presented the subsections in this way in order to prevent repetition.

Not only are these identities or conditions interwoven in the description of intersectionality, but as will be illustrated below, the major concepts within these social processes have dynamic relationships with those of the second sub-category of intergenerationality I, further suggesting the complexity of EM. It was also shown that reporting and taking action involves the interplay of the multiple compounded factors mentioned in IS.

Figure 7. 2. Intersectionality



This theory explains why the first immigrant Pakistanis who are now becoming old are more likely to be living on the margin and how the intersection of the different factors which increase their marginalization also increase their risk of EM.

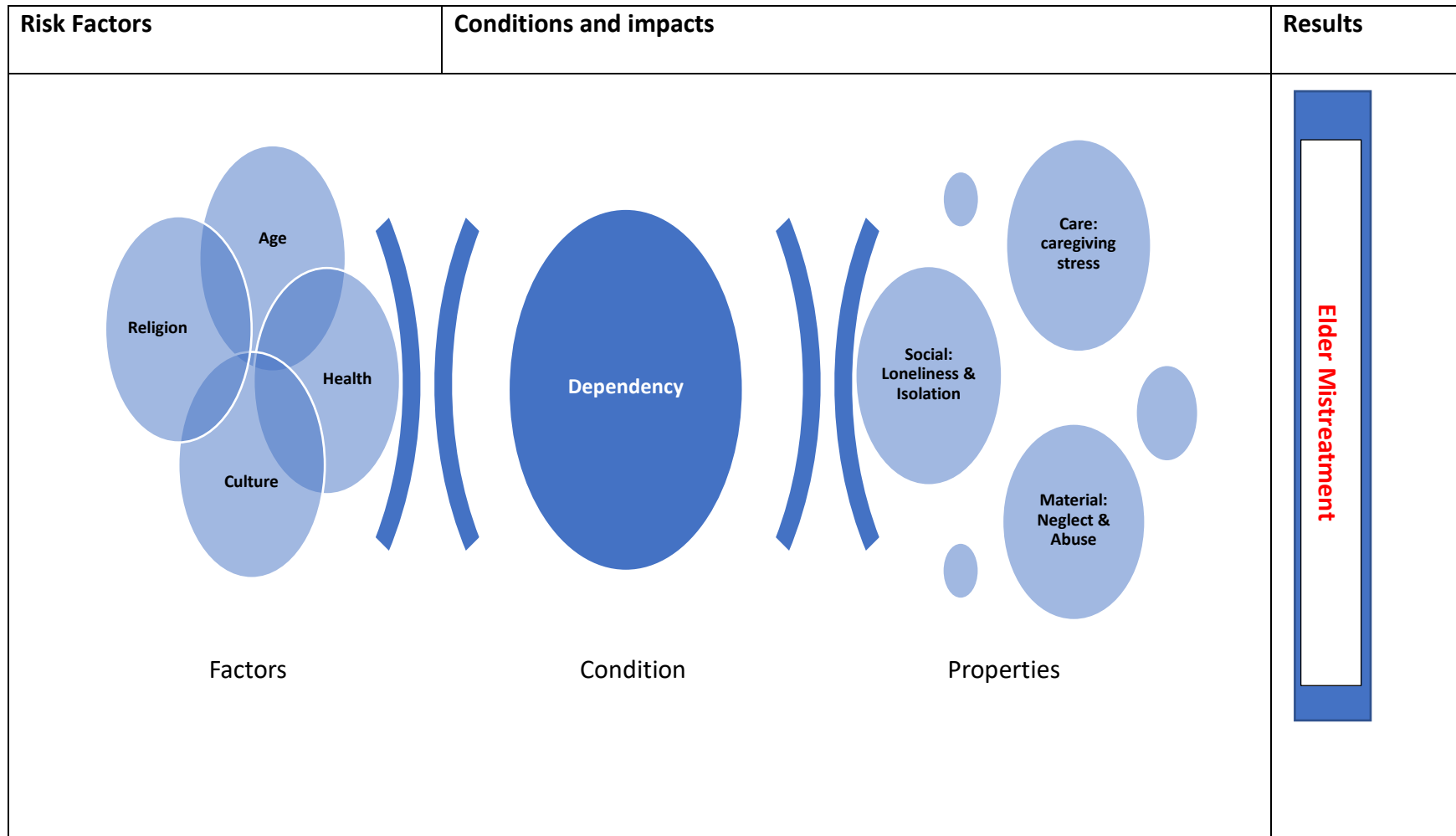
7.3.1 Being old

As the findings showed, the older immigrant Pakistanis are beginning to notice the impact of their life-long marginalization (for example in housing, education and employment) and their traditional lifestyle (for example, an unhealthy diet and lack of physical activity) on their physical and mental health in later life. It was also found that the greater the disadvantages which individuals have experienced in early life, the more likely they were considered to be living with age- and health-related dependences. To complicate the matter, however, the risk of becoming dependent increases when socio-cultural ideologies are involved. Pakistanis have traditionally believed that in later life they will take a step back from the material world and settle themselves in a more spiritual and religious realm. Similarly, older Pakistanis culturally see later life as a period for rest and for being served by their young generations, further suggesting their dissociation from healthy ageing. As was suggested in Chapter 5 and discussed above, the cumulative impact of life-long marginalization, the traditional lifestyle and socio-cultural ideologies are now established as being linked to older people's risk of dependence – physical, economic and social – on others. Being old and dependent, older people were considered to be putting excessive stress on their families, which potentially increases their risk of social isolation, family neglect and mistreatment (see Figure 7.3). For example, when family caregiving was seen to be taxing or exceeding family caregivers' resources – financial, social or material – or endangering their health, it was perceived to be stressful and distressing, as these comments show:

...don't really feel comfortable looking after them [older parents] because the way this country is, you have to do work, like you know full day work, you are coming from the work and you are so tired, you want to go bed really, and next morning you have to get up and out, ... then children

(Mr. Javeed, YP)

Figure 7. 3. Being old



...money would be like for me, because if I am not out working, then I can't be able to pay my petrol and take her to her appointments then I have to like take time off work... if I am bit ill, I can't exactly sit, lay down and chill ... I have to be on top 24/7.

(Ms. Zohra, YP)

Age is not the only factor; the addition of another modality of oppression, for example, gender here, compounds the problem. This is considered next.

7.3.2 Being Female

Gender was another important domain; its overlap with the many modalities of oppression such as culture, religion and socio-economic status was perceived to increase the inequality, marginalization or dependency which results in older Pakistani women experiencing and even accepting violence in a family relationship. The cumulative effects of multiple modalities of oppression on the life of Pakistani immigrant women living on the margin in the UK were highly emphasised. The intersection of these modalities of oppression, therefore, will be discussed next.

When socio-cultural ideologies such as patriarchy and hierarchy intersect, it creates structural inequalities in Pakistani communities which primarily disadvantage women in terms of material and social benefits. For example, immigrant women who had been forced to leave school at a young age or who were heavily controlled in the household explained that they saw themselves as less empowered and privileged in the family and in society because they lack socio-economic skills such as literacy, driving ability and language proficiency, and consequently live with poor socio-economic status, in other words, on the margin. Because they are dependent and controlled, they were considered to be living in isolation and thus potentially accepting their mistreatment in an abusive environment and/or their failure to access support:

Because our women are more controlled... more submissive. They are not familiar with the law as much as a man, they will be more vulnerable to financial abuse because children will want them to assign their inheritance etcetera, etcetera.

(Mr. Khalid, EP)

To complicate the situation, being widowed brings with its multiple jeopardies for older Pakistani women from their age, marital status, ethnicity and gender. As discussed previously, immigrant older Pakistani women in the contemporary world are highly dependent on their husbands, so when they lose them, they find themselves unsupported and vulnerable, and potentially facing poverty, as the next comment illustrates:

For six months, when my husband died, they did not give me anything [social benefits]. I faced so many problems. In the beginning, I did not know anything. I never went out for anything...there are many problems if you cannot speak the English language.

(Ms. Zeenat, EP)

This extract shows that the longer a socio-economically dependent immigrant Pakistani woman lives, the more likely she will be to have either to live alone or to be dependent. To complicate the situation, the traditional patriarchal system also disapproves of widows and deprives them of their rights to independent and individual survival, thus increasing their risk of dependency, isolation and marginalization. This highlights the implication of multiple intersecting factors on women and an exchange recorded between the male participants in their focus group discussion below is a clear example of this:

Interviewer: If an older woman's husband has died, should she be okay to get married again?

Mr Sharjeel: look if she has children, then if they treat badly with mum, then they are "Intayai begairet" (extremely dishonoured) children. Who we called with B swear word, that they make their old mother helpless that she ends up getting married again. Only extremely disgraced children will do that

Interviewer: does the community approve it [widow's marriage]?

Mr Vazir: No, no, the community does not easily approve it. They rarely accept it

Importantly, the more disadvantaged statuses women belong to, the greater their risk of living on the margin or of mistreatment. For example, when the scripts of both culture and religion are manipulated to advantage men, subordination and violence against women become socially approved. In the division of properties and inheritance, for example, the female participants explained that only male children are beneficiaries and that older women, particularly widows, are often deprived of their inheritance because Islam cuts them out and the Pakistani culture eliminates their rights to their parents' or partner's property, consequently increasing their risk of living in poverty and dependence on others, as the next comment shows.

Religiously you should split whatever they got between their children, sons and daughters and family but traditionally if you go by the culture it goes to sons. I know now people are speaking up so that causing you know friction ... even if the parents are alive ... already people [children] starting you know I want this, and I want that so that cause as kind of abuse as well

(Ms. Sadaf, YP)

Not only individual but collective parameters and identities were also found main source driving disadvantages for Pakistani; ethnicity, therefore is considered next.

7.3.3 Being Pakistani

In the wider social context, the risks associated with ethnicity are hidden but crucial and were regarded as multiplicative. The findings showed that the intersection of different socio-political ideologies and practices such as capitalism, familism, nationalism, ageism, racism and patriarchy lead to multiple jeopardies for Pakistanis.

The participants believed that community practices and public institutions fundamentally reinforce these ideologies and systematically marginalize the Pakistani community in general and older people in particular within British society. Describing the example of his late father's admission to an NHS hospital in England, one participant explained that because institutional racism was deeply rooted and accepted in the hospital, his father experienced neglect and mistreatment while in care:

The care provided, especially for the people from you know Pakistan or Asian background, I do not think the NHS really good at making for their needs so. I just felt that he [my father] was just neglected.

(Mr. Nabeel, EP)

To complicate the matter, if the modalities of oppression and the disadvantages of social identity are both multiple, the risk of experiencing EM increases in these social institutions. Describing her personal experience of having to wait a whole day to be seen in the NHS, Ms Zeenat believed she had experienced both institutional racism and institutional ageism by being a woman, old, Pakistani and with a language barrier:

They [hospital staff] made me wait outside then from there at 1 o'clock in the morning I got the bed in [Name] Hospital. I stayed there for eight days. So, such kind of troubles come. To some people, they see quickly and others they make them wait all day. [Interviewer: What were the reasons?] Age as well as language.

(Ms. Zeenat, EP)

It is not just being denied access to services, but also the lack of equal participation in social and public institutions which has significant social and economic impacts on Pakistani communities. Longstanding poverty was given as a good example of communities' marginalization in education, housing, health and employment and was often linked with disturbed family dynamics and IG conflicts, as one older person who had experienced discrimination throughout his life and had seen his children facing it as well, explained:

I find unfortunately, our children, they are discriminated when it comes to job opportunities...trapped in low wage jobs, then they have to work longer...high mortgages...it is difficult...and then spare time for parents.

(Mr. Nabeel, EP)

From this and many other examples, it was clear that many of the participants believed that British society continues to harbour negative social ideologies such as capitalism, classism, ageism and racism, and people who are deprived, weak, immigrant and old were considered to receive limited attention, value and respect in society, thus potentially pushing them to the margin, as this comment shows:

People don't like you know overseas people in this country ... and especially elder people, because when you reach old age you are not beautiful, you are not handsome, you are not you know, people give value in this country if somebody is very fit, somebody is very good at communication, if somebody has got very good health, good looking, good money, everybody talks to them.

(Mr. Javeed, YP)

Not only this, but participants believed that members of the minority, immigrant and marginalized group were the first to be blamed for and to experience the negative impacts of any socio-political changes in the country. The recent Brexit referendum was given as one example indicating a rise in nationalism, socially approved violence and the victimization of minority ethnicities. The participants feared that the increasing Islamophobia, xenophobia and racism is increasing the risk of hate, exclusion and the marginalization of Pakistanis in public and social places and institutions, especially of the older people and women because of their other disadvantaged and obvious social identities, as one of the city councillors explained:

It is different to them [older people] so they may, obviously may be level of hate crimes and phobia but obviously, since back the referendum, there is been a rise in hate crimes...if you go other aspects of the country ... a lot of Pakistani elderly community may get treated, a bit more harshly or bit differently.

(Mr. Mubarak, SH)

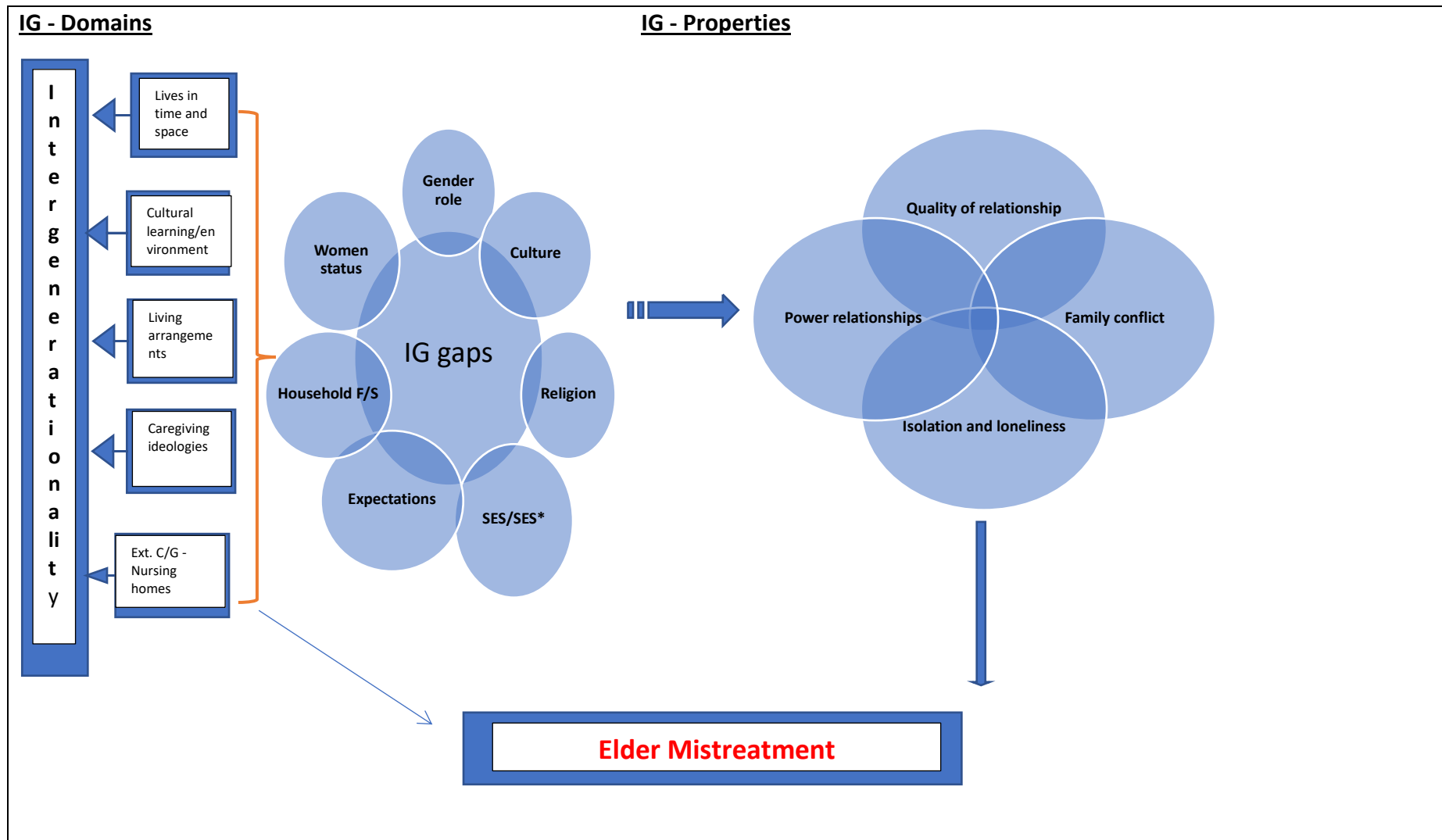
This category has illustrated the intersection of multiple interwoven factors that increases the risk of older people of mistreatment. As EM is multi-etiological and its risk goes further than individual characteristics, how the interactions and relationships, and more importantly the intersection of these factors influence the risk of EM is of importance; therefore this is considered next.

7.4 Subcategory 2: Intergenerationality

In common usage, intergenerationality is defined as the interaction between members of different generations. As was clearly shown in the previous chapter, the relationships and

consequently the interactions between old and young Pakistani generations are changing, so it is important to understand the impact of this on older people. Intergenerationality was therefore identified as an important sub-category of the theory as it highlights the cultural, material and social factors which shape and influence IG relationships and interactions. In this sub-category, arguments were made around the impacts of the spatiality, temporality, positionality and personality of individuals in their relationships as well as the wider philosophical and ideological domains such as familism, gender, caregiving, culture, traditions and religion which shape IG relationships, expectations and experiences in Pakistani communities (see Figure 7.4). It was also discussed how IG differences in these domains affect IG solidarity and the quality of IG relationships, family dynamics and familial roles.

Figure 7. 4. Intergenerationality



*SES/SES = Socio economic status (e.g., social network, poverty, poor health, poor housing) / Socio economic skills (e.g., education, communication, language, driving skills)

7.4.1 Transformation of notions of family

As was discussed in Chapter 5, culture plays a vital role in shaping and influencing the perceptions, relationships and interactions of older people in families and in wider society. In Pakistani culture and religion, older people traditionally hold hierarchical power, position and status in the household, even though this is often quite subtle. Because of their age and their experience of life, older people have been believed to be wise and sage in Pakistani communities, and younger members of the family seek their support and advice on complex decisions and important life transactions. Children involving their older parents in all the interactions and decisions of their lives and careers was considered to provide the older people with a sense of being part of the family and of being valued. As the data analysis showed, many of the older participants thought that the younger generations do not now adhere to these cultural values. Many participants believed that this exclusion is perceived as disrespectful and as mistreatment because it is emotionally traumatizing for older people:

I think biggest sort of abuse is losing their status...when children are not listening to them...if they are not respected as they used to be, say you know so many years ago, as our elderly people used to be, and their status in the household, I think those people have lost that, that, that in itself is abuse and mistreatment.

(Mr. Akash, SH)

Comparison of the comments made by the young and the old participants suggests that it is not necessarily the case that both categories of participants hold uniform views of Pakistani culture. It was found that IG differences between cultural ways of living in the community are widening, thus potentially heightening the risk of IG conflicts, as the following comment shows:

If an older woman seen me out with my jeans on, she probably talks about me and she be like oh no why she is wearing that, can't she see her skin is showing, bloody blah blah. She is this she is that but for me, it is something I wear to fit in ... I suppose ... between generations that so make them clash because they don't want them doing that because it's bad shaming them but then the old generation don't understand that this is the way of life.

(Ms. Zohra, YP)

For older people, on the other hand, this transition of young generations into modern life was seen as an erosion of traditions, and Mr Hasan described his experiences of feeling emotionally and psychological hurt in relationships:

My own daughter in law, when I visit, sometimes, she is wearing jeans and blouse ... I say to her, my dear daughter I do not like this, I feel shy, ashamed. You are my daughter, and I cannot see my daughters in this dress, I feel embarrassed/shy in it. This is a fact in the house.

(Mr. Hasan, EP)

To complicate the situation, not only did these core cultural values seem to be abandoned in modern times, they were also considered to be outdated and backward by young participants. In these modern, liberal times, the younger participants wondered how women's freedom, social mobility and independence can be restricted today, for example. Not only their cultural values, but also older people themselves were regarded as out-of-date as a result. Role reversal was explained as one of the reasons for this; young people now hold the privileges and the power in the IG relationship, as this comment shows:

It is been a different shift in balance because young generations...have a lot of...financial power and education...integration within society...they are sort of able to counter attack these bad stereotypes...traditions and practices.

(Ms. Mariam, SH)

If this role reversal also involves role failure in an IG relationship, the participants discussed how the risk of older people living on the margin increases. Not only would older parents expect less in relationship if loyalty, culture or resources are eroded, they were also considered to be at higher risk of experiencing neglect, resentment and isolation in IG relationships as a result, as this next participant explained:

I think another cause of elder abuse is that the generation that they been raised up so the children or maybe gone strayed, gone on the wrong way or ... had disturbed childhood themselves, or the parents could not give them the time... to sort of help them, ... that means there is been lots of resentment so that the reason why maybe it's probably the abuse ...the neglect from children.

(Ms. Erum, FFG)

It was clear from findings that as the IG differences widen in each of the domains discussed above, more and more material and non-material losses would be incurred in their relationships by older people. Loss in care is also one of the significant factors and has potential implication on older people in later life, therefore, it is considered next.

7.4.2 Loss of care

Not only parents' perceived failure, but also their children's failure in relationships was also identified as a major factor leading to IG conflict. As discussed earlier, living together with and being looked after by family members is important to the mental and psychological well-being of older people. Not only did older people see caregiving as a cultural, cyclic or moral responsibility of their children, they also believed that it would assure them of a sense of belonging and of security. The analysis of the findings showed that these values of interdependence and familism are beginning to be replaced by individualism and materialism, and more and more older people see care as a normative exchange. Older people see this as the exploitation and mistreatment of them by their children, as this stakeholder explained:

the younger generation does not even realise how hardship their parents have seen in this country, and to give them this younger generation a luxurious life, but on the other side they, how they are treated, I would say very badly. For being older, I think they do feel traumatised psychologically that is why they are really regretting that why they came here, in such country where their own kids cannot look after them.

(Mr. Umar, SH)

The findings showed that caregiving, on the other hand, is not only IG and/or gendered, it is also often polarized, particularly in multi-generational households. After marriage in Pakistani communities, for example, the new daughter-in-law moves into her husband's house and lives with his family. Culturally, the care of the older parents in the household is regarded as the responsibility of the daughter-in-law. In the light of changing societal norms and the dilution of cultural traditions, however, this polarity in care was thought to be beginning to

diminish, and this was believed to have a negative impact on older people's future care. The comparative analysis of caregiving ideologies and gender roles showed that the young people viewed IG tension as inevitable if care is culturally forced or polarized, as this daughter-in-law showed:

You don't get appreciated as much as they think it's your job [caregiving] and I think that's upsetting sometimes...mother in law is like different rules for daughter in law and...daughter...it is just culture...but it is hard...you clash all the times.

(Ms. Sadaf, YP)

As discussed earlier, however, culturally the conflict between mother-in-law and daughter-in-law is normalized, so older mothers-in-law were believed to be more likely to live on the margin as the young generations are more privileged and powerful in the IG relationship by being born in the UK with a better socio-economic status. An older participant suggested that the wider the differences which an older person will have with a daughter-in-law, the more likely it will be that that person will be 'rusting' at home because of sub-standard care, neglect and mistreatment:

The one who is daughter in law, she is not willing to look after them [parent-in-laws]. Children [of older parents and husband of wife] are helpless. What should they do? The house will be ruined/divided. Then what happens some people go to nursing homes and some people do not like going to nursing homes. They just die rusting in home, understand?

(Mr. Suhail, EP)

It is not only their children's practices and perceptions which are determinants of older people's quality of care in the household, but also those of other family members, including a spouse. Although many practices related to care were regarded as religiously and culturally rooted in the community, not all of them were considered conducive to improving the ageing experiences of older people, particularly those who are suffering from mental health problems. Mental health is a stigmatized issue in Pakistani communities and the participants spoke about how older and/or young people will traditionally attempt to hide it or address the issue only within the family setting. This under-provision of medical or social care for an

older person with a mental health problem by the family was believed to put older people at risk of neglect, mistreatment and, importantly, denial of access to appropriate care, as this participant explained:

....literally to the point that they have to babysit the person with depression or Alzheimer they will do so, without actually gaining getting any external help, you know.....some people think it's something associated with ... maybe black magic or even possession with Jinn ... so people do cover these aspects and the solution is that ... they will sort of try to find the spiritual remedy or spiritual healing.

(Ms. Mariam, SH)

Although the traditions of family care exist, some participants saw them as on the verge of transformation, shifting the provision of care to outside the family. However, as discussed in Chapter 5, the external sources of long-term care, such as nursing homes, are ill-prepared to meet the cultural and religious needs of the community, so the likelihood of older people being at risk of having to live in isolation, neglect and mistreatment was seen as inevitable in nursing homes. In cases of dependence, mental or physical, the IG relationships of older people were seen critical. It was reported that older people who have greater differences with their children were more likely to end up in a nursing home, and often to have to live with a poor quality of care, neglect and emotional pain, and older people have no confidence in care outside the home:

When we talk to someone who is in the elderly home you know they are just crying, and they are making dua (pray) to almighty Subahantullah that oh Allah take our life, that this is very painful, they are feeling very bad when they are taken out from home to a nursing home.

(Mr. Waqar, SH)

7.5 The dynamic relationship between IS and IG

The theory developed through this thesis also proposes that there is a dynamic and reciprocal relationship between the various basic social processes of IS and IG, further suggesting the complex nature of the phenomenon. The findings suggested that social isolation and

loneliness among older Pakistanis could be the result of IG gaps in families as well as the intersection of multiple disadvantageous statuses such as gender, age and acculturation gaps in society. For example, traditional-thinking older people who strongly identified themselves with Pakistani culture and norms were more likely to be living on the margin in their families, communities and society because they were considered less acculturated in addition to being old and Pakistani. As a result, othering within Pakistani communities, described as the exclusion of and resentment against people with traditional views, was regarded as a subtly accepted form of street abuse which they experienced regularly, as this victim explained:

You know these youngsters, girls and boys. When older people pass the street, they tease or insult. When we see them, we try to avoid them, try to pass at distance and are not close to them, otherwise, they will definitely say something rubbish.

(Mr, Vazir, MFG)

In an abusive situation, on the other hand, reporting it and taking action are also strongly linked with IS and IG and the dynamic relationship between their domains and properties. There are multiple barriers such as gender, religion, culture, access to and awareness of services, and the IG relationships and expectations which members of Pakistani communities will consider before reporting any incident of EM. If an older Pakistani woman, for example, has to report EM, the overlap of the different disadvantages such as socio-economic resources (such as language and transport), cultural ideologies (such as honour and shame) and services (such as trust and access) would make it harder for her to seek support. This suggest that there is not always one single factor that prevent action taking but the intersection and relationships of multiple restrictive factors.

7.6 Conclusion

The focus of this chapter was to develop and present the resulting GT of EM among community-dwelling Pakistanis living in the UK. The theory developed from this thesis proposes that EM is a complex and multi-etiological phenomenon which can be explained through two sub-categories and other interlinked factors. One of the central sub-categories of the theory is intersectionality, which suggests that the risk of mistreatment among older Pakistanis rises when multiple disadvantageous social identities overlap. In addition,

spatiality, temporality and rapidly changing socio-cultural ideologies and practices were believed to shape and influence the IG gaps between young and old Pakistani generations. As a result, older people could experience social isolation, loneliness, neglect, emotional and psychological pain, and mistreatment in their family relationships and interactions. Furthermore, older Pakistanis are more likely to be living in abusive relationships or situations if reporting it and taking action are influenced by domains of IS and IG such as gender, the language barrier and dependency.

In the next chapter, I discuss the usefulness of this theory both for helping us to understand better the perceived phenomenon of EM among community-dwelling Pakistanis living in the UK and for identifying potential implications for policy, research and practice.

Chapter 8

Discussion

8.1 Introduction

In the previous chapters, the dynamic relationship between the central concepts and the development of the resulting theory about EM among Pakistanis have been presented. In this chapter, I first present my reflections on and evaluation of the quality of the overall research process and its product, the resulting theory of 'Living in the margins'. Second, the significance of the findings will be discussed, analysed and explained taking into account what is already known about the field of EM; an analysis and review of the theory in the context of existing theoretical models of EM will also be presented. Finally, the limitations of the current study and the implications of the findings for practice and policy will be discussed and suggestions for future research in this field will be made.

The aim of study was to construct a mid-range theory to develop the understanding of and actions taken to address EM in Pakistani communities in the UK from the perspectives of a group of community-dwelling older people, family caregivers and relevant community stakeholders. This was achieved by developing a set of research questions from the sensitizing concepts discussed in the previous chapters. These research questions were:

- What do community members understand by the term EM?
- What are the social, cultural and material factors which shape and maintain the practice of EM?
- What are the barriers which the community faces in reporting EM?
- What are the strategies and coping mechanisms in the face of EM?

The knowledge acquired from this research is important for improving practices and interventions in the area of family caregiving and adult safeguarding, but it can only make a real contribution to changing or improving practices if it is the result of high-quality, well-designed research. I shall therefore now consider the quality of this study.

8.2 Quality of the study

To determine the quality of a research study, it is important that the processes and products (Charmaz, 2014; Denzin and Lincoln, 2011) involved meet the standards of the criteria which they were expected to meet. Because this study used a CGT methodology, the evaluation criteria for 'quality' suggested by Charmaz (2014) were used. She suggested considering four key elements – credibility, originality, resonance and usefulness – for evaluating GT research and these will be considered in turn.

Credibility

Credibility is an important criterion for establishing trust in qualitative findings. Charmaz (2014) set out the following questions on this aspect of research quality:

- “Has your research achieved intimate familiarity with the settings or topic?
- Are the data sufficient to merit your claims? Consider the range, number, and depth of observations contained in the data.
- Have you made a systematic comparison between observations and between categories?
- Do the categories cover a wide range of empirical observations?
- Are there strong logical links between the gathered data and your argument and analysis?
- Has your research provided enough evidence for your claims to allow the reader to form an independent assessment – and agree with your claims?”

Being both Pakistani and a health-care professional, I was familiar with and had a basic knowledge of both the topic and the participants of the study. This was an asset in planning the introductory strategies of my research design and questions. Even though I shared the same background with most of the participants, considering the sensitive nature of the topic, I spent a significant amount of time with them in order to establish trust and rapport prior to asking them about their participation in the study. For three months, for example, I attended the events and workshops organized for older Pakistanis by the local charities which were my stakeholders in the study in order to gain a sense of both the settings and the potential participants. This prolonged engagement was useful for reassuring participants about the importance of sharing their perspectives and experience of EM in a more open and trusted environment.

I carried out a comprehensive search strategy to extract and evaluate the existing literature in order to identify sensitizing concepts and develop the research questions on the topic of EM. The varied and significant material which I encountered was useful as a starting point to gain insight, direction and familiarity with important concepts and to reflect and document the assumptions which I already had on the topic.

In addition, the use of multiple approaches to collect and analyse the rich and thick data demonstrates that the data acquired merit the claims made in the study. Methodological triangulation (Korstjens and Moser, 2018), for example, was used to collect data by applying parallel approaches such as in-depth interviews, focus groups and field notes. Data triangulation, on the other hand, was used to collect data from wide range of participants – older people, family members and community stakeholder – over different time frames across a number of geographically dispersed locations within one city. Furthermore, the participants were asked a wide range of questions, as suggested in the interview guide, to collect data on different important concepts of this sensitive subject. In this, the etiquettes and expectations (Charmaz, 2014) of interviewing on sensitive topics, such as softening the questions or depersonalizing questions and scenarios, were also used to encourage the participants to talk about their views, experiences and perspectives. As a result, the variations and dimensions on the central themes and categories which emerged suggest that the data were saturated.

To ensure that the resulting theory is systematic, inclusive and grounded in the data, the data were constantly compared from the beginning of the research. All the transcripts (of interviews and focus groups), memos and analytical codes were labelled and relabelled and read and reread by me to ensure that the categories were rigorously compared and logically interlinked. Persistent observations were maintained until the most relevant concepts and central themes were found, and this was further achieved using the additional principles of CGT, such as theoretical sorting, diagramming and integrating (Charmaz, 2014).

To facilitate the “transferability judgement” (Korstjens and Moser, 2018) by potential users and readers, the study provides a thick description of the research participants’ backgrounds, their behaviour and experiences as well as their context. In Chapter 4 (the Methodology chapter), a rich description of the study sample and sampling (size, demographics, strategies, inclusion and exclusion criteria), study settings and context, and the interview guide

(including changes which occurred during the research process, for example as a result of a pilot study) was provided. The findings of the study are transferrable to similar populations, but the extent to which the study overall is transferrable to other populations will be discussed in the limitations section later in this chapter.

Originality

Originality is another important criterion of qualitative research to ensure that the findings of the study are novel or unusual and suggest creativity. Charmaz (2014) suggested considering the following set of questions on this aspect of research quality:

- “Are your categories fresh? Do they offer new insight?”
- Does your analysis provide a new conceptual rendering of the data?
- What is the social and theoretical significance of this work?
- How does your GT challenge, extend, or refine current ideas, concepts, and practices?”

This is, to the best of my knowledge, the first qualitative research study which has explored the mistreatment of older Pakistanis who are settled in the UK, and most importantly, a study which has explored the perspectives of a wide range of participants. Previously, the theoretical explanations of EM have been borrowed from other disciplines or are hypothetical or have focused on single etiological accounts of EM. My theory of EM among Pakistani immigrant communities provides fresh, systematic and multi-factorial explanations and brings together novel concepts and otherwise hidden meanings, experiences and perspectives. The resultant theory not only complements the existing knowledge but also challenges it and adds new evidence to this particular field of research, which I shall discuss further later in this chapter. In brief, this theory highlights the importance of taking cognisance of the IG and IS factors which increase the risk of EM, but which have received little attention in the existing literature.

Resonance

Resonance refers to a researcher’s position of openness and receptivity towards the potential meaning(s) embedded in data (Given, 2008). Charmaz (2014) suggested asking the following questions on this aspect of research quality:

- “Do the categories portray the fullness of the studied experience?”
- Have you revealed both liminal and unstable taken-for-granted meanings?
- Have you drawn links between larger collectivities or institutions and individual lives, when the data so indicate?
- Does your GT make sense to your participants or people who share their circumstance? Does your analysis offer them deeper insights about their lives and worlds?”

The rich, substantial and relevant data gathered in this study portray the deep, full and reverberating voices of the participants. As the systematic and rigorous analysis demonstrates, attention was paid to the use of language, the experiences and events in the various settings, and the discourse which the participants employed to reveal the hidden and taken-for-granted meanings. The participants were encouraged to present, explain and justify their meanings and actions with alternative explanations considering that social reality is multiple and fluid. The assumption of children failing in the filial obligation of elder care, for example, was not based on single perspectives such as the dilution of cultural norms or acculturation gaps but was also explored by asking participants about the cumulative losses and the pressures which adult children experience from providing care for their older parents. By doing this, the theory reveals the taken-for-granted assumptions about the nature of family care within the community and suggests that stereotypes in public institutions and the wider literature such as ‘they look after their own’ are not always valid. In this way, the theory explains the relationships between macro social institutions and individual lives. Furthermore, the multi-etiological and multi-system propositions of the theory clearly define the links between larger collectivities and individual lives.

Usefulness

Charmaz (2014) suggested considering the following items to ensure the usefulness of a research study:

- “Does your analysis offer interpretations that people can use in their everyday worlds?”
- Do your analytic categories suggest any generic processes?
- If so, have you examined these generic processes for tacit implications?
- Can the analysis spark further research in other substantive areas?

- How does your work constitute to knowledge? How does it contribute to making a better world?”

The theory developed from the data acquired provides comprehensive, logical and tightly linked, but also easy to navigate, explanations about important concepts, experiences and perspectives which both academic and non-academic people can integrate into their respective contexts. Furthermore, the key categories of intersectionality and intergenerationality, the basic social, psychological and cultural processes, and the wide range of conditions, variations and dimensions, are all clearly identified, established and illustrated in Chapter 7. In the resulting theory, the study highlights the implications for practices and policies and raises suggestions for future research, which I come to later in this chapter.

8.3 Reflexivity: Reflecting on the research process

Reflexivity is an integral part of the evaluation criteria for qualitative research and can demonstrate the transparency and trustworthiness of the study (Korstjens and Moser, 2018; Gentles et al., 2014). As discussed in Chapter 4, the researcher is considered as an instrument of data collection in qualitative research, and researchers inevitably bring their personal biographies into their research, such as personal history, culture, and their view of themselves and others (Denzin and Lincoln, 2005; Creswell, 2013); I therefore consider reflexivity to be a pivotal element of my study. Charmaz (2014) defined reflexivity as “the researcher’s scrutiny of the research experiences, decisions, and interpretations in ways that bring him or her into the process” (p. 344). This includes critical self-reflection and acknowledgement of one’s own biases, predeterminations and assumptions; the researcher/participant interactional influences; the influences of the research on the researcher; the researcher’s influence on the research design, analysis and presentation; and other influences on the research, here particularly my status as a PhD student, my supervisors and relevant university bodies.

In Chapter 4, I explained my personal and professional knowledge and perspectives which might have influenced the research. I also described my approaches towards the data collection and analysis which might have had an effect on the research process. The different measures which I undertook, such as keeping and maintaining a reflexive diary, the use of

constant comparison approaches to compare data, codes and categories, and the memo writing, all provided a sense of the critical distance which I sought to keep in regard to my research products and procedures.

Whilst I have clearly illustrated some of my earlier influences on the research, following Charmaz's (2014:319) suggestion of "looking back on the steps at the end of the research journey", I still feel the need to reflect on my decisions, influences and involvement in the overall research process in order to provide a detailed insight into the study for others.

At the beginning of the study and the data collection, for example, I was sceptical about my research population and their contributions to the data on such a sensitive topic as EM; this misgiving, to a degree, might have interfered with my ability to engage enthusiastically with the participants. I was aware that ethnic populations such as Pakistanis are under-represented in the literature, so their active participation in the study and their contribution to the data were a major concern for me. To avoid imposing such biases on the research process, I began reading about interviewing techniques on sensitive topics and the ways of establishing a relationship of trust and a rapport with the study participants. Furthermore, the prolonged engagement which I maintained with the participants was useful both for addressing my reservations and for ensuring the participants' active involvement in the study.

As well as the fact that my earlier engagement with potential participants had helped me in recruiting and building rapport, I believe that this researcher/participant interaction (Gentles *et al.*, 2014) might have played a role in the participants' perceptions of me and of the research and, more importantly, the information which they gave me as I collected the data. Although the pre-recruitment strategies, for example, the discussions during the piloting fieldwork, the consent material and the information sheets, gave the participants sufficient time for meaningful and informed participation, they might have influenced the participants to prepare and provide academic, non-spontaneous or fixed responses; in other words, they might have told me what they thought I wanted to hear.

Not only these earlier engagements but also my lack of adequate research experience on the topic and on the research methods used could also be reasons for my early interviews producing descriptive and factual responses rather than theoretical information. In my first interviews, I followed my interview guides precisely in order to collect data. However, as the

process and my experience progressed, my relationship with the participants changed from being static and structured and became co-constructive interactions. The interview strategies which I applied, such as depersonalizing the questions, softening the questions, and listening and navigating the questions around a participant's experiences and perspectives, became useful for obtaining conceptual data. I began to see logical and theoretical relationships between and among the emerging concepts.

However, I think my outside position as a researcher was an important source of difference preventing me from fully understanding some of the actual experiences of the participants. Despite having prior knowledge of the topic, the fact that my parents are not here in the UK meant that I did not have any personal experience of providing care to an older family member. It was only through speaking with the younger participants that I began to question my predeterminations and the taken-for-granted meanings of participants' caregiving stress in the family setting. Although I began to sense the social, economic and psychological impacts of caregiving on the young family members, I wanted them to open up and express themselves fully. In order to bring myself closer to the participants and understand their personal experiences, I began to share my own experiences of patient care as a health-care professional. The family caregivers appreciated my comparisons with their caregiving and the stresses which it produced; this approach of empathising with the participants was useful for eliciting otherwise hidden experiences and meanings.

Although my prolonged engagement improved trust and rapport, access to all of the participants was not always granted as I had expected. Gender was one of key sources of social differences which I believed influenced interactions, as well as the recruitment, with a few of the female participants. For instance, when I had my second meeting with the stakeholder at PCAA (the Pakistan Community and Advice Association), she told me that older women were unwilling to be interviewed by a male researcher. Although we offered gender-matched interviews, we were not contacted by any older women participants from PCAA. Although this issue of my gender was not raised by other female participants, I consulted the literature on a researcher's gender in qualitative interviews (Williams and Heikes, 1993) in order to prepare myself for the concerns which might be raised when interviewing a participant of the opposite gender. What I learned was useful for building trust and avoiding awkward situations. For example, when interviewing female participants, I maintained

appropriate eye contact, kept safe spacing, and offered gender-matched chaperon. In addition, I shared the same ethnic and cultural background as the participants, so I was aware of the issue of gender in such male and female interactions.

I must also acknowledge the explicit and implicit influences of other people (such as my supervisors) and university bodies on the study design, the study questions and the overall methodology.

As part of the PhD process, postgraduate students at the University of Sheffield are required to pass a 'confirmation review' at the end of their first year, in which they justify the significance of their study. My initial protocol proposed that family-based recruitment strategies would be used to collect data from older people and their family caregivers. Considering the sensitive nature of the topic, however, the review panel recommended adopting alternative recruitment strategies in order to avoid safeguarding issues in the family. Although this feedback changed my initial decisions on the methodology, I believe that it was an important recommendation by the review panel which made the study both feasible and safe.

After passing my confirmation review, I submitted my research proposal for ethical approval. Here, I must acknowledge the advice and recommendations of others, particularly for PhD students working on a sensitive or taboo subject, to consider the careful planning of their ethical application. To demonstrate that the proposed study is ethically sound, I provided comprehensive details and documents on important issues such as participants' safety, confidentiality and recruitment; the researcher's safety and identity; and the protection and management of the study data. However, I did not include any systematic and structured disclosure plan in my first draft of the proposal, and the ethics committee pointed this out and guided me by their feedback to integrate it into the study. This feedback improved the study's feasibility and robustness.

Because I am a PhD student, the supervisor/supervisee relationship (Ramalho et al., 2015) has played an important role as a check-in exercise and has been mutually beneficial. I strongly admit that the interaction with my supervisors and its impact on the co-construction of this study cannot be separated from the study. My supervisors, Professor Tony Ryan and Dr Sharron Hinchliff, are both experienced qualitative researchers and have extensive

research profiles in the field of older people and family care. It was an advantage for me to be able to draw on their experience and knowledge for shaping and improving the design and methodology of the study. I met them at least once a month for my PhD supervision and this regular interaction throughout the process of research on various aspects of the study – study design, methodology, data collection and analysis – must be gratefully acknowledged.

My interaction was not limited to my participants and my supervisors; contact with other scholars and academics through conferences, workshops and paper/poster presentations have been important influences which I need to acknowledge. I have attended a number of conferences and workshops, both regional and international, at which I have presented the preliminary findings of my research. I have not only met experts in the field of EM at these conferences, some of them have also remained in touch by email and have shared some important material on the topic. As previously stated, I have also written a review paper on EM in collaboration with my supervisors and have received feedback from the editor and peer-reviewers of the journal. A full list of conference papers, research papers and poster presentations are attached in the appendices (appendix 24). I am happy to acknowledge that these interactions with experts and scholars in the field through these channels have played an implicit role in shaping my thinking on the topic of EM

The researcher's influence on a study is a central issue in qualitative research, but it is also significant to mention the impact of the research, particularly when it is of a sensitive nature, on a researcher in terms of time, decisions and thinking. It has been more than two years since I transcribed the interviews with my participants, but there are some comments which I am still unable to forget, and it always hurts me to think of them. I had never expected that older people from Pakistani communities would be experiencing the levels of helplessness, ageism and marginalization in such a way that they feel uprooted, invisible and useless as a consequence of migrating into British society. Not only this influence on me as a researcher, I believe it might have some ways influence on my transcription or analysis of the data. The way I sensed the data during the analysis might have potentially shaped my findings, as a result.

8.4 Comparison of thesis findings with existing knowledge

Previous researchers, ((for example (Mowlam et al., 2007; Chokkanathan and Lee, 2005; Pillemer and Finkelhor, 1988; Kosberg et al., 2003)) have studied the phenomenon of EM

extensively in different populations across different countries. My study was focused on Pakistanis who are living in the UK and was aimed at constructing a theory which will inform the understanding of EM from the perspective of community-dwelling older people, family caregivers and relevant stakeholders. As explained in the previous chapter, this theory states that IG and IS factors increase the risk of older people of living on the margin and enduring neglect and mistreatment. As a result, the key underpinnings of the theory are that EM is multi-etiological, multi-system and could occur in both trusted and non-trusted relationships. In this section, therefore, these key points and other important findings of my theory and the study will be discussed, analysed and explained in the context of what is already known in the field of EM. Next, the resulting theory developed from these findings will be reviewed taking account of the current theoretical models of EM.

8.4.1 Intersectionality and key factors

The theory derived from the thesis highlights that different intersecting factors and their dynamic relationship with each other help to explain the conditions which increase the risk of older people being subjected to EM. Each IS variable was described as a disadvantaged social identity, such as age, gender and ethnicity. These factors were noticed to intersect in both micro and macro systems, beginning with an individual's characteristic such as age.

Being old

More than half of the older participants in the study mentioned experiencing at least one long-term illness, a finding consistent with those of Ahmad and Walker's (1997) study of Asian older people in the UK. In line with several other studies conducted in the UK (Mowlam *et al.*, 2007), the US (Burnes *et al.*, 2015) and with Asian populations (Chokkanathan and Lee, 2005; Oh *et al.*, 2006), the participants showed that the decline in health – physical and mental – and its associated effects such as lower quality of life, inappropriate behaviour and poor socio-economic status, lead to dependency on and challenges for family members in looking after older people, thus rendering older people vulnerable to mistreatment. In addition to these material factors, my theory further shows that the attitude of older Pakistanis towards later life is religiously and culturally rooted, and that not all aspects of this attitude encourage

active ageing, and as a result increase older people's dependence on family members and consequently their risk of neglect and mistreatment. This demonstrates that researchers and practitioners should not only take older Pakistanis' physical conditions into account when explaining, exploring or addressing the nature of EM in their communities, but also assess the cultural and religious ways of living their later life.

Being female

Gender was highlighted as a defining factor in EM on the grounds that older Pakistani women are subject to multiple modalities of oppression all of their lives. This finding contradicts those of some previous studies that men are at greater risk of abuse than women (Pillemer and Finkelhor, 1989; Enguidanos et al., 2014). In line with other studies, the findings of the current study suggest that EM is embedded in the patriarchal and masculinist construction of gender ideologies in Pakistani communities and that as a result, older women's voice and choice are silenced (Guruge et al., 2010), their mobility is controlled (Bowes *et al.*, 2012) and their status continues to be classed as inferior (Nagpaul, 1997) and therefore their dependence on others is inevitable.

Although many studies have looked at isolated factors of EM, the theory of 'living in the margins' has a strong emphasis on the intersection of these indicative factors, such as the relationship of women's socio-economic skills and status with their level of dependence on family members, the stigma and shame attached to widowhood or living independently in the home, and women's awareness of and access to public and service institutions. The findings of this study and the resulting theory state that older Pakistani women's risk of living in an abusive environment will increase if they hold multiple disadvantageous statuses, for example, if they are dependent, controlled and also isolated, a finding which contradicts those of some studies which have claimed that 'family togetherness' is the main reason why older women stay in abusive relationships.

The relationship between gendered role socialization and the physical exploitation and social isolation of older women is another example; a finding consistent with that of a Canadian study by Guruge *et al.* (2010). This finding can be partially explained by the fact that the division of labour in a Pakistani household is gendered. This also shows that social workers

who visit these older people should evaluate who does all the household work in the family in order to identify their risk of physical exploitation.

Being Pakistani

At the societal level, the broader socio-cultural factors and their intersection were key issues in explaining the reasons and or conditions which are likely to raise older Pakistani's risk of living on the margin. Poverty, for example, as a risk factor for EM was another valuable finding of my theory, a result consistent with a UK study of elder abuse and neglect (O'Keeffe *et al.*, 2007) but differing from that of a US study which found that the socio-economic dependence of the perpetrator and/or caregiver was the main cause of EM (Pillemer and Finkelhor, 1989). However, my theory points to household income (Tareque *et al.*, 2015) rather than individuals' incomes and to economic dependency as principal causes of household tension. For Pakistanis living in a multi-generational household, the participants believed that poverty is often the result of the interplay between multiple intrinsic (such as cultural restrictions on women's employment, the religious prohibition of interest-based incentives, the knowledge of benefits and language barriers) and extrinsic (such as racism, ageism and marginalization, for example, in the employment of old and/or young people and in public and social institutions) factors influencing the whole family, thus, potentially leading to contextual conflicts.

The theory also asserts that simply by being Pakistani, older people are more vulnerable to street and societal abuse (Bowes *et al.*, 2012a; Guruge *et al.*, 2010), which contradicts Hernandez-Tejada *et al.*'s (2013) finding that there is no link between ethnicity and the mistreatment of older people in society. This difference in the findings could partially be explained by the fact that the later study was conducted in the US, thus potential cultural differences. The literature referred to many factors which the Pakistani respondents stated increase the risk of older people encountering street abuse, such as racist attitudes and prejudices (Bowes *et al.*, 2012), age discrimination (Guruge *et al.*, 2010) and stereotyping and bullying (Taylor *et al.*, 2014).

The theory extends this to point out that traditional older Pakistanis who strongly identify with and practise the Pakistani culture and religion are at greater risk of street and societal abuse and racism. In the light of recent societal changes, traditional Pakistanis often

experience 'othering', described as an act of socially approved exclusion and devaluing of older Pakistanis who are less acculturated in British society, in both IG relationships and wider societal interactions. The theory proposed three levels of 'othering' which traditional older people experience:

- *The IG level of othering*: faced by British-born children who dissociate themselves from the Pakistani identity and culture and see it as backward culture and thus not only fail to give due respect to older people as is expected in the culture but also undervalue the traditional norm.
- *The cohort level of othering*: by liberal-minded older colleagues who distance themselves from the traditional Pakistanis because they consider them to be the principal targets of the generalized racism which they experience from living in the UK.
- *The societal level of othering*: by those elements of the general public who consider traditional Pakistanis as a racially and culturally inferior part of society who are failing to integrate into the wider society.

These findings have greater implications for traditional older Pakistanis in both community and societal relationships and interactions. Social isolation, loneliness and marginalization and its consequences such as street abuse were major concerns raised by the older Pakistani respondents. It appeared that the younger generation and those older people who are well assimilated, and have accepted to live with liberal values of British society, viewed the traditional older people as a stigma or unwanted mark on their community or identity. It was implied that many British born young Pakistanis perceive the Pakistan culture as backward, authoritative and patriarchal that restricts their freedom and opportunities to progress. Since this culture often appears to them in the form of these traditional older people, it might be speculated that the hostile and unfriendly attitude of the younger generation toward them in the community and local streets is the result of this.

Social isolation in general, however, was identified as a characteristic of migrant families in which the neglect and mistreatment of an older person is more likely; a finding consistent with those of other studies carried out with older Asian people re/settled in western countries

(Kalavar and Van Willigen, 2005; Choudhry, 2001). In line with those of previous studies (Victor et al., 2012; Guruge et al., 2010; Bajekal et al., 2004), the findings suggest that the linguistic and social isolation among older immigrants who are living either in multi-generational households (Ng and Northcott, 2015) or nuclear families (Victor *et al.*, 2012) is linked with their socio-economic resources (such as driving and language skills), their opportunities to integrate and understand the host culture, their limited awareness of the provisions and services available, their migratory losses and patterns, and their dependence on family members. Social isolation was considered to increase mental health problems such as depression and stress and therefore increase the potential risk of self-neglect and/or mistreatment.

The theory of living in the margins further asserts that the level of perceived loneliness in a multi-generational household is linked with the amount of quality time spent on maintaining relationships. As the gaps in knowledge, technology, language and culture are widening between Pakistani-born older people and their UK-born children, members of a family find no common goals or interest in communicating in addition to the fact that young people can face overwhelming responsibilities both in large households and outside the home.

The findings also showed that simply because of their gender, older women can suffer disproportionate levels of isolation and loneliness when indicative factors intersect, such as patriarchal control over social mobility, gender insensitivities in service provision and socio-economic dependence on others.

These findings suggest that there are dynamic relationships between the IS factors shaping the IG relationships (*see next*).

8.4.2 Intergenerationality and key factors

The second proposition of the theory of living in the margins asserts that EM is essentially an IG phenomenon. The theory acknowledges the consensus among the participants that IG differences increase family conflict, thus increasing the potential for EM, a finding consistent with those of studies which focused on IG relationships in Asian communities (Chokkanathan and Lee, 2005; Nagpaul, 1997; Sharma and Kemp, 2012). Human perceptions are shaped and influenced by space, time and culture and the current findings have shown that the

interpretations of older Pakistanis and their UK-born second and third generations vary on various aspects of religious, cultural and familial ideologies and practices. As a result, the discrepancy between spoken and unspoken expectations (such as gender roles, family cohesion and elder veneration) is inevitable. I discuss these mismatches next.

The theory of 'living in the margins' emphasises that the lack of respect for older people is perceived as a most serious, most hurtful and growing form of EM, a finding consistent with those of studies conducted with other Asian populations (Sharma and Kemp, 2012; Bowes et al., 2012a; Tam and Neysmith, 2006). In line with the findings of other researchers (Bajekal et al., 2004; Guruge et al., 2010; Nagpaul, 1997), the participants listed a number of conditions strongly linked with older people's perceptions of disrespect, such as the rise in ageism, materialism and the erosion of the cultural and religious values which determine the hierarchical status and position of older people in the family. Some authors have seen parents' lax attitude and children's poor upbringing as the principal causes of parents losing value and respect in later life (Erlingsson et al., 2005; Taylor et al., 2014). However, the current findings show that the first immigrant Pakistanis' failure in the parenting role is not necessarily linked with their lax attitude, but with a range of economic, migratory and acculturation-related issues. Despite this, role failure was highlighted as a potential reason for older Pakistanis experiencing neglect and disrespect. The findings also showed that the loss of the generational hierarchy and authority occurs when IG roles are reversed, and their children become the main sources of older people's support in the UK. As a result, the power and respect which is traditionally earned and associated with age in the culture can no longer be taken for granted.

Another important finding on the notion of disrespect was the role of language in shaping the perception and interpretation of disrespect between generations, a finding consistent with those of studies specifically conducted on verbal abuse (Nandlal and Wood, 1997) and disrespect (Tam and Neysmith, 2006). Because of the cultural, spatial and temporal differences which exist between immigrant Pakistanis and their British-born children, the referential and contextual meanings of some words could be interpreted differently; disrespect in this case.

Refusal to respond to older parents was also acknowledged as a most hurtful and disrespectful act of EM in the findings, which has also been termed 'silent treatment' in a

Japanese study (Anme, 2004). The findings also showed the spatial and temporal construction of what the various participants regarded as EM. This finding can be partially explained by the fact that acculturation, language and cultural gaps exist between the young and old Pakistani generations.

The study also found that one way of showing respect to older people was to meet their unambiguous and explicit expectations of living together with and being looked after by family members. Care by their adult children was seen to assure older people's sense of belonging and being valued, so it has remained a major reason for parents' material investment in their children. However, it was reported that these material investments often fail to meet non-material expectations, thus raising older people's risk of financial abuse, a finding consistent with those of other Asian studies (Jamuna, 2003; Nagpaul, 1997). This finding can be partially explained by the fact that perceptions of the duty of care and trust in relationships are changing as cultural interpretations of the exchanges of care are changing.

The findings also showed that the strains incurred in caregiving were a major factor in increasing IG gaps and rendering older people vulnerable to neglect and mistreatment, a finding widely argued in the EM literature. As the caregiving is gendered and polarized in multi-generational households, the findings showed clearly that friction between a daughter-in-law and her older in-laws on caregiving further complicates a relationship which is already tense because of the differences in socio-economic power and maternal status.

The analysis also showed that the intersection of risk factors plays a key role in this aspect of IG relationships and caregiving. The literature names many factors which were stated by the participants to intersect and then increase older people's risk of EM, such as cross-gender care (Katbamna et al., 2004), the pressures of modern life on children (Bowes *et al.*, 2012), lack of family (Dong and Simon, 2008), family pressures and the absence of appropriate and adequate social support (Chokkanathan, 2014; Katbamna et al., 2004). The theory further extends to claim that institutional racism and stereotyping delay or deter accessing appropriate support services, thus potentially increasing the pressure on families to be self-sufficient in Pakistani communities.

On the other hand, older Pakistanis with mental health problems were reported to be at higher risk of neglect in family care, a finding consistent with that of a study which explored

South Asians' experiences of dementia and service response (Bowes and Wilkinson, 2003). These findings are partially explained by the fact that mental health is a stigmatised issue in the community which can hinder access to support services.

The theory also shows that in addition to family settings, older Pakistanis are at greater risk of living on the margin in formal long-term institutions (such as nursing and care homes), as they are perceived as a source of EM by older immigrant Pakistanis. Similar to the findings of Ploeg *et al.* (2013), the participants stated that ethnic older people have strong opinions about nursing home placement and consider it as the abandonment, neglect and disrespect of older Pakistanis. Interestingly, whereas older white people find the option of going into formal care provision as the retention of their decision-making power, individuality and choice (Minichiello *et al.*, 2000), their counterpart Pakistanis felt that they would retain more control and quality of life (such as a religious and cultural environment, companionship and security) in an acknowledged abusive family relationship than in a formal care setting such as a nursing home. The major reasons why older Pakistanis hold such a strong opinion of nursing homes were stated to be the culture, the poor quality of care (Mowlam *et al.*, 2007) and the variety of barriers facing ethnic communities in nursing homes (Mold *et al.*, 2005a). This demonstrates the need to draw the attention of service providers and policy makers to the need for culture-centred care in nursing homes for the growing numbers of ageing Pakistanis in the UK.

8.4.3 Reporting and action taking

The under-reporting of older people experiencing EM was a finding consistent with those of studies conducted across different populations and countries. In line with previous research (Chokkanathan, 2014; Bowes *et al.*, 2012a; Mowlam *et al.*, 2007), the participants identified several barriers to reporting EM, including the perception of abuse (such as *karma*), socio-cultural issues (shame, honour, love, loyalty, family), fear (of family breakdown, worsening the situation, repercussions on children/perpetrator/self), socio-economic factors (such as transport, language, communication) and structural issues (such as limited family and/or social support and the accessibility, availability and appropriateness of services). These factors in themselves are not unique to older Pakistani immigrants. What might be unique, however, is the interplay of the fine strands within each restrictive barrier to reporting which

influence people about whether to choose to endure or expose the abuse. The notion of honour, for example, was perceived as not just an individual's own self-esteem but a collective property of families and communities which is interwoven and influenced by people's culture, religion and history; so a victim of mistreatment will potentially consider how reporting it will affect the honour of other members of the family and the community as well as their own reputation in the society.

Similar to reporting, action taking and coping were stated to be informal and cultural responses to EM, a finding consistent with that of an Indian study by (Chokkanathan et al., 2014). However, these findings contradict those of a qualitative UK study of elder abuse and neglect (Mowlam *et al.*, 2007) which suggested that a victim will seek distance from the perpetrator by getting a divorce or moving out. This could be partly explained by the nature of multi-generational living arrangements and the stigma and shame associated with separation and divorce in the community, thus demonstrating that victims of EM are actually more likely to continue to live in an abusive environment.

The theory shows that taking action is a complex but prescriptive process which involves the three TIP elements: Tolerate abuse first, particularly if it does not contain physical aggression; second, if abuse needs exposing, it should be addressed Informally; and finally, Prevent the factors which trigger EM.

8.5 Theoretical alignment: EM theory in the context of other theories

Theories play a central role in explaining the behaviours, situations and events around the phenomenon of a study, and by doing this they recommend effective interventions and preventions (Roberto and Teaster, 2017). To develop a theory on EM, however, Burnight and Mosqueda (2011) recommended three steps that a researcher should take: (1) to have empirical data on EM; (2) to review the major theoretical approaches to EM; and (3) to propose a new model of EM. Here, I shall explain the significance of my data-driven theory in the context of the existing theoretical frameworks of EM.

At present, as discussed in Chapter 2, there are various theoretical explanations of the phenomenon of EM. Although these theories provide meaningful insights into the problem, many of them are borrowed from other disciplines such as criminology, sociology and family

violence and there are many limitations associated with their application in the field of EM. Furthermore, the vast majority of these theories provide a single source for an explanation of EM. For example, the situational theory, also known as caregiver stress theory, explains that excessive stress on a caregiver can render an older person vulnerable to mistreatment.

The theory which was developed through this thesis suggests that EM is a complex and multi-etiological phenomenon which could be understood by examining the different contexts in which it happens. This statement is congruous with the ecological theoretical model proposed by Schiamberg and Gans (1999a) which recognizes that there are multiple sources of EM at individual, family, community and society level; therefore, one single explanation of EM will be over-simplistic. The theoretical model which they proposed is fundamentally driven by two broader explanatory frameworks: the human ecological perspective (Bronfenbrenner, 1979; Bronfenbrenner, 1986) and the life course perspective (Bengtson and Allen, 1993).

Some researchers (for example, Parra-Cardona *et al.*, 2007; Horsford *et al.*, 2011) expanded Schiamberg and Gans's (1999a) ecological model by identifying diverse risk factors associated with ethnic communities living in the US. Parra-Cardona *et al.* (2007), for example, found that the country of origin, language, cultural identity, health-care barriers, and gender role were additional factors to integrate in the ecological model in order to better understand EM in Latino families. Similarly, Horsford *et al.* (2011) proposed adding unique risk factors into the original ecological model in order to understand the nature of EM in Afro-American families. These factors included caregiving skills, elders' distrust of institutions, denial, stressed family networks and the legacy of slavery.

The purpose of this current study was to construct a mid-range substantive theory of EM which can provide insight into the phenomenon of EM among Pakistanis who are living in the UK. One of the strengths of GT research, the methodological approach adopted in this study, is that the knowledge generation within it is a constantly "evolving" (Morse, 1997) and "modifiable process" (Glaser, 1978, p.5) by incorporating new information. As the result, the existing theories hold up and new theories being added to them makes them more robust. This process is referred to as 'emergent fit'; it extends the application of substantive theory to wider contexts and settings. In the context of this current study, I believe that the ecological model of EM developed by Schiamberg and Gans (1999) is relevant, fits and works, but that

the theory of 'living in the margins' further strengthens and extends its usage to wider settings and populations. I discuss this extension next.

The ecological theory of EM assumes that EM is essentially an IG phenomenon. Although my study complements the view of the ecological model that EM occurs predominantly in an adult child and ageing parent relationship, it further suggests that it could happen in both trusted and non-trusted relationships. My theory suggests that the perpetrator could also be the partner or a proxy member of the household, for example, the daughter-in-law of an older victim. The theory also contends that EM in a trusted relationship could also extend to friends, colleagues or older cohorts from same ethnic background, as well as abuse by people unknown to the victim; street racism is a common example of this.

Second, the theory of living in the margins also argues for the consideration of the intersection of multiple modalities of oppression leading to the conditions and factors which result in EM, which is a major omission in the original ecological model.

In keeping with the ecological model, the theory asserts that older Pakistanis' experiences of mistreatment are influenced by the series of multiple environments in which an older person is embedded and interacts with. Table 8.1 shows the additions and extensions which my theory attaches to the ecological model.

In brief, for example, within a microsystem, Schiamberg and Gans (1999) proposed that older widows, simply because of their gender, are less likely to be exposed to abuse than a married elder because of the living arrangements meaning that a widow is more likely to be living alone. The findings of my study, however, suggest that older Pakistani widows are at an equal or potentially higher risk of EM by being dependent and controlled because they often happen to be living in shared rather than solitary accommodation. I would therefore suggest that both married and widowed older women should be considered at greater risk of EM.

Within the family microsystem, Schiamberg and Gans (1999) also suggested that specific characteristics of the interactions between an older person and an adult child can increase the risk of EM; for example, the financial dependence of the young person on the victim of EM. I would add that the intersection rather than just the interaction of multiple IG and other factors increases vulnerability to EM; for example, the intersection of institutional racism, interpersonal ageism and household poverty.

In meso/exosystems, I would suggest adding the identity, acculturation and integration related factors to the ecological model. Parents' failure to acculturate in British society, for example, might not only increase their dependence and the caregiving burden on their children but could also lead to role reversal, with the older person losing her/his perceived hierarchical role and respect in the family. Similarly, their children's dissociation from the native Pakistani identity and culture has a significant emotional and psychological impact on older parents.

In addition to cultural norms and public policy (Schiamberg and Gans, 1999b), the theoretical model which emerged from my study also proposes a wide range of factors at the macro-system level, such as religion, ageism and racism, which could increase the vulnerability of older people in the society. These factors have been comprehensively discussed in the findings and theory chapters.

Because the theory presented in this thesis acknowledges the risk factors in the ecological systems of EM, this theory might also be called a 'cultural theory' as the interpretations of most of the factors were shaped and influenced by the participants' own cultural understanding of EM. As discussed above, EM is predominantly an IG phenomenon in the Pakistani community, so the cultural and societal values with which each generation was born and brought up were of significance in their understanding of EM. At the wider societal level, similarly, the cultural understanding of the first immigrant Pakistanis towards the UK and its modern values were stated as being the main sources of their segregation and the acculturation-associated factors of EM. The findings have shown that the participants' experiences, words and social interaction (Hegel et al., 1977) for interpreting EM are not only linked but cultural.

Table 8. 1. The ecological model and my additions from the GT of 'living in the margins'

Ecological Model	IS/IG Theoretical Model
<p>Microsystem <i>Adult child - Abuser microsystem</i></p> <ul style="list-style-type: none"> • Substance abuse • Mental/emotional illness • Dementia • Lack of caregiving, experience/reluctance, stress and burden • Personality traits and lack of social support <p><i>Ageing parent – Victim microsystem</i></p> <ul style="list-style-type: none"> • Gender • Marital status • Age • Health and/or dementia • Provocative behaviour • Substance abuse • Psychological factors and social isolation 	<p>Microsystem: <i>Adult child microsystem</i></p> <ul style="list-style-type: none"> • Stress and burden • Substance abuse • Lack of caregiving experience • Lack of family and social support • Cumulative losses in caregiving (such as economic, social, personal, career) <p><i>Older persons microsystem</i></p> <ul style="list-style-type: none"> • Health (cognitive and physical) • Gender • Marital status • Social isolation • Attitude toward age (inactive ageing) • Socio-cultural skills
<p>Family microsystem</p> <ul style="list-style-type: none"> • Dependence • Living arrangements • History of abuse • IG transmission of violence • Multi-generational demands 	<p>Family micro system <i>IG relationships and differences in</i></p> <ul style="list-style-type: none"> • Spatiality and temporality • Living arrangements • Cultural learning / practices on violence • Gender role and status • Role failure / role reciprocity / role modelling / role reversal • Dependency / household poverty • Powers and status
<p>Meso/Exosystem</p> <ul style="list-style-type: none"> • Employment status • Financial resources • Social isolation and lack of formal support • Social isolation and • Lack of support (adult day care) 	<p>Meso/Exosystem</p> <ul style="list-style-type: none"> • Socio-cultural resources (such as driving and language skills) • Socio-economic status • Acculturation; integration; identity • Social isolation • Lack of family or social support
<p>Macro System</p> <ul style="list-style-type: none"> • Cultural norms • Public policy 	<p>Macro system</p> <ul style="list-style-type: none"> • Cultural norms • Religion • Ageism • Othering (by young generation and cohort) • Racism in society • Socio-political changes in the country • Public and social institutions (such as social care services, nursing homes)

8.6 Limitations of the study

This study offers a rich and rare insight into the sensitive and taboo subject of EM within the Pakistani community. It has provided insights which would not have been obtained through quantitative measures. Not only this study present rich and thick account of participants, it defends its position for its high quality and rigor. Even so, there are a number of limitations related to the methodology and design, so caution should be exercised when interpreting the findings and the theory.

First, the study was confined to one geographical location and had a relatively small sample, which was, however, balanced in that the sample represented different categories of participant: older people, family caregivers and community stakeholders. Furthermore, the participants were recruited through community agencies and were cognitively fit and physically independent (except for some of the older participants), so the findings might have differed for individuals with impairments. As a result, the transferability of the findings to other ethnicities or to the general population is very low. However, as discussed above, if the findings are considered in the context of the ecological model, they can be extended to wider contexts and populations.

Although my status (Pakistani background) was an asset for recruiting and establishing a rapport with the participants, it might have influenced their responses and the findings of the study. To address this possibility, I have clearly discussed my personal and professional background in order to advise the reader to interpret the findings with caution.

The study used the focus group method to gather data in addition to individual interviews, and this technique has limitations such as moderator bias, issues of social identification and social desirability, and participants' homogeneity. As explained in reflexivity, issues such as my gender and ethnicity in collection of data were significant factor for socially desirable responses. These factors should be undertaken when applying or interpreting the result.

Some of the interviews and both of the focus group discussions were conducted in Urdu and were subsequently translated and transcribed by me into English. It is therefore possible that I might have lost some information or cultural nuances during the recording or the translation of the data.

There might be risk of sample bias as well, considering the sensitive nature of topic. As a result, people who are not comfortable or those who are more vulnerable might have not taken part in the study.

Finally, the aim of the study was to develop, as far as possible, a substantive theory of EM in Pakistani communities. The study was designed to gather information on participants' individual perspectives rather than their personal experiences of EM. Caution should therefore be taken when interpreting or applying the findings to a situation involving actual cases of EM.

8.7 Conclusion

In this chapter, I have demonstrated that the study is credible, original, resonant and useful and that it meets the required quality in its processes and product, the resulting theory regarding EM among Pakistanis living in the UK. One of the strengths of this study is that it has given a voice to otherwise invisible and marginalized populations in the UK. Furthermore, the study has generated rich and thick knowledge of EM by addressing a range of diverse but relevant perspectives, thus revealing assumptions which have been taken for granted in the previously existing knowledge. The diverse and distinct findings of my research also expand the existing knowledge, and its emergent fit with other substantive theories enables the transfer and application of the results to wider contexts and populations. A success of this study is the construction of a substantive theory which I have termed 'living in the margins', which argues for the consideration of IG and IS factors and their relationships in increasing the risk of EM in the Pakistani communities in the UK. Furthermore, this study is expected not only to attract the attention of researchers, policy-makers and practitioners to the important cultural, religious, social and individual factors of EM, but also raises further implications for research, policies and practices. These are discussed next.

8.8 Implications and recommendations for research, practices and policy

Implications and recommendation for practices

Following implications for practice and policy can be drawn from this study's findings.

- This study has drawn attention to the fact that EM is predominantly an IG phenomenon in Pakistani communities in the UK. With the rise of modernism and materialism, the findings have suggested that the IG gaps between the young and the old are widening and that the practices and interpretations of various forms of behaviour are individual. Respect, and the lack of it, of older people, for example, emerged as an integral aspect of IG relationships and interactions. IG relationships play vital role in family dynamics. It is therefore recommended that public, social and private institutions should work together to introduce local and national policies and protocols to ensure that children are given education on elder veneration, familism and equality at all pedagogical institutions from home, schools and mosques to all community and religious centres.
- The research findings gathered that the community perceive EM from an abstract rather than a material position. Lack of respect in IG and wider social relationships is important to older people. The findings therefore first demonstrate the need to draw the attention of researchers and policy makers to the existence of this type of abuse and emphasise the need to classify EM more broadly in order to include disrespect in its rubric. Second, as the findings related to disrespect are subjective, they cannot be assessed by objective measures; this has implications for the definition and measurement of EM and subsequently for social work practices.
- The findings have also shown that the different Pakistani respondents recognized marginalization and racism in public and social institutions as an additional form of EM. This is considered to have implications for the health and well-being of older people but the subsequent economic implications for society as well as the implications for services in regard to the health and safety of older Pakistanis are also noteworthy. Lack of trust in services, for example is a significant barrier to accessing caregiving support and reporting to services, so there is a need for agencies to build a rapport and ensure that the community will be treated fairly and equally, and the participants regarded this as an as important step.

- In the face of the current rapid socio-cultural transformation, the participants believed that the community's views on family caregiving and formal long-term institutions are changing. It was found that older people still held unambiguous expectations of their families for care, but that young people did not necessarily feel obliged to meet those expectations and were more likely consider accessing social services and long-term facilities for the care of their older relatives. This has implications for social services for support as the numbers as well as the life expectancy of older Pakistanis are increasing; the findings also suggest that age- and health-related dependence among the older is also rising. This has implications for private care providers of long-term services such as nursing homes, and it raises critical questions about whether they are prepared for this influx. This study has highlighted a range of cultural, religious and environmental barriers for Pakistanis living in nursing homes. Policymakers and practitioners should work together with private care providers to maximize facilities for Pakistani to ensure person centred care in nursing homes.
- Isolation and loneliness are growing issues, and strongly linked with EM in Pakistani communities. The study reported multiple local, national and interpersonal factors that influence social life of older people. Findings suggest that the policy makers and practitioners need to work on community engagement interventions, which are sensitive to older people's religious, gender and cultural, needs.
- Findings from the study showed that the language barrier was regarded as a significant issue for older Pakistanis, particularly older women, because it could very likely restrict effective reporting of mistreatment. The study suggests that the services would need to work on improving and making more available interpretation and translation services for the community.
- In the face of EM, the reporting and coping strategies were discussed as religious, cultural and informal in the community. As it was found that community and religious leaders and members of relevant charities had no training on dealing with EM, and they were found to have advised older people to remain in an abusive environment, this has obvious implications for older people and subsequently for the under-reporting of EM. It is therefore recommended that social services should work with

communities and community organizations to deliver public awareness programmes on EM and how to deal with it.

Future research priorities and recommendations

Findings of the research have highlighted multiple areas where further research can help improving our understanding of the EM. These identified research priorities for future research are described below:

- This study has highlighted a range of social, cultural and religious barriers, which increase anxiety and uncertainty, as well as older people's risk of EM in care homes, and further research with Pakistanis and care staff who are actually resident or working in a nursing home might help with understanding the experiences of their care-receiving and care-providing situations. The findings also recommend exploring the alternative, acceptable and appropriate options, which older people adopt or prefer for care, such as nursing homes specifically for Pakistanis.
- The findings of this research suggest that EM is both IG as well as a social phenomenon. Multiple risk factors were identified at the family setting describing the IG relationships and IG gaps. However, further research is required to explore the determinants of social and street abuse of older Pakistanis by their descendant generations.
- Isolation and loneliness is growing issues among marginalized and traditional Pakistani older people. Findings of my research highlighted some local, IG, cultural, and wider factors which increase level of isolation and loneliness in the community. However, at present, there are no resources that support or measure to understand the complexity and culturally sensitive nature of the problem. Further, research should be a priority in developing a resource package that enables practitioners and the public to address the issue of loneliness and isolation in the Pakistani community.
- This research has highlighted the importance of the Quran and Sharia in finding alternative explanations to address the phenomenon of elder mistreatment in the community. I would recommend further qualitative research on 'the role of religion

and religious books and scripts on determining people help seeking trends and behaviours' in Pakistani community.

- The findings of this study have highlighted multiple barriers in reporting EM in the community. The study has also focused and discussed multiple preventive measures to address EM in the Pakistani community. However, further research is needed which focuses on help seeking facilitators.

References

- Acierno, R., Hernandez, M. A., Amstadter, A. B., Resnick, H. S., Steve, K., Muzzy, W. & Kilpatrick, D. G. 2010. Prevalence and Correlates of Emotional, Physical, Sexual, and Financial Abuse and Potential Neglect in the United States: The National Elder Mistreatment Study. *American Journal of Public Health*, 100(2), pp 292-297.
- Action on Elder Abuse 1995. *What is Elder Abuse? Action on Elder Abuse*, London: Action on Elder Abuse.
- Ahmad, W. I. U. & Walker, R. 1997. Asian older people: Housing, health and access to services. *Ageing and Society*, 17(2), pp 141-165.
- Alexandra Hernandez-Tejada, M., Amstadter, A., Muzzy, W. & Acierno, R. 2013. The national elder mistreatment study: race and ethnicity findings. *J Elder Abuse Negl*, 25(4), pp 281-93.
- Anetzberger, G., Korbin, J. & Tomita, S. 1996. Defining elder mistreatment in four ethnic groups across two generations. *J Cross-Cultural Gerontol*, 11(2), pp 187-212.
- Anetzberger, G. J. 2005. The Reality of Elder Abuse. *Clinical Gerontologist*, 28(1-2), pp 1-25.
- Anme, T. 2004. A study of elder abuse and risk factors in Japanese families: Focused on the Social Affiliation Model. *Geriatrics & Gerontology International*, 4(S262-S263).
- Annells, M. 1996. Grounded theory method: Philosophical perspectives, paradigm of inquiry, and postmodernism. *Qualitative health research*, 6(3), pp 379-393.
- Anwar, M. 1978. The myth of return: Pakistanis in Britain.
- Aspinall, P. J. & Jacobsen, B. 2004. Ethnic disparities in health and health care: a focused review of the evidence and selected examples of good practice: Executive summary.
- Bajekal, M., Blane, D., Grewal, I., Karlsen, S. & Nazroo, J. 2004. Ethnic differences in influences on quality of life at older ages: A quantitative analysis. *Ageing & Society*, 24(5), pp 709.
- Baker, A. A. 1975. Granny-battering. *Modern Geriatrics*, 5(20-24).
- Baker, S. E., Edwards, R. & Doidge, M. 2012. How many qualitative interviews is enough?: Expert voices and early career reflections on sampling and cases in qualitative research.
- Ballard, R. 2003. The South Asian presence in Britain and its transnational connections. *Culture and economy in the Indian diaspora*, 197-222.
- Becker, H. S. 1996. The epistemology of qualitative research. *Ethnography and human development: Context and meaning in social inquiry*, 27(53-71).
- Bengtson, V., L & Allen, K., R 1993. The life course perspective applied to families over time. *Sourcebook of family theories and methods*. Springer.
- Biggs, S. 1996a. A family concern. Elder abuse in British social policy. *Critical Social Policy*, 16(63-88).

- Biggs, S. 1996b. A family concern: Elder abuse in British social policy. *Critical Social Policy*, 16(47), pp 63-88.
- Biggs, S., Phillipson, C. & Kingston, P. 1995. *Elder abuse in perspective*: Open University Press.
- Birbili, M. 2000. Translating from one language to another. *Social research update*, 31(1), pp 1-7.
- Blakemore, K. 2000. Health and social care needs in minority communities: an over-problematised issue? *Health Soc Care Community*, 8(1), pp 22-30.
- Blakemore, K. & Boneham, M. 1994. *Age, Race and Ethnicity: A Comparative Approach. Rethinking Ageing Series*: ERIC.
- Blumer, H. 1971. Social problems as collective behavior. *Social problems*, 298-306.
- Bowes, A., Avan, G. & Macintosh, S. 2008. *They put up with it what else can they do? Mistreatment of black and minority ethnic older people and the service response*: Age Concern Scotland.
- Bowes, A., Avan, G. & Macintosh, S. 2011. Dignity and respect in residential care: issues for black and minority ethnic groups. *report to the Department of Health, available at: www.panicoa.org.uk/sites/assets/dignity_and_respect_in_residential_care.pdf (accessed 9 July 2014)*.
- Bowes, A., Avan, G. & Macintosh, S. B. 2012a. Cultural Diversity and the Mistreatment of Older People in Black and Minority Ethnic Communities: Some Implications for Service Provision. *Journal of Elder Abuse and Neglect*, 24(3), pp 251-274.
- Bowes, A., Avan, G. & Macintosh, S. B. 2012b. Cultural diversity and the mistreatment of older people in black and minority ethnic communities: some implications for service provision. *Journal of elder abuse & neglect*, 24(3), pp 251-74.
- Bowes, A. & Wilkinson, H. 2003. 'We didn't know it would get that bad': South Asian experiences of dementia and the service response. *Health & social care in the community*, 11(5), pp 387.
- Brammer, A. & Biggs, S. 1998. Defining elder abuse. *Journal of Social Welfare and Family Law*, 20(3), pp 285-304.
- Bristowe, E. & Collins, J. B. 1988. Family mediated abuse of noninstitutionalized frail elderly men and women living in British Columbia. *Journal of Elder Abuse & Neglect*, 1(1), pp 45-64.
- Bronfenbrenner, U. 1979. *The ecology of human development: Experiments by design and nature*. Cambridge, MA: Harvard University Press.
- Bronfenbrenner, U. 1986. Ecology of the family as a context for human development: Research perspectives. *Developmental psychology*, 22(6), pp 723.
- Bryman, A. 2008. *Social research methods*. London: Oxford university Press.
- Burnes, D., Pillemer, K., Caccamise, P. L., Mason, A., Henderson, C. R., Jr., Berman, J., Cook, A. M., Shukoff, D., Brownell, P., Powell, M., Salamone, A. & Lachs, M. S. 2015a. Prevalence of and

- Risk Factors for Elder Abuse and Neglect in the Community: A Population-Based Study. *Journal of the American Geriatrics Society*, 63(9), pp 1906-12.
- Burnes, D., Pillemer, K., Caccamise, P. L., Mason, A., Henderson, C. R., Jr., Berman, J., Cook, A. M., Shukoff, D., Brownell, P., Powell, M., Salamone, A. & Lachs, M. S. 2015b. Prevalence of and risk factors for elder abuse and neglect in the community: A population-based study. *Journal of the American Geriatrics Society*, 63(9), pp 1906-1912.
- Burnight, K. & Mosqueda, L. 2011. Theoretical Model Development in Elder Mistreatment,
- Burston, G. 1975. Letter: Granny-battering. *Br Med J*, 3(5983), pp 592-592.
- Charmaz, K. 2006. *Constructing grounded theory: A practical guide through qualitative analysis*: sage.
- Charmaz, K. 2014. *Constructing grounded theory*: Sage.
- Choi, N. G. & Mayer, J. 2000. Elder abuse, neglect, and exploitation: Risk factors and prevention strategies. *Journal of gerontological social work*, 33(2), pp 5-25.
- Chokkanathan, S. 2014. Factors associated with elder mistreatment in rural Tamil Nadu, India: a cross-sectional survey. *International Journal of Geriatric Psychiatry*, 29(8), pp 863-870.
- Chokkanathan, S. & Lee, A. E. Y. 2005. Elder Mistreatment in Urban India: A Community Based Study. *Journal of Elder Abuse & Neglect*, 17(2), pp 45-61.
- Chokkanathan, S., Natarajan, A. & Mohanty, J. 2014. Elder abuse and barriers to help seeking in Chennai, India: A qualitative study. *Journal of Elder Abuse & Neglect*, 26(1), pp 60.
- Choudhry, U. 2001. Uprooting and resettlement experiences of South Asian immigrant women. *Western journal of nursing research*, 23(4), pp 376-393.
- Clarke, A. E. 2003. Situational analyses: Grounded theory mapping after the postmodern turn. *Symbolic interaction*, 26(4), pp 553-576.
- Cooper, C., Selwood, A. & Livingston, G. 2008. The prevalence of elder abuse and neglect: a systematic review. *Age Ageing*, 37(2), pp 151-60.
- Corbin, J. & Strauss, A. 2008. *Basics of qualitative research 3e*. London: Sage.
- Council, S. C. 2011. *Population and Health of Sheffield* [Online]. Sheffield. Available: <https://www.sheffield.gov.uk/your-city-council/sheffield-profile/population-and-health.html> [Accessed 10/11/2015 2015].
- Creswell, J. W. 2013. *Qualitative inquiry and research design: Choosing among five approaches*: Sage.
- Daly, J. M., Merchant, M. L. & Jogerst, G. J. 2011. Elder abuse research: A systematic review. *Journal of Elder Abuse and Neglect*, 23(4), pp 348-365.
- DeLiema, M., Gassoumis, D., Homeier, C. & Wilber, H. 2012. Determining prevalence and correlates of elder abuse using promotores: low-income immigrant Latinos report high rates of abuse and neglect. *Journal of the American Geriatrics Society*, 60(7), pp 1333.

- Denzin, N. K. & Lincoln, Y. S. 2005. *The Sage handbook of qualitative research*: Sage.
- Denzin, N. K. & Lincoln, Y. S. 2011. *The Sage handbook of qualitative research*: Sage.
- Department for Work & Pensions. 2010. Family Resources Survey, Department for Work & Pensions (London).
- Department of Business, E. a. I. S. 2016. Annual Report. 2017 ed. London: Department of Business, Energy and Industrial Strategy.
- Dey, I. 1999. *Grounding Grounded Theory: Guidelines for Qualitative Inquiry*: Emerald Group Publishing Limited.
- Dhruvarajan, V. 1993. Ethnic cultural retention and transmission among first generation Hindu Asian Indians in a Canadian prairie city. *Journal of Comparative Family Studies*, 63-79.
- Dildar, S. & Saeed, Y. 2012a. EXPLORATORY STUDY OF THE NATURE OF VIOLENCE AGAINST ELDERLY IN DISTRICT GUJRAT, PAKISTAN. *Academic Research International*, 2(3), pp 661.
- Dildar, S. & Saeed, Y. 2012b. Exploratory study of the nature of violence against elderly in district Gujrat, Pakistan. *Academic Research International*, 2(3), pp 661.
- Dixon, J., Manthorpe, J., Biggs, S., Mowlam, A., Tennant, R., Tinker, A. & McCreddie, C. 2009. Defining elder mistreatment: reflections on the United Kingdom Study of Abuse and Neglect of Older People. *Ageing and Society*, 30(03), pp 403.
- Dong, X. & Simon, M. A. 2008. Is greater social support a protective factor against elder mistreatment? *Gerontology*, 54(6), pp 381-8.
- Dong, X. & Simon, M. A. 2013. Elder abuse as a risk factor for hospitalization in older persons. *JAMA Intern Med*, 173(10), pp 911-7.
- Dong, X. Q. 2015. Elder abuse: Systematic review and implications for practice. *Journal of the American Geriatrics Society*, 63(6), pp 1214-1238.
- Dong, X. Q., Chang, E. S., Wong, E., Wong, B. & Simon, M. A. 2011. How do U.S. Chinese older adults view elder mistreatment? Findings from a community-based participatory research study. *Journal of Aging and Health*, 23(2), pp 289-312.
- Draper, A. K. 2004. The principles and application of qualitative research. *Proceedings of the nutrition society*, 63(4), pp 641-646.
- Dunne, C. 2011. The place of the literature review in grounded theory research. *International journal of social research methodology*, 14(2), pp 111-124.
- Enguidanos, M., Deliema, M., Aguilar, I., Lambrinos, J. & Wilber, H. 2014. Multicultural voices: attitudes of older adults in the United States of America about elder mistreatment. *Ageing & Society*, 34(5), pp 877.

- Erlingsson, C. 2007a. Elder abuse through a prism of perceptions: perspectives of potential witnesses.
- Erlingsson, C. L. 2007b. Searching for elder abuse: a systematic review of database citations. *J Elder Abuse Negl*, 19(3-4), pp 59-78.
- Erlingsson, C. L., Saveman, B.-I. & Berg, A. C. 2005. Perceptions of Elder Abuse in Sweden: Voices of Older Persons. *Brief Treatment and Crisis Intervention*, 5(2), pp 213-227.
- Evandrou, M. 2000. Social inequalities in later life: the socio-economic position of older people from ethnic minority groups in Britain. *Popul Trends*, 101), pp 11-8.
- Faulkner, R. R. 2009. Improvising on sensitizing concepts. *Ethnographies Revisited: Conceptual Reflections from the Field*, 79-91.
- Fenton, S. 1987. *Ageing minorities: black people as they grow old in Britain*: Commission for Racial Equality.
- Flick, U. 2002. *An introduction to qualitative research*: Sage Publications Limited.
- Flood, A. 2010. Understanding phenomenology: Anne Flood looks at the theory and methods involved in phenomenological research. *Nurse researcher*, 17(2), pp 7-15.
- Gaikwad, V., Sudeepa, D. & Madhukumar, S. 2011. A community based study on elder abuse and depression in Bangalore. *International Journal of Public Health and Human Rights*, 1(1,), pp 01-04.
- Gentles, S. J., Jack, S. M., Nicholas, D. B. & McKibbin, K. 2014. Critical approach to reflexivity in grounded theory. *The Qualitative Report*, 19(44), pp 1-14.
- George, J. 1994. Racial Aspect of Elder Abuse. In: Eastman, M. (ed.) *Old Age Abuse*. London: Chapman and Hall.
- Given, L. M. 2008. *The Sage encyclopedia of qualitative research methods*: Sage publications.
- Glaser, B. G. 1998. *Doing grounded theory: Issues and discussions*: Sociology Press.
- Glaser, B. G. Constructivist grounded theory? *Forum qualitative sozialforschung/forum: Qualitative social research*, 2002.
- Glaser, B. G. & Strauss, A. L. 1965. Discovery of substantive theory: A basic strategy underlying qualitative research. *American Behavioral Scientist*, 8(6), pp 5-12.
- Glaser, B. G. & Strauss, A. L. 1967. *The discovery of grounded theory: Strategies for qualitative research*: Transaction publishers.
- Glendenning, F. 1997. The mistreatment and neglect of elderly people in residential centres: Research outcomes. *Action on Elder Abuse*, 151.
- Grant, M. J. & Booth, A. 2009. A typology of reviews: an analysis of 14 review types and associated methodologies. *Health Information & Libraries Journal*, 26(2), pp 91-108.

- Grewal, I., Nazroo, J., Bajekal, M., Blane, D. & Lewis, J. 2004. Influences on quality of life: a qualitative investigation of ethnic differences among older people in England. *Journal of Ethnic and Migration Studies*, 30(4), pp 737-761.
- Gupta, R. 2002. Consideration of nursing home care placement for the elderly in South Asian families. *Journal of Immigrant Health*, 4(1), pp 47-56.
- Guruge, S., Kanthasamy, P., Jokarasa, J., Wan, T. Y. W., Chinichian, M., Shirpak, K. R., Paterson, P. & Sathanathan, S.-S. 2010. Older women speak about abuse & neglect in the post-migration context.
- Halai, N. 2007. Making use of bilingual interview data: Some experiences from the field. *The Qualitative Report*, 12(3), pp 344.
- Hall, P. A. 1987. Minority elder maltreatment: Ethnicity, gender, age, and poverty. *Journal of Gerontological Social Work*, 9(4), pp 53-72.
- Hallberg, L. R. 2006. The "core category" of grounded theory: Making constant comparisons. *International Journal of Qualitative Studies on Health and Well-being*, 1(3), pp 141-148.
- Hanes, E. & Machin, S. 2014. Hate crime in the wake of terror attacks: Evidence from 7/7 and 9/11. *Journal of Contemporary Criminal Justice*, 30(3), pp 247-267.
- Hegel, G. W. F., Miller, A. V. & Findlay, J. N. 1977. *Phenomenology of Spirit*.
- Holloway, I. & Wheeler, S. 2013. *Qualitative Research in Nursing and Healthcare*: John Wiley & Sons.
- Horsford, S. R., Parra-Cardona, J. R., Post, L. A. & Schiamberg, L. 2011. Elder abuse and neglect in African American families: Informing practice based on ecological and cultural frameworks. *Journal of Elder Abuse and Neglect*, 23(1), pp 75-88.
- Hudson, M. F. & Carlson, J. R. 1998. Elder abuse: Expert and public perspectives on its meaning. *Journal of Elder Abuse and Neglect*, 9(4), pp 77-97.
- Inman, A. G., Devdas, L., Spektor, V. & Pendse, A. 2014. Psychological Research on South Asian Americans: A Three-Decade Content Analysis. *Asian American Journal of Psychology*, 5(4), pp 364-372.
- Inman, A. G., Howard, E. E., Beaumont, R. L. & Walker, J. A. 2007. Cultural transmission: Influence of contextual factors in Asian Indian immigrant parents' experiences. *Journal of Counseling Psychology*, 54(1), pp 93.
- Jackson, S. L. & Hafemeister, L. 2013. Understanding Elder Abuse: New directions for developing theories of elder abuse occurring in domestic settings, Justice, N. i. o. (Washington, DC).
- Jambunathan, S., Burts, D. C. & Pierce, S. 2000. Comparisons of parenting attitudes among five ethnic groups in the United States. *Journal of Comparative Family Studies*, 395-406.
- Jambunathan, S. & Counselman, K. 2002. Parenting attitudes of Asian Indian mothers living in the United States and in India. *Early Child Development and Care*, 172(6), pp 657-662.

- Jamuna, D. 2003. Issues of elder care and elder abuse in the Indian context. *Journal of aging & social policy*, 15(2), pp 125.
- John, W. S. & Johnson, P. 2000. The pros and cons of data analysis software for qualitative research. *Journal of nursing scholarship*, 32(4), pp 393-397.
- Kalavar, J. M. & Van Willigen, J. 2005. Older Asian Indians resettled in America: Narratives about households, culture and generation. *Journal of Cross-Cultural Gerontology*, 20(3), pp 213-230.
- Katbamna, S., Ahmad, W., Bhakta, P., Baker, R. & Parker, G. 2004. Do they look after their own? Informal support for South Asian carers. *Health & social care in the community*, 12(5), pp 398-406.
- Kaur, J., Kaur, J. & Sujata, N. 2015. Comparative study on perceived abuse and social neglect among rural and urban geriatric population. *Indian journal of psychiatry*, 57(4), pp 375.
- Killick, C., Taylor, J., Begley, E., Carter, A. J. & O'Brien, M. 2015. Older People's Conceptualization of Abuse: A Systematic Review. *Journal of Elder Abuse & Neglect*, 27(2), pp 100-121.
- Korstjens, I. & Moser, A. 2018. Series: Practical guidance to qualitative research. Part 4: trustworthiness and publishing. *European Journal of General Practice*, 24(1), pp 120-124.
- Kosberg, I., Lowenstein, A., Garcia, L. & Biggs, S. 2003. Study of Elder Abuse Within Diverse Cultures. *Journal of Elder Abuse & Neglect*, 15(3), pp 71.
- Lachs, M. S. & Pillemer, K. 1995. Abuse and neglect of elderly persons. *New England Journal of Medicine*, 332(7), pp 437-443.
- Lachs, M. S. & Pillemer, K. 2004. Elder abuse. *Lancet*, 364(9441), pp 1263-1272.
- Lachs, M. S., Williams, C., O'Brien, S., Hurst, L. & Horwitz, R. 1997. Risk factors for reported elder abuse and neglect: A nine-year observational cohort study. *Gerontologist*, 37(4), pp 469-474.
- Lachs, M. S., Williams, C. S., O'Brien, S., Pillemer, K. A. & Charlson, M. E. 1998. The mortality of elder mistreatment. *Jama-Journal of the American Medical Association*, 280(5), pp 428-432.
- Lee, H. Y. & Lightfoot, E. 2014. The Culture-embedded social problem of elder mistreatment: A review of international literature on Asian elders. *Journal of Aggression, Maltreatment and Trauma*, 23(1), pp 5-19.
- Lievesley, N. 2010. The future ageing of the ethnic minority population of England and Wales. *Older BME People and Financial Inclusion Report*, CPA: London. Accessed online(28/10/11) <http://www.cpa.org.uk/information/reviews/thefutureageingoftheethnicminoritypopulationofenglandandwales.pdf>.
- Locke, K. 2001. *Grounded theory in management research*: Sage.

- Manthorpe, J. & Bowes, A. 2010. Age, ethnicity and equalities: synthesising policy and practice messages from two recent studies of elder abuse in the UK. *Social policy and society*, 9(2), pp 255-266.
- Massey, D. S., Arango, J., Hugo, G., Kouaouci, A., Pellegrino, A. & Taylor, J. E. 1993. Theories of international migration: a review and appraisal. *Population and development review*, 431-466.
- McCosker, H., Barnard, A. & Gerber, R. Undertaking sensitive research: Issues and strategies for meeting the safety needs of all participants. Forum Qualitative Sozialforschung/Forum: Qualitative Social Research, 2001.
- McCreadie, C. & Jack, R. 1996. *Elder abuse: Update on research*: Age Concern Institute of Gerontology.
- McGhee, G., Marland, G. R. & Atkinson, J. 2007. Grounded theory research: literature reviewing and reflexivity. *Journal of advanced nursing*, 60(3), pp 334-342.
- Minichiello, V., Browne, J. & Kendig, H. 2000. Perceptions and Consequences of Ageism: Views of Older People. *Ageing and Society*, 20(3), pp 253-278.
- Mir, G. & Sheikh, A. 2010. 'Fasting and prayer don't concern the doctors ... they don't even know what it is': communication, decision-making and perceived social relations of Pakistani Muslim patients with long-term illnesses. *Ethnicity & Health*, 15(4), pp 327-343.
- Mir, G. & Tovey, P. 2002. Cultural competency: professional action and South Asian carers. *Journal of management in medicine*, 16(1), pp 7-19.
- Mold, F., Fitzpatrick, J. M. & Roberts, J. d. 2005a. Caring for minority ethnic older people in nursing care homes.
- Mold, F., Fitzpatrick, J. M. & Roberts, J. D. 2005b. Minority ethnic elders in care homes: a review of the literature. *Age Ageing*, 34(2), pp 107-13.
- Montgomery, P. & Bailey, P. H. 2007. Field notes and theoretical memos in grounded theory. *Western Journal of Nursing Research*, 29(1), pp 65-79.
- Moon, A. 2000. Perceptions of elder abuse among various cultural groups: Similarities and differences. *Generations*, 24(2), pp 75-80.
- Moon, A., Tomita, S. K. & Jung-Kamei, S. 2002. Elder Mistreatment Among Four Asian American Groups. *Journal of Gerontological Social Work*, 36(1-2), pp 153-169.
- Moon, A. & Williams, O. 1993. Perceptions of elder abuse and help-seeking patterns among African-American, Caucasian American, and Korean-American elderly women. *Gerontologist*, 33(3), pp 386-395.
- Morgan, D. L. 1996. *Focus groups as qualitative research*: Sage publications.
- Moriarty, J. 2008. The health and social care experiences of black and minority ethnic older people. *Race Equality Foundation*.

- Morse, J. M. 1997. Considering theory derived from qualitative research. *Completing a qualitative project: Details and dialogue*, 163-188.
- Morse, J. M. 2000. Determining sample size. *Qualitative health research*, 10(1), pp 3-5.
- Mowlam, A., Tennant, R., Dixon, J. & McCreadie, C. 2007. UK study of abuse and neglect of older people: qualitative findings. *London: National Centre for Social Research*, 90.
- Mullatti, L. 1995. Families in India: Beliefs and realities. *Journal of Comparative Family Studies*, 11-25.
- Mysyuk, Y., Westendorp, R. G. & Lindenberg, J. 2013. Added value of elder abuse definitions: a review. *Ageing Res Rev*, 12(1), pp 50-7.
- Nagpaul, K. 1997. Elder abuse among Asian Indians: traditional versus modern perspectives. *Journal of Elder Abuse & Neglect*, 9(2), pp 77-93.
- Nandlal, J. M. & Wood, L. A. 1997. Older People's Understandings of Verbal Abuse. *Journal of Elder Abuse & Neglect*, 9(1), pp 17-31.
- Nations, U. 2015. *World Population Ageing 2015*, (New York).
- Naughton, C., Drennan, J., Lyons, I. & Lafferty, A. 2011. The national prevalence study of elder abuse and neglect in Ireland. *Irish Journal of Medical Science*, 180(
- Nesbitt, S. & Neary, D. 2001. *Ethnic minorities and their pension decisions: A study of Pakistani, Bangladeshi and White men in Oldham: YPS*.
- Ng, C. F. & Northcott, H. C. 2015. Living arrangements and loneliness of South Asian immigrant seniors in Edmonton, Canada. *Ageing and Society*, 35(03), pp 552-575.
- Norris, D., Fancey, P., Power, E. & Ross, P. 2013. The critical-ecological framework: advancing knowledge, practice, and policy on older adult abuse. *J Elder Abuse Negl*, 25(1), pp 40-55.
- Nurjannah, I., Mills, J., Park, T. & Usher, K. 2014. Conducting a grounded theory study in a language other than English. *Sage Open*, 4(1), pp 2158244014528920.
- O'Keeffe, M., Hills, A., Doyle, M., McCreadie, C., Scholes, S., Costantine, R., Tinker, A., Manthorpe, J., Biggs, S. & Erens, B. 2007. UK Study of Abuse and Neglect of Older People Prevalence Survey Report,
- Ogg, J. & Bennett, G. 1992. Elder abuse in Britain. *BMJ : British Medical Journal*, 305(6860), pp 998-999.
- Oh, J., Kim, H. S., Martins, D. & Kim, H. 2006. A study of elder abuse in Korea. *International Journal of Nursing Studies*, 43(2), pp 203-214.
- ONS 2012. *Ethnicity and National Identity in England and Wales 2011*.

- Parra-Cardona, J. R., Meyer, E., Schiamberg, L. & Post, L. 2007. Elder abuse and neglect in Latino families: an ecological and culturally relevant theoretical framework for clinical practice. *Fam Process*, 46(4), pp 451-70.
- Parveen, S., Morrison, V. & Robinson, C. A. 2013. Ethnicity, familism and willingness to care: Important influences on caregiver mood? *Aging & mental health*, 17(1), pp 115-124.
- Payne, B. K., Berg, B. L. & James, L. D. F. 2001. Attitudes about Sanctioning Elder Abuse Offenders among Police Chiefs, Nursing Home Employees, and Students. *International Journal of Offender Therapy and Comparative Criminology*, 45(3), pp 363-382.
- Perry, J. & Blackaby, B. 2007. *Community Cohesion and Housing: a good practice guide*: Chartered Institute of Housing Coventry.
- Phelan, A. 2008. Elder abuse, ageism, human rights and citizenship: implications for nursing discourse. *Nurs Inq*, 15(4), pp 320-9.
- Pickard, L., Wittenberg, R., Comas-Herrera, A., King, D. & Malley, J. 2007. Care by spouses, care by children: Projections of informal care for older people in England to 2031. *Social policy and society*, 6(03), pp 353-366.
- Pillemer, K., Connolly, M. T., Breckman, R., Spreng, N. & Lachs, M. S. 2015. Elder mistreatment: priorities for consideration by the white house conference on aging. *Gerontologist*, 55(2), pp 320-7.
- Pillemer, K. & Finkelhor, D. 1988. The prevalence of elder abuse: a random sample survey. *The Gerontologist*, 28(1), pp 51.
- Pillemer, K. & Finkelhor, D. 1989. Causes of elder abuse: Caregiver stress versus problem relatives. *American Journal of Orthopsychiatry*, 59(2), pp 179-187.
- Ploeg, J., Lohfeld, L. & Walsh, C. A. 2013. What Is "Elder Abuse"? Voices From the Margin: The Views of Underrepresented Canadian Older Adults. *Journal of Elder Abuse and Neglect*, 25(5), pp 396-424.
- Rahman, K. M., Tareque, M. I., Munsur, A. M. & Rahman, M. M. 2010. Elderly abuse: Causes and determinants in rural Naogaon district of Bangladesh. *Journal of Population and Social Studies*, 19(1), pp 25-36.
- Ramalho, R., Adams, P., Huggard, P. & Hoare, K. Literature review and constructivist grounded theory methodology. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, 2015.
- Richards, L. 2014. *Handling qualitative data: A practical guide*: Sage.
- Roberto, K. A. & Teaster, P. B. 2017. Theorizing elder abuse. *Elder abuse*. Springer.
- Rodwell, M. K. & O'Connor, M. K. 1998. *Social Work, Constructivist Research*: Garland Pub.
- Rutherford, T. & Socio, A. 2012. Population ageing: statistics. *House of Commons library (Standard not*. Retrieved Jan 2, 2013, from: www.parliament.uk/topics/PopulationArchive.

- Saikia, A. M., Mahanta, N., Mahanta, A., Deka, A. J. & Kakati, A. 2015. Prevalence and risk factors of abuse among community dwelling elderly of Guwahati City, Assam. *Indian journal of community medicine: official publication of Indian Association of Preventive & Social Medicine*, 40(4), pp 279.
- Sawatzky, J. & Fowler-Kerry, S. 2003. Impact of caregiving: Listening to the voice of informal caregivers. *Journal of Psychiatric and Mental Health Nursing*, 10(3), pp 277-286.
- Scheppers, E., Van Dongen, E., Dekker, J., Geertzen, J. & Dekker, J. 2006. Potential barriers to the use of health services among ethnic minorities: a review. *Family practice*, 23(3), pp 325-348.
- Schiamberg, L. B. & Gans, D. 1999a. An ecological framework for contextual risk factors in elder abuse by adult children. *Journal of Elder Abuse and Neglect*, 11(1), pp 79-103.
- Schiamberg, L. B. & Gans, D. 1999b. An ecological framework for contextual risk factors in elder abuse by adult children. *Journal of Elder Abuse & Neglect*, 11(1), pp 79-104.
- Segal, U. A. 1999. Family violence: A focus on India. *Aggression and Violent Behavior*, 4(2), pp 213-231.
- Seidman, I. 2006. *Interviewing as qualitative research: A guide for researchers in education and the social sciences*: Teachers college press.
- Sharma, K. & Kemp, C. L. 2012. "One should follow the wind": Individualized filial piety and support exchanges in Indian immigrant families in the United States. *Journal of Aging Studies*, 26(2), pp 129-139.
- Shaw, A. 2004. Immigrant Families in the UK. *The blackwell companion to the sociology of families.*, 270.
- Sheffield City Council. 2017. Sheffield Community Knowledge Profile, (Sheffield).
- Shenton, A. K. 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*, 22(2), pp 63-75.
- Sin, C. H. 2006. Expectations of support among White British and Asian-Indian older people in Britain: the interdependence of formal and informal spheres. *Health & social care in the community*, 14(3), pp 215-224.
- Sinha, D. 1984. Some recent changes in the Indian family and their implications for socialisation. *Indian Journal of Social Work*.
- Skirbekk, V. & James, K. S. 2014. Abuse against elderly in India - The role of education. *BMC Public Health*, 14(1), pp.
- Sokolowski, R. 2000. *Introduction to phenomenology*: Cambridge University Press.
- Starks, H. & Trinidad, S. 2007. Choose Your Method: A Comparison of Phenomenology, Discourse Analysis, and Grounded Theory. *Qualitative Health Research*, 17(10), pp 1372-1380.

- Steinmetz, S. K. 1988. *Duty bound: Elder abuse and family care*: Sage Publications, Inc.
- Stewart, D. W. & Shamdasani, P. N. 2014. *Focus groups: Theory and practice*: Sage publications.
- Strauss, A. & Corbin, J. 1998. *Basics of qualitative research techniques*: Sage publications Thousand Oaks, CA.
- survey, E. h. c. 2007. English House condition Survey. September 2009 ed. London: UK Government.
- Talpur, A. A., Ryan, T., Ali, P. & Hinchliff, S. 2018. Elder mistreatment in South Asian communities: a review of the literature. *The Journal of Adult Protection*, 20(5/6), pp 193-206.
- Tam, S. & Neysmith, S. 2006. Disrespect and isolation: elder abuse in Chinese communities. *Canadian Journal on Aging*, 25(2), pp 141-153.
- Tareque, M. I., Islam, T. M., Koshio, A. & Kawahara, K. 2015. Economic Well-Being and Elder Abuse in Rajshahi District of Bangladesh. *Research on Aging*, 37(2), pp 200-224.
- Taylor, B. J., Killick, C., O'Brien, M., Begley, E. & Carter-Anand, J. 2014. Older people's conceptualization of elder abuse and neglect. *J Elder Abuse Negl*, 26(3), pp 223-43.
- Tessier, S. 2012. From field notes, to transcripts, to tape recordings: Evolution or combination? *International Journal of Qualitative Methods*, 11(4), pp 446-460.
- Tomita, S. K. 1994. The consideration of cultural factors in the research of elder mistreatment with an in-depth look at the Japanese. *Journal of Cross-Cultural Gerontology*, 9(1), pp 39-52.
- UK Office for National Statistics 2007. General Household Survey 2007.
- UK Office for National Statistics 2011. International Migrants in England and Wales 2011.
- UK Office for National Statistics. 2012. Population Ageing in the United Kingdom, its Constituent Countries and the European Union, Statistics, O. f. N. (London).
- UK Office for National Statistics 2014. Population by Country of Birth and Nationality Report, August 2014.
- UK Office for National Statistics. 2017. Families and Households, UK Office for National Statistics (London).
- Victor, C. R., Burholt, V. & Martin, W. 2012. Loneliness and ethnic minority elders in Great Britain: an exploratory study. *J Cross Cult Gerontol*, 27(1), pp 65-78.
- Victor, C. R. & Yang, K. 2012. The prevalence of loneliness among adults: a case study of the United Kingdom. *The Journal of psychology*, 146(1-2), pp 85-104.
- Wallace, R. B. & Bonnie, R. J. 2003. *Elder Mistreatment:: Abuse, Neglect, and Exploitation in an Aging America*: National Academies Press.
- Williams, C. L. & Heikes, E. J. 1993. The importance of researcher's gender in the in-depth interview: Evidence from two case studies of male nurses. *Gender & Society*, 7(2), pp 280-291.

Wolf, R. S. 1984. Elder Abuse and Neglect: Final Report from Three Model Projects and Appendixes 1 and 2.

World Health Organisation. 2018. Elder Abuse. Geneva: WHO.

World Health Organization 2002. World report on violence and health.

Yan, E., Chan, K. L. & Tiwari, A. 2015. A systematic review of prevalence and risk factors for elder abuse in Asia. *Trauma Violence Abuse*, 16(2), pp 199-219.

Yan, E. & Tang, C. S. K. 2001. Prevalence and psychological impact of Chinese elder abuse. *Journal of Interpersonal Violence*, 16(11), pp 1158-1174.

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Appendix 1:
Pre-protocol fieldwork report

Pre-protocol fieldwork was undertaken by the primary researcher to clarify some issues around the selection and recruitment of the research participants, and the research documents. This fieldwork did not form of any part of data for the study/analysis, but it was aimed to support in clarifying some objectives.

The researcher consulted with potential researcher participants (stakeholders, older people, and unpaid carers i.e., family members), supervisory team, and the further literature during this course of pre-protocol fieldwork to address these issues.

The outcome of this pre-protocol fieldwork is described as below:

1. Research documents (Participant information sheet and Consent form)

1.1 Participant information sheet (PIS):

Three potential participants (an older person, unpaid carer, and a stakeholder) were given PIS to read.

There were two concerns identified in the PIS: the title of the study and confidentiality/disclosure issue.

It was observed that the title of the study was confusing to participants, particularly; the phrase 'growing older in foreign land' as it was giving mixed meaning to young and older people. Therefore, the title of the study is now changed and simplified. The title in the PIS, however, is deliberately kept unspecific about the precise nature of the proposed interview content, focusing on health, well-being and difficulties experienced by older people so as to preserve confidentiality if other household members were to see the PIS. The PIS is although clear that the aim is to gather participant's views regarding the elder mistreatment in family caregiving.

The second concern was about participant's confidentiality and disclosure protocol. It was also observed that participants were having difficulty in understanding the disclosure procedure. Therefore, it is now changed and rephrased in confidentiality section as:

Everything that is discussed in the interview remains confidential. Confidentiality would only ever be broken where people are in a situation of extreme and immediate harm or are being harmed and are unable to act to protect themselves.

1.2. Consent Form:

Three potential participants (an older person, unpaid carer, and a stakeholder) were given consent form to read. There was no concern identified related to the comprehension of the consent form. The participants reported that consent form is pretty clear, simple, and easy to understand.

Interview Guide (IG) - Individual interviews and Focus groups

1. IG for individual interview:

Questions of interview guide were asked from four potential participants (a stakeholder, an unpaid carer, and two older people). It was observed that there are too many questions about demographic data in the interview guide for individual interviews, which were making it more interrogative. Therefore, the demographic questions are limited in the interview guide.

2. Interview guide for focus groups:

After consultation with supervisors, and feedback from the ethic committee, the IG for focus groups has also been changed. There are no questions about demographic data in topic guides of FGD. In addition to this, there are ground rules introduced in FGD guide to address the issue of participant's confidentiality.

3. Hypothetical statement:

Researcher received consisted result when discussed hypothetical statements with participants. However, it was observed that seven hypothetical statements were too many to include in one interview or FGD. Beside this, it was observed that existing hypothetical statement are long. Therefore, some short hypothetical statement could be included. It was also found that participants were able to bring their own hypothetical statements during the interviews that were reflecting more specifically to their community or culture. Therefore, the researcher will limit the number of selected hypothetical statements and will allow participants to discuss/generate new hypothetical statement during interviews/focus group that are more relevant to their culture and ethnicity.

Ethnicity:

"Ethnicity is a multi-faceted and changing concept loosely related to country of birth, ancestral country of birth, language spoken at home, skin colour, national and geographical origin, racial group and religion". (ONS, 2011)

The researcher consulted with potential participants, supervisors, and the further literature to ensure participants' selection indicates homogeneity to inform consisting results. The aim of this study is to produce sufficient data that generate a middle range theory rather than the overwhelming data that becomes difficult to analyze. Therefore, it was important to make a clear decision on selecting research participants those who are homogenous.

Discussion with participants and the review of the further literature suggested that differences exist among these three ethnicities (Bengalis, Indians, and Pakistanis) at family, community, and societal level about the language, culture, religious beliefs, living standards, and lifestyle. It was also feared that selecting all three ethnicities would generate overwhelming and quite heterogeneous data. The researcher, therefore, has decided to focus on single ethnicity to generate sufficient data to generate a grounded theory.

It is now decided to focus on the understanding of EM in Pakistanis who are living in the UK. This decision is taken after reviewing the literature, consulting with supervisors, and some technical issues such as access to research participants, researcher's background and knowledge about Pakistani people, and limitation related to language issues. The review of literature also suggests that there is less research that has been conducted on EM in Pakistani communities compared to other two communities. It was also found that Pakistani communities are more isolated and marginalized group.

Other issues:

Gender:

1. For Focus groups

Key stakeholders at PCAA suggested that focus group discussion with female participants would be difficult, if the PI conducts it, being a male. It was planned to recruit female researcher who can facilitate focus group discussion with participants. The researcher has spoken to key persons who actually organize/facilitate the group meeting for women. The Key person at PCAA shared an interest in facilitating/chaperoning FGD (Female) for the researcher if required. This key person has a good relationship with older women who attend these groups meetings at PCAA. In addition to this, the key person is bilingual (English and Urdu speakers) and share a similar background with participants such ethnicity, language, and culture.

Stakeholder at Roshni did not explicitly indicate that women who attend group meetings at Roshni would decline to participate in focus groups with the primary researcher, being male. It was then prioritized and planned to conduct FGD with women who attend elder group at Roshni premises.

2. For individual interviews:

Stakeholders at PCAA and Roshni suggested that they will share the participant information sheet with the men and women who attend group meetings at their premises. About the issue of gender, they said that there are chances that women will be more likely to participate in an individual interview than focus groups with a male researcher. Stakeholder suggested that it would be easier for women to share their views with a male researcher about the topic in one to one setting than in front of other group members. Interview will although be gender-matched if requested.

Recruitment:

The researcher has met with many older people at group meetings arranged by stakeholders, who shared an interest in participating in the study. Beside this researcher has met additional gatekeepers at Pakistan Muslim centre, Sharrow Community Forum, and Shipshape centre who also shared an interest in the study. The researcher has developed a good relationship with the participants, and this will probably help in participant's recruitment.

Appendix 2:
Published article

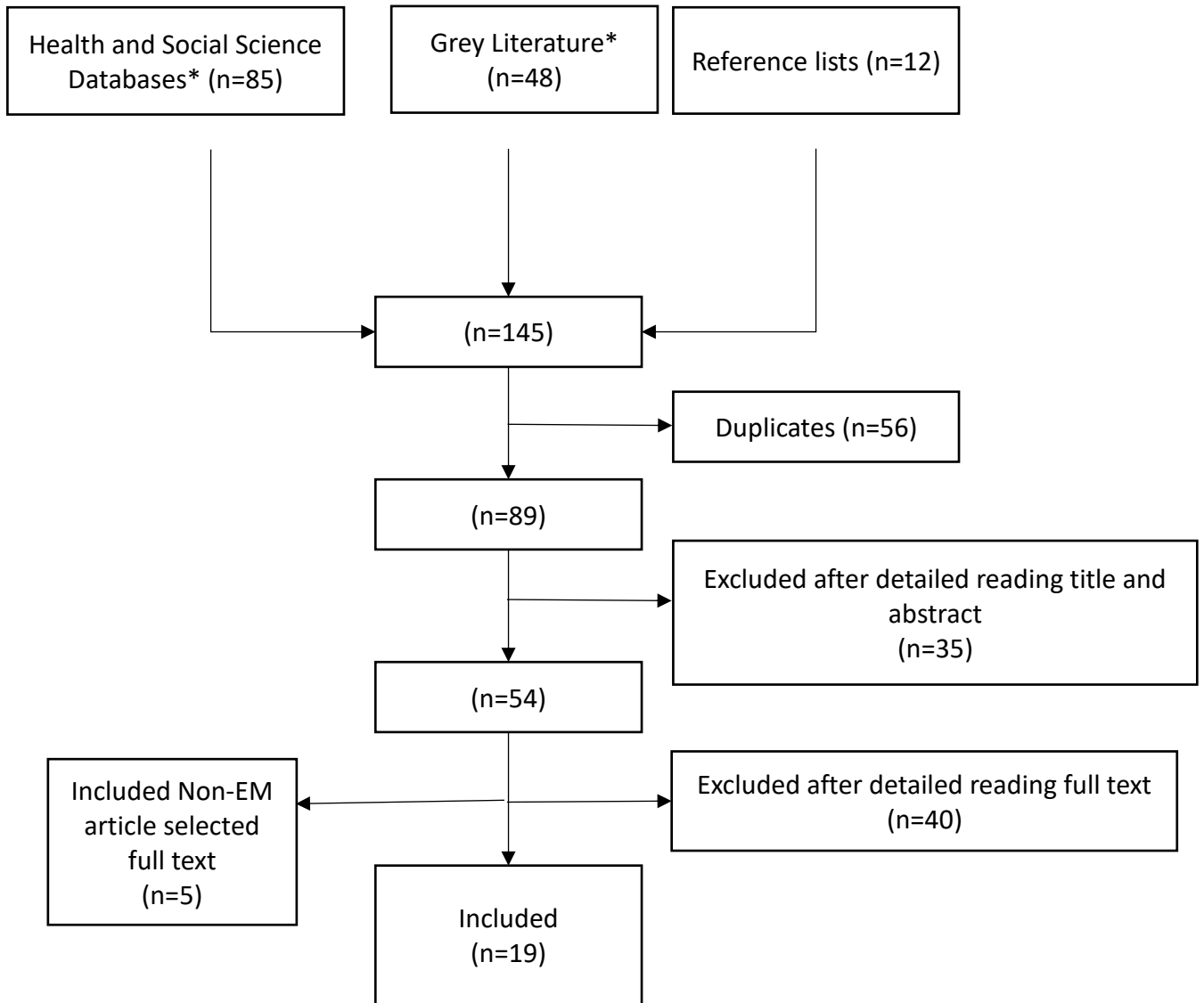
Title: Elder mistreatment in South Asian communities: a review of the literature

Authors: Ashfaque Talpur, Tony Ryan, Parveen Ali, Sharron Hinchliff

Publisher: The Journal Adult Protection

Link to article: <https://www.emerald.com/insight/content/doi/10.1108/JAP-06-2018-0011/full/html>

**Appendix 3:
Flow chart and filtering**



Note: This is a modified Prima flow chart

Appendix 4: Search strategies

Keywords used for search	Selected Databases*
<p>Abuse*, mistreatment, inadequate care, maltreatment, neglect, perpetrator, victims</p> <p>Old, geriatric, age, aged, ageing, Violence,</p> <p>Sexual, physical, psychological, emotional, verbal, financial,</p> <p>Asian, South Asian, Black, Minority, ethnic groups, Pakistani, Indian, Bangladeshi, demographic characteristics, racial and ethnic groups, ethnicity</p> <p>Home care service, domiciliary, community, community-dwelling, domestic</p> <p>Definition, detection, prevention, types, forms, reporting, systematic, narrative, literature review, causes, signs and symptoms, intervention, screening, prevalence, risk factors, risk indicators, theories, help seeking, recognizing, identifying</p> <p>Culture, religion, sociocultural, Race, inequality, norms, dignity, respect, shame, lifestyle, expectation, socioeconomic, compassion, ageist, patriarchy</p> <p>Perceptions, view, beliefs, perspective, experience, understanding</p> <p>UK, United Kingdom, England, Wales, Scotland, Ireland,</p> <p>Stress, burnout, morbidity, mortality</p>	<p>NICE/HAAD 6 databases are</p> <ul style="list-style-type: none"> • AMED (EBSCO) • EMBASE (Elsevier) • BNI (Procite) • MedLine • PsycInfo (APA) • CINAHL (EBSCO) <p>Other Databases</p> <ul style="list-style-type: none"> • Scopus • Applied Social Sciences Index and Abstraction (ASSIA) • Social Care online • Cochrane Library • Web of Science <ul style="list-style-type: none"> ○ Social Science Citation Index <p>Grey Literature</p> <ul style="list-style-type: none"> • Google Scholar • Psychline • EThOS • Proquest Dissertation and thesis • CPA – Centre for Policy on Ageing/ AgeInfo • Help Age India • Action on Elder Abuse • British Geriatric Society <p>Book holding</p> <ul style="list-style-type: none"> • University of Sheffield <p>Relevant Journals individually searched</p> <ul style="list-style-type: none"> • Informa (Taylor and Francis Online Database) <ul style="list-style-type: none"> ○ Journal of Elder abuse and Neglect (Informa) ○ Ageing and mental health ○ Ageing and Health ○ Ethnicity and health • The Gerontologist • Geriatric psychiatry • Geriatric Nursing • Journal of adult protection • Age and Ageing • Educational Gerontology • International journal of migration, health and social care • Journal of Gerontological social work • The Journal of Gerontological Society of America • British medical journal • British Nursing Journal • Ageing and Society

Example of Keyword search

Sr. No	Boolean	Main concept	Citations	Boolean	Alternative Terms	Citations	Total
		“Elder Abuse”	5501	OR	“Elder mistreatment”	1625	5790
		“South Asian”	10637	OR	Pakistani, Indian, Bangladeshi		
	AND	Community		OR	Family settings		

**Appendix 5:
Selected Studied**

Selected studies on EM:								
#	Author/ study	Purpose	Design	Sampling	Sample	Data collection	Data analysis	Findings
1	(Chokkanathan and Lee, 2005)	Examine the extent and correlates of elder abuse in Chennai, India	Cross sectional	Random sampling	400 community dwelling age 65+	Face to face interviews Instrument: CTS	Logistic regression	Overall Prevalence (14%); chronic verbal (10.8%); financial (5.0%); physical (4.3%); and neglect (4.3%). About 50% of abused reported multifaceted abuse. The main victim was female (31.5 vs. 15.8%) and main perpetrator was son (83.6%). Mistreated adults were more depressed and less satisfied with life. EM found recurrent.
2	(Chokkanathan, 2014)	To investigate the factors associated with the mistreatment of older adults living in rural Tamil Nadu	Cross sectional Survey design	Two stage cluster sampling	902 older adults aged 61 + years	Interviewer based questionnaire Instrument: CTS	univariate and multivariate logistic regression analyses	Overall prevalence (21%); Psychological abuse most common (19.2%); financial (12.7%); Neglect (12.4%); physical (12.3%). About 83% suffered more than one form of abuse. EM is related to several factors associated with the perpetrator and the family environment. Perpetrator factors include middle age, a tertiary education (protective), alcohol consumption and the mistreatment of other family members. Family environment

								factors include family stress and low cohesion.
3	(Skirbekk and James, 2014)	To investigate the role of education on the prevalence of elderly abuse	Cross sectional Survey	Random sampling	9852 old adults from 8329 households aged 60 and over	Face to face interviews Instrument: own questionnaire	Logistic regression	Overall prevalence 11%. Physical 5.3%, verbal 10.2%, economic 5.4, disrespect 6.0% and neglect 5.2%. Verbal abuse used to force financial transactions. Son was most common perpetrator. Gender (women) were more likely to report EM except for physical abuse. Formal education among elderly was significantly related to reduce elderly abuse. Other factors leading EM were low cognitive abilities, lowest caste (low economic status), widowhood, urban living arrangements and numbers of children.
4	(Saikia et al., 2015)	To assess the prevalence of abuse among community dwelling elderly and to identify the various risk factors	Cross sectional	Non random sampling	331 aged 60+	Interview Instrument: H-S EAST	Descriptive analysis	Overall prevalence (9.3%). The Main Perpetrator was son (51.6%). Statistically significant risk factors were Age (>85 years); Sex (female); living status (living with children/relatives without spouse); functional status (non-intact).
5	(Kaur et al., 2015)	To compare the perceived abuse and social neglect among elderly residing in selected rural and urban areas.	Cross sectional	Cluster random sampling	200 aged 60+	Interview Instrument: own questionnaire	Descriptive analysis	Perceived physical (25%); Psychological (71%); Financial (37%); Sexual (0%); Social neglect (74%). Perceived physical abuse

								was higher among elderly residing in rural areas and psychological among urban elderly. No sexual abuse was reported. Physical abuse was highly perceived by female and financial abuse by male. A significant association was found between psychological abuse and educational status, which inferred that as the level of education increases perception of psychological abuse also increases.
6	(Gaikwad et al., 2011)	To find out the prevalence of elder abuse and its relationship with depression in the rural community	Cross sectional	Systematic random sampling	127 aged 60+	Interview Instrument: own questionnaire	Descriptive analysis	Overall prevalence (40.94%); Physical (18.89); Psychological (37.79%); Financial (30.71). Elder abuse was significantly associated with depression ($p < 0.001$). None of the victim reported abuse to authorities or sought help with it.
7	(Tareque et al., 2015)	to examine the distribution of wealth and then tests association between elder abuse and wealth.	Cross sectional survey	Random sampling	896 respondents, (477 rural areas and the rest from urban areas; 60+ years	Interviewer based questionnaire Instrument: own questionnaire	Descriptive ; PCA; logistic regression	62% people from poor household face abused compare to 6% from rich household; Neglect (59.7% vs. 17.79%); Emotional abuse (6.11% vs 5.35%); Abandonment (67% vs 1.22%); Physical abuse (3.06% vs 1.22%); and Sexual abuse (0%). Marital status, place of residence, and educational

								status were associated to abuse. Older people living in urban areas and have a higher education level were less likely to face abuse.
8	(Rahman et al., 2010)	To explore the causes and determinants of elderly abuse	Cross sectional	probability proportional to size (PPS) Sampling.	743 elderly above 60 + years of age	Interview Instrument: Own questionnaire	Univariate analysis; logistic regression	Overall prevalence = 27.2%; mental (76.7%), economical (3.0%), and physical (1.0%). Significant factors associated with abuse were gender (female), level of education (no education), widow, not working, and unhealthy.
9	(Nagpaul, 1997)	to examine different perspectives of elder abuse in the context of traditional and modern cultural values in New Delhi, India & Ohio, US	Qualitative	Not clear	20 families; 2 FGD (1x Age 55-65 and 2 age 24 – 35 yrs)	Informal interviews, Participant observation, Archives and 2 focus group discussions	Not clear	Participants responded to various case studies. Findings were around psychological abuse (e.g. purposeful indifference), physical abuse (no data presented), financial abuse; women discriminated against because of low status in religion and culture. Interesting comparisons between young group of participants and old.
10	(Chokkanathan et al., 2014)	To understand why older persons abused by their family members in India do not seek help.	Qualitative	Selective sampling	six adults aged 65 years and above who had been physically abused	In-depth interviews over three visits	Thematic analysis	The barriers preventing a person from seeking help were service-related (accessibility, and lack of trust); religious (Karma); family (deleterious effects on family, family members' responses to help seeking); individual (socioeconomic

								dependency, self-blame).
1 1	(Bowes et al., 2012a)	Identify the impact of cultural diversity on understandings of EM, and to explore the implications of diverse understandings for the provision of service to older people and their carer in an ethnically diverse society.	Qualitative	Opportunistic sampling strategy	28 service providers and 58 BME (South Asian, Chinese, African Caribbean, White European)	semi-structure Interviews and Seven focus group discussion	Thematic analysis	Five (9%) disclose experienced themselves abused. Awareness of different types of mistreatment varied; lack of respect (74%), psychological (72%), verbal (64%), neglect (10%), physical (41%), and sexual (5%). Family pressure, caregiver stresses were reported cause elder mistreatment. Forty-six (81%) respondents would do nothing about EM. Reasons included cultural factors, shame, dependency, fear, lack of alternatives, and wider social exclusion. Service provider's perspectives were to connect with local BME communities, develop cultural competence, and involve in multi-agency working. Challenges were colour-blind approach, funding and BME links.
1 2	(Dildar and Saeed, 2012a)	To explore the nature of abuse against elderly in district Gujrat, Pakistan.	Qualitative	Purposive	13 women and men aged 60+	semi-structured interviews	Thematic analysis	Main themes were psychological abuse and financial abuse, other themes were neglect and physical abuse
1 3	(Ploeg et al., 2013)	To explore the definition and perception of elder abuse among marginalized groups	Qualitative	Purposive	87 participants	10 Focus groups	Descriptive analysis	Participants were able to identify traditional forms of elder abuse – physical, sexual, psychological,

								financial and neglect. Participants also considered less frequent abuses – systematic or government abuse
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Empirical Studies those indicate RF or were relevant but not focused on EM					
	Authors	Objective	Methodology	Findings	
1	(Grewal et al., 2004)	To identify the factors that influence the quality of life of older people from ethnic minority groups	Design: Qualitative Settings: Dallas Fort, US Sample: 73; age 60 -74 years; Pakistani, Indian, Caribbean, and White English Data Collection: In depth interviews	Six factors identified influencing their quality: having a role, support network, income and wealth, health, having time, and independence	
2	(Katbamna et al., 2004)	Explore South Asian carers' experiences of informal support	Design: Qualitative Settings: Sample: 105 South Asian (Punjabi Sikh, Pakistani, Bangladeshi, and Gujarati Hindu) carers. Data Collection: In-depth Interview and FGD	Limited for carer in extended and nuclear families. Social norms hinder help seeking.	
3	(Ahmad and Walker, 1997)	Explore the experiences of housing, health and access to services for older Asian people.	Design: Survey Settings: Bradford, UK Sample: 104 Asian older people from four Asian populations, Pakistani, Bangladeshi, Indian Sikhs and Indian Hindus Data collection: interviews	Poverty, limited entitlements, inadequate housing, low level of knowledge of health and social service, and problems of access to welfare benefits, health and social care were highlighted findings. Also divided families caused by restrictive immigration rules, resulting elders low family support in UK	
4	(Parveen et al., 2013)	Effects of ethnicity on caregiver motivations, coping responses and mood	Design: Cross sectional Survey Settings: UK Sample: 235 family caregiver; 162 White British and 73 South Asian Data collection; Questionnaire	South Asian caregivers were younger, had high level of familism, and used behavioral disengagement and religious coping.	
5	(Ng and Northcott, 2015)	Examine the relationship between self reported loneliness and living arrangements	Design: Survey Settings: Edmonton, Canada Sample: 161 older people age 60 and over; South Asian Data collection; interviews	More than one in three respondents indicated feeling lonely occasionally, frequently or all of the time; those living with others, it was amount of waking time spent alone at home and the quality of family relationships rather than living arrangement per se that significantly predicted self-reported loneliness	
	Authors	Objectives	Methodology	Results	
1	(Jamuna, 2003)	Examine issues of elder care and elder abuse in the Indian context	Design: literature review Settings: India Sample: Not given	Poverty, degeneration, dependency and past relationship are significant factors related to elder abuse in India. Focuses on materialism, modernism and individualism	



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Of
Sheffield.

Appendix 6:

Invitation Letter

Treatment of older people in Pakistani communities

Dear

I am writing to ask for your help with an important study. The study will focus on the life experience and well-being and treatment of older people from Pakistani background.

I would like to interview people who are community/religious leader or member of charity about a range of issues, such as what is the treatment of older people, what are your experiences of interacting with older peoples from Pakistani communities, and problems older people from Pakistani communities face and their use of informal and formal help seeking.

Taking part in the study is voluntary, but I hope that you will be willing to help. All the interviews or discussion will be treated with strict confidence, in accordance with the Data Protection Act. This study involves taking part in 30 to 45minutes face to face interview with the researcher. A £10 gift voucher will be presented in recognition of your time and inconvenience.

I am a PhD student, at University of Sheffield. This study forms part of my PhD program.

In the meantime, if you have any queries about the study please contact me at 07756128944

Thank you for your help

Yours sincerely

A handwritten signature in black ink that reads 'Ashfaque'.

Ashfaque Talpur

Primary Researcher

Email: Ashfaque.talpur@sheffield.ac.uk

Address: The University of Sheffield, Barber House Annexe, 3a Clarkehouse Road, Sheffield, S10 2LA.

Appendix 7:
Introduction of Research Participants

Category One: Older People:

Mr Hasan:

Mr Hasan is 73 years old gentlemen. He was born in Pakistan and moved to the UK when he was very young. He had no formal education; however, he did some language and mechanic courses at his early stage of life in the UK. He is married and has five children. They all are married and live separately. Mr Hasan lives with his wife and he is the main carer for her as she is unwell. He is now retired; however, he works as volunteer for a charity.

Mr Khalid:

Mr Khalid is 62 years old gentlemen. He is educated up to primary school. He was born in Pakistan and moved to the UK when he was just about 10 years old. He is married and has children and grandchildren. He lives with his wife and his children.

Mr Suhail:

Mr Suhail is 79 years old gentlemen. He is educated up to Matric level. He was born in Pakistan. He is married and lives with his wife. His children are all married. He is retired and lives on his pension. He spends his days going to mosque five times a day to offer Namaz (prayers) and visit friends in local community centres.

Mr Nabeel:

Mr Nabeel is 56 years old gentlemen. He was born in Pakistan and came to the UK when he was young child. He is married and live with his wife and children He holds a diploma. He is currently employed and works in the hospital.

Ms Janat

Mr Janat is 60 years old lady. She was born in Pakistan and came to the UK about 50 years ago. She is divorced and lives with her son. She spends her day visiting others in neighbourhood or local charity. She is unemployed and lives on social benefits.

Ms Rahila.

Ms Rahila is 56 years old women. She is educated up to 11th class in Pakistan. She was born in Pakistan and came to the UK as dependent to her husband. She is divorced and lives on her own. She gets social benefits for housing and income.

Ms Zeenat:

Ms Zeenat is 67 years old women. She was born in Pakistan and moved to the UK about 50 years ago. She is a widow and lives with two grandsons. She spends her days by visiting a local centre, or local mosque, or someone's house in the neighbourhood.

Ms Sabreen:

Ms Sabreen is 56 years old lady. She was born in Pakistan and came to the UK with her husband. She has studied up to diploma level and currently working in the hospital. She is married and lives with her husband and a son.

Category Two: Young people:**Mr Usman:**

Mr Usman is 48 years old gentleman. He was born in the UK. He studied law at the University of Sheffield and currently working as self-employed. He is also the main carer of her mum. He has been looking after his mum for last 12 years. He has arthritis and difficulty in walking.

Ms Zohra:

Ms Zohra is 19 years old young lady. She was born in the UK. She is single and lives with her mum. She went up to college and has got level three diploma. She works full time in a store. She is the main unpaid carer of her mum.

Ms Amina:

Ms Amina is 25 years old lady. She was born in Pakistan but have been living in the UK for last ten years. She is single and lives with her parents. She is also unpaid carer for her mother,

who suffer from chronic back pain, high blood pressure and diabetes. Her daily routine varies and often revolves around going to work, studying, doing household work, taking mum to appointments and providing her care she needed.

Ms Sadaf:

Ms Sadaf is 43 years old women. She was born in Pakistan but moved to the UK when she was a little baby. She is educated up to GCSE. She is married and lives with her husband, children and mother in law. She is full time mum and full-time unpaid carer for her mother in law. Her mother in law suffer multiple health problems and has limited mobility. She spends day by dropping and picking up children from school then in the evening to mosque, doing all household work, and providing care to mother in law. She is also keen practicing Muslim, offer prayers five times a day.

Mr Muhammad:

Mr Muhammad is 46 years old gentleman. He was born in the UK. He has done BA in marketing and working as self-employed. He is married and lives with his wife and children. He looked after his dad for about 20 years and his father was bedridden. His father is passed away, but Mr Muhammad is currently looking after his mum who is problems with her mobility.

Mr Javeed:

Mr Javeed is 37 years old gentleman. He was born in Pakistan, however, has been living in the UK for last 15 years. He is educated up to diploma level and works in the hospital. He is married and lives with children and his mother. He spends his day by going to work and looking after children and parents.

Category Three: Stakeholders

Mr Akash

Mr Akash is 58 years old gentleman. He is councillor in a ward, where Pakistanis are densely populated. He also works with a lot of voluntary organisations. He has also worked as an employee and then non-executive director of a local charity. He was also the main unpaid carer of his both parents when they were alive.

Ms Mariam

Ms Mariam declined to disclose her age.. She was born in the UK.. She did not mention her education. She works as development worker for a charity. Charity works for Asian women only and have multiple resources for information, capacity building and skills developments.

Mr Zubair:

Mr Zubair is 34 years old gentleman. He was born in the UK. He is Muslim. He works as Independent Living Coordinator (ILC) for a charity in Sheffield. He also works as an Imam and teacher for a mosque. As an ILC at local charity, he provides information, advice and support to older population on different health and social needs including housing, benefit, care, and other services. As an Imam and teacher, his role involves giving children Islamic education.

Mr Waqar:

Mr Waqar did not disclose his age. He is Muslim. He works as a senior Imam at a local Mosque. He was born in Pakistan but now settled in the UK. His main role involves teaching children Islam and lead the prayers five times a day and organize or attend religious gatherings. As a religious leader, he is often presented with family and community problems in the mosque, where he guides and resolves these issues with religious guidelines.

Mr Mubarak:

Mr Mubarak is 27 years old gentleman. He is a councillor where Pakistanis are densely populated. Besides being a councillor, he works with different community associations and charities, most of them working on mental health issues in the communities.

Mr Umar

Mr Umar is 44 years old gentleman. He was born in Pakistan but have been living in the UK for last 15 years. He is executive member of a charity. The charity works for improving the culture and educate people on integrating to the values of the UK. Charity work also involved improving intergenerational relationships in the community.

Mr Arshad

Mr Arshad is 49 years old gentleman. He was born in Sheffield, UK. However, he has spent brief part of his life in Pakistan for education. He works for a local mosque and different other charities. He also runs a group called 'Elder Muslim group' of male Muslims age 55 and over every fortnight with a charity.

Mr George

Mr George is 70 years old gentleman. He is councillor. He is involved with different charities; however, the main charity he volunteers for is Sheffield Hospice. He also runs a group in local area.

Appendix 8:

Topic Guide – Interview – Stakeholders (First)

The purpose of this research study is to explore the understanding of South Asian men and women about the elder treatment in family care giving and relationships.

There are three key research objectives: to explore,

- Understanding and perspective of elder mistreatment
- Risk perception and risk indicators of elder mistreatment in family dynamics and traditions
- Barriers and facilitators in taking action

1. Introduction and consent

- Introduce to self and the research
- Clarify the content of the interview
- Explain confidentiality and gain verbal consent
- Length of interview (1 hour with breaks) and recording, and nature of discussions
- Remind participant of £10 gift voucher as thank you for their time and help
- Check whether have any question and happy to continue

2. Background (Demographic) data

- Age.....
- Area/Location.....
- Educational achievement.....
- Gender.....
- Religion.....
- Ethnicity.....
- Country of Birth.....
- Name of organization.....
- Job title or role of respondent.....

3. Understanding of elder mistreatment

- Perspective and definition of mistreatment
- Types of mistreatment
- Reasons of mistreatment and who is more likely to experience mistreatment – gender, age
- Any experience personal or others of mistreatment
- Impact of mistreatment

4. Barriers and facilitator of mistreatment

- What are/should be coping mechanism in face of abuse
- What are the first and or best channels of support/reporting
- Awareness of support services/help
- What stops in seeking help

5. Services/role related:

- Description of activities
- Services provided for older people,
- Experience of working with mistreated SA older people
- Responds to EM
- Any training received on EM

Interview probes

Can you tell me more about that?

Can you give me an example?

So you are saying...?

Have you always felt this way?

What is significant about this to you?

How so?

How has your approach changed over time?

And what do you think of that approach?

Appendix 9:

Topic guide - Focus group discussion - Older people (First)

The purpose of this research study is to explore the understanding of South Asian men and women about the elder treatment in family care giving and relationships.

1. Introduction and consent

- Introduce to self and the research
- Clarify the content of the interview
- Explain confidentiality and gain verbal consent
- Length of focus group and recording, and nature of discussions
- Remind participant about refreshment (break)
- Check whether have any question and happy to continue

2. Background (Demographic) data

- Age.....
- Area/Location.....
- Religion.....
- Ethnicity.....
- Country of Birth.....

3. Topics

- Talk about Health (interpretations, meanings, views, knowledge)
Health in general, health changes in old age,
- Talk about migration
Life in new country, comparison between country, acculturation, lifestyle,
- Talk about treatment of older people
Views about older people care, role and responsibilities in care and in family
- Health care services
Access, availability, facilities, difficulties
- Hypothetical statements (Appendix 9)

Appendix 10:

Topic Guide - Interview -Older people and unpaid carers (First)

The purpose of this research study is to explore the understanding of South Asian men and women about the elder treatment in family care giving and relationships.

There are three key research objectives: to explore,

- Understanding and perspective of elder mistreatment
- Risk perception and risk indicators of elder mistreatment in family dynamics and traditions
- Barriers and facilitators in taking action

1. Introduction and consent

- Introduce to self and the research
- Clarify the content of the interview
- Explain confidentiality and gain verbal consent
- Length of interview (1 hour with breaks) and recording, and nature of discussions
- Remind participant of £10 gift voucher as thank you for their time and help
- Check whether have any question and happy to continue

2. Background (Demographic) data

- Age.....
- Area/Location.....
- Educational achievement.....
- Gender.....
- Religion.....
- Ethnicity.....
- Country of Birth.....
- Living arrangements (living alone or with someone)
- Marital status: (married, sing, widowed, divorced)
- Economic status/occupation
- Caregiving responsibilities
- Day to day living (social life and activities, receipt of health and social care support, daily routine) and social contacts
- Health (general – dependency/longstanding illness, mental health, and any alcohol consumption)

3. Family dynamics and traditions

- Different culture roles and definitions
- Family and community role in conflicts and care
- Compare the treatment of older people in the country of origin and the UK
- Views about Care homes and institutionalizing of older person

4. Social structure and processes

- Migratory experiences; bad and good both
- Views on Traditionalism and Modernism
- Factors influence on the treatment of older people (probe culture, religion, and other social norms)
- Understanding and interpretations of health and wellbeing and ageing

4. Hypothetical Statements

- Scenarios (Appendix 8)

5. Understanding of elder mistreatment

- Perspective and definition of mistreatment
- Types of mistreatment
- Reasons of mistreatment and who is more likely to experience mistreatment – gender, age
- Any experience personal or others of mistreatment
- Impact of mistreatment

6. Barriers and facilitator of mistreatment

- What are/should be coping mechanism in face of abuse
- What are the first and or best channels of support/reporting
- Awareness of support services/help
- What stops in seeking help

7. Care giving and Care giving stresses (for unpaid carers only)

- Feelings/willingness in providing care to your family member
- Motivating and discouraging factors in care giving
- Views about Care homes and institutionalizing parents/partner
- Experiences of health and social care services
- Factors cause stress while providing care to your older family member

Interview probes

Can you tell me more about that?

Can you give me an example?

So you are saying...?

Have you always felt this way?

What is significant about this to you?

How so?

How has your approach changed over time?

And what do you think of that approach?

Appendix 11:

Topic Guide – Interview – Stakeholders (Revised)

The purpose of this research study is to explore the understanding of Pakistani men and women about the elder treatment in family care giving and relationships.

There are three key research objectives: to explore,

- Understanding and perspective of elder mistreatment
- Risk perception and risk indicators of elder mistreatment in family dynamics and traditions
- Barriers and facilitators in taking action

1. Introduction and consent

- Introduce to self and the research
- Clarify the content of the interview
- Explain confidentiality and gain verbal consent
- Length of interview (1 hour with breaks) and recording, and nature of discussions
- Remind participant of £10 gift voucher as thank you for their time and help
- Check whether have any question and happy to continue

2. Background (Demographic) data

- Age.....
- Gender.....
- Religion.....
- Name of organization.....
- Job title or role of respondent.....

3. Understanding of elder mistreatment

- Perspective and definition of mistreatment
- Reasons of mistreatment and who is more likely to experience mistreatment – gender, age
- Impact of mistreatment

4. Barriers and facilitator of mistreatment

- What are the first and or best channels of support/reporting
- Awareness of support services/help
- What stops in seeking help

5. Services/role related:

- Description of activities
- Services provided for older people,
- Experience of working with mistreated Pakistani older people

- Responds to EM
- Any training received on EM

Interview probes

Can you tell me more about that?

Can you give me an example?

So you are saying...?

Have you always felt this way?

What is significant about this to you?

How so?

How has your approach changed over time?

And what do you think of that approach?

Appendix 12:

Topic guide - Focus group discussion - Older people (Revised)

Welcome:

Thanks for agreeing to be part of the focus group. We appreciate your willingness to participate.

Introduction:

Moderator(s)

Purpose of focus group

The reason we are having this focus group is to explore the understanding of Pakistani men and women about elder treatment in family care giving and relationships.

Ground rules:

1. I want you to do talking. I would like everyone to participate
2. There is no right or wrong answers, every person's experiences and opinions are important
3. I would like to stress that we want to keep the session confidential, so I ask that you not use names or anything directly when you talk about your personal experiences. I also ask you not to share your personal experiences of elder mistreatment. If you have had experienced mistreatment, please see me after the focus group and we will have chat about it. We also ask that you do not discuss other participants' responses outside of the discussion. However, because this is in a group setting, the other individuals participating will know your responses to the questions and we cannot guarantee that they will not discuss your responses outside of the focus group.
4. I will be tape recording the group. We/I do not identify anyone by names in our report. You will remain anonymous.

3. Topics

- Talk about Health (interpretations, meanings, views, knowledge)
Health in general, health changes in old age,
- Talk about migration
Life in new country, comparison between country, acculturation, lifestyle,
- Talk about treatment of older people
Views about older people care, role and responsibilities in care and in family
- Health care services
Access, availability, facilities, difficulties
- Hypothetical statements

Appendix 13:

Topic Guide - Interview - Older people and unpaid carers (Revised)

The purpose of this research study is to explore the understanding of Pakistani men and women about the elder treatment in family care giving and relationships.

There are three key research objectives: to explore,

- Understanding and perspective of elder mistreatment
- Risk perception and risk indicators of elder mistreatment in family dynamics and traditions
- Barriers and facilitators in taking action

1. Introduction and consent

- Introduce to self and the research
- Clarify the content of the interview
- Explain confidentiality and gain verbal consent
- Length of interview (1 hour with breaks) and recording, and nature of discussions
- Remind participant of £10 gift voucher as thank you for their time and help
- Check whether have any question and happy to continue

2. Background (Demographic) data

- Age.....
- Educational achievement.....
- Gender.....
- Country of Birth.....
- Living arrangements (living alone or with someone)
- Marital status: (married, sing, widowed, divorced)
- Economic status/occupation

3. Family dynamics and traditions

- Different culture, family/community roles and definitions
- Compare the treatment of older people in the country of origin and the UK
- Views about Care homes and institutionalizing of older person

4. Social structure and processes

- Migratory experiences; bad and good both
- Views on Traditionalism and Modernism
- Factors influence on the treatment of older people (probe culture, religion, and other social norms)

4. Hypothetical Statements

5. Understanding of elder mistreatment

- Perspective and definition of mistreatment
- Reasons of mistreatment and who is more likely to experience mistreatment – gender, age
- Any experience personal or others of mistreatment
- Impact of mistreatment

6. Barriers and facilitator of mistreatment

- What are/should be coping mechanism in face of abuse
- What are the first and or best channels of support/reporting
- Awareness of support services/help
- What stops in seeking help

7. Care giving and Care giving stresses (for unpaid carers only)

- Feelings/willingness in providing care to your family member
- Motivating and discouraging factors in care giving
- Views about Care homes and institutionalizing parents/partner
- Experiences of health and social care services
- Factors cause stress while providing care to your older family member

Interview probes

Can you tell me more about that?

Can you give me an example?

So you are saying...?

Have you always felt this way?

What is significant about this to you?

How so?

How has your approach changed over time?

And what do you think of that approach?

Appendix 14:

Methodological Journal Entry and Memo on '*Gender and family caregiving*'

Journal Entry: 23/03/2017:

Focus group with Male participants:

Very interesting focus group discussion with older Pakistani people. Similar to female focus groups last week, family caregiving emerged important notion to older people, particularly when they are now living in a foreign county and have limited family or community presence. In family caregiving, gender plays pivotal role in Pakistani families. It was interesting observation when I presented a question to participants in focus group; that what if older parent had no son to provide care in their old age. All participants went silent for a while and one of them taking long deep breath, in a pity voice said, Allahu Akbar (God is most great), suggesting how sad it would be for old parents not to have son.

Memo writing: 12/04/2017

I wrote this memo, while still transcribing and revisiting transcripts of data.

In Pakistani communities, son is considered as main source of support in old age. Therefore, from the beginning, the married couple prefer to have male child in the family. Parents invest disproportionately into son, in terms of time, teachings, and resources, assuming once old, their son will be there to look after them. In this process of child growing up, parents trained their sons the importance of familism, elder veneration, and religious obligations to parents. Furthermore, in Asian families, after marriage, daughter leaves the parents' house to live with her husband or her in laws house. Whereas, when a son gets married, he brings wife to parents' house. Care of older person is assumed as collective responsibility of son and daughter in law. These are some of the reasons, that Pakistani people prefer to have son; an old-age security.

Appendix 15:

Memo: Gender and perspective of Elder Mistreatment

Date: 20/04/2017

How men and women see elder mistreatment in Pakistani communities varies significantly. Women does not see elder mistreatment as it happens; she tends to foresee the consequence within it. Since the socioeconomic status of migrant Pakistani woman is underprivileged, she appears to evaluate her position, powers, relationships and significant other factors before processing to contemplate the mistreatment or any other wrong doings. It seems simply difficult for her to call mistreatment or abuse as abuse; she goes through a complex mechanism to position herself vulnerable.

For instance, if indulging into an argument or physical clash with her children or husband, leads to abandonment, she would probably normalize the abuse, or labels it normal household issue, or blamed as heat or time of a conflict, or simple misunderstanding rather than claiming to be victim of mistreatment.

Need to ask further questions, specific to gender and mistreatment to develop the category.

Appendix 16 Ethics- letter of approval



Downloaded: 28/08/2019
Approved: 23/01/2017

Ashfaque Talpur
Registration number: 150122166
School of Nursing and Midwifery
Programme: PhD

Dear Ashfaque

PROJECT TITLE: Understanding Elder Mistreatment in Pakistanis who are living in the UK. A Constructivist Grounded Theory Study

APPLICATION: Reference Number 012313

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 23/01/2017 the above-named project was **approved** on ethics grounds, on the basis that you will adhere to the following documentation that you submitted for ethics review:

- University research ethics application form 012313 (dated 04/01/2017).
- Participant information sheet 1025883 version 2 (21/12/2016).
- Participant information sheet 1025884 version 2 (21/12/2016).
- Participant information sheet 1025885 version 2 (21/12/2016).
- Participant consent form 1025886 version 2 (21/12/2016).

If during the course of the project you need to [deviate significantly from the above-approved documentation](#) please inform me since written approval will be required.

Yours sincerely

Parveen Ali
Ethics Administrator
School of Nursing and Midwifery

Appendix 17:

Participant Information sheet – Interview - Stakeholders (revised)

Title of the study: Treatment of older people in Pakistani communities who are living in the UK

Investigator: Mr. Ashfaque Talpur (Principal investigator)

Prof. Tony Ryan (Lead Supervisor)

Dr. Sharron Hinchliff (Co-Supervisor)

Department: School of Nursing and Midwifery, University of Sheffield, Sheffield, UK.

You are being invited to take part in this research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. You will be given **£10 gift voucher** as a thank you for your time. Thank you for reading this.

Purpose of the study:

This study is about how older people age 55 and over from Pakistani ethnic minority groups are treated within their family care giving settings and relationships as well in the wider society. The study objectives also include exploring/understanding the perspective, knowledge, and services provided about elder mistreatment by community stakeholders that include religious leaders, community leader, and the members of community charity organizations.

What does taking part in the research involve?

The research involves taking part in an individual interview with the researcher, held at place of your preference. Before interview, you will be given the opportunity to ask any questions about the research and be asked to sign a consent form. The interview is expected to last for approximately 1 hour. In the interview, you will be asked about your views regarding the elder mistreatment in Pakistani communities.

Do I have to take part?

Participation is entirely voluntary. It is up to you to decide whether or not to take part in the research. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You can still withdraw from the study at any time without it affecting any benefits that you are entitled to in any way. You do not have to give a reason. You are free to refuse to answer some or all the questions if you do not feel comfortable with those questions.

What are the possible disadvantages and risk of taking part?

The study involves no physical risk to participants. It may raise some questions that you would like to talk over. The interview will be stopped if you show any sign of being distressed or if you ask for it. Your wishes to terminate the interview will be respected.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that the information provided will help building evidence on the perspectives and experiences of any mistreatment or difficulties older people and their care providers' face in family caregiving relationships. This will in turn help in identifying the culture/context appropriate service needed to address the concerns of this age group of people.

Will my participation be confidential?

All information about you collected during the study will be kept strictly confidential and stored in accordance with the Data Protection Act. The only people who will have access to information about you will be members of the research team. All data (anonymised transcriptions and consent forms), whether electronic or paper or in any other form will be destroyed by December 2021.

What will happen to the results of the research?

The findings of this research will be presented in a short report and will be made available to all study participants. A detailed report of the research will form part of a PhD thesis, which will be available at the University of Sheffield's library. Please note that individual participants will not be identified in any report or publication from this research.

Who has ethically reviewed the research?

The University of Sheffield's Research Ethics Committee has approved the research

Contact for further information

Ashfaque Talpur, PhD student, School of Nursing and Midwifery, University of Sheffield, Barber House Annexe, 3a Clarkehouse Road, Sheffield, S10 2LA; Work Number: 07756128944; Email: ashfaque.talpur@sheffield.ac.uk

Some useful numbers:

Action on Elder Abuse: 08088088141

Sheffield Adults Safeguarding 01142736870

Age UK: 08001692081

NHS services: 111

Thank you taking time to read this information sheet. You will be provided with a copy of this information sheet and a signed and dated copy of the consent form to keep. A second copy will be kept for research project records.

Appendix 18:

Participant information sheet – focus group – older people

Title of the study: Treatment of older people in Pakistani communities who are living in the UK

Investigator: Mr. Ashfaque Talpur (Principal investigator)

Prof. Tony Ryan (Lead Supervisor)

Dr. Sharron Hinchliff (Co-Supervisor)

Department: School of Nursing and Midwifery, University of Sheffield, Sheffield, UK.

You are being invited to take part in this research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Refreshments will be provided at the end of focus groups.

Purpose of the study:

This study is about how older people age 55 and over from Pakistani ethnic minority group is treated within their family care giving settings and relationships as well in the wider society. The primary aim of this study is to explore the understanding of Pakistani men and women about difficulties, life experiences, and family interactions in relation to old age.

What does taking part in the research involve?

Your participation will involve contributing your thoughts and ideas in a group discussion (focus group) that will take approximately 45 – 90 minutes of your time. Focus group will be consists of 6 – 10 participants. Topics will include about health concerns in old age, migration, acculturation, and growing old in the UK, and the treatment of older people in the UK. Some hypothetical statements (cases) about elder treatment will also be shared to get participant's interpretations. Focus group will take place at date, time, and venue convenient to all participants. The focus group will be audio-recorded. Before focus group, you will be given the opportunity to ask any questions about the research and will be asked to sign a consent form.

Do I have to take part?

Participation is entirely voluntary. It is up to you to decide whether or not to take part in the research. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form and you can still withdraw at any time without it affecting any benefits that you are entitled to in any way. You will be unable to withdraw data collected about yourself after you have participated in the focus group.

What are the possible disadvantages and risk of taking part?

The study involves no physical risk to participants. It may raise some questions/issues that you would like to talk over. You will be advised not to disclose any personal experiences of elder mistreatment during the focus groups.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that the information provided will help building evidence on the perspectives and experiences of any mistreatment or difficulties older people and their care providers' face in family caregiving

relationships. This will in turn help in identifying the culture/context appropriate service needed to address the concerns of this age group of people.

Will my participation be confidential?

All comments and responses will be treated confidentially unless required by law. However, because this is in a group setting, the other individuals participating will know your responses to the questions and we cannot guarantee that they will not discuss your responses outside of the focus group.

The only people who will have access to information about you will be members of the research team.

What will happen to the results of the research?

The findings of this research will be presented in a short report and made available to all study participants. A detailed report of the research will form part of a PhD thesis, which will be available at the University of Sheffield's library. Please note that individual participants will not be identified in any report or publication from this research.

Who has ethically reviewed the research?

The University of Sheffield's Research Ethics Committee has approved the research

Contact for further information

Ashfaque Talpur, PhD student, School of Nursing and Midwifery, University of Sheffield, Barber House Annexe, 3a Clarkehouse Road, Sheffield, S10 2LA; Work Number: 07756128944; Email: ashfaque.talpur@sheffield.ac.uk

Some useful numbers:

Action on Elder Abuse:	08088088141
Sheffield Safeguarding Adults	01142736870
Age UK:	08001692081
NHS services:	111

Thank you taking time to read this information sheet. You will be provided with a copy of this information sheet and a signed and dated copy of the consent form to keep. A second copy will be kept for research project records.

Appendix 19:

Participant information sheet – interview – older people and unpaid (revised)

Title of the study: Treatment of older people in Pakistani communities who are living in the UK

Investigator: Mr. Ashfaque Talpur (Principal investigator)

Prof. Tony Ryan (Lead Supervisor)

Dr. Sharron Hinchliff (Co-Supervisor)

Department: School of Nursing and Midwifery, University of Sheffield, Sheffield, UK.

You are being invited to take part in this research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. You will be given **£10 gift voucher** as a thank you for your time. Thank you for reading this.

Purpose of the study:

This study is about how older people age 55 and over from Pakistani ethnic minority groups are treated within their family care giving settings and relationships as well in the wider society. The primary aim of this study is to explore the understanding of Pakistani men and women about difficulties, life experiences, and family interactions in relation to old age.

What does taking part in the research involve?

The research involves taking part in an individual interview with the researcher, held at place of your preference. Before interview, you will be given the opportunity to ask any questions about the research and be asked to sign a consent form. The interview is expected to last for approximately 1 hour. In the interview, you will be asked about your views regarding the elder mistreatment in family caregiving and community/society interactions.

Do I have to take part?

Participation is entirely voluntary. It is up to you to decide whether or not to take part in the research. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form and you can still withdraw at any time without it affecting any benefits that you are entitled to in any way. You do not have to give a reason. You are free to refuse to answer some or all the questions if you do not feel comfortable with those questions.

What are the possible disadvantages and risk of taking part?

The study involves no physical risk to participants. It may raise some questions that you would like to talk over. The interview will be stopped if you show any sign of being distressed or if you ask for it. Your wishes to terminate the interview will be respected. Participant who appear to need help will be advised to seek professional help from their GPs or can be signposted to other sources of help and advice.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that the information provided will help building evidence on the perspectives and experiences of any mistreatment or difficulties older people and their care providers' face in family care giving relationships. This will in turn help in identifying the culture/context appropriate service needed to address the concerns of this age group of people.

Will my participation be confidential?

Everything that is discussed in the interview remains confidential. The only people who will have access to information about you will be members of the research team. All data (anonymised transcriptions and consent forms), whether electronic or paper or in any other form will be destroyed by December 2021.

Confidentiality would only be broken if it was felt that you were at risk of harm. In such circumstances you will be fully advised of any actions taken by the research team in contacting other professionals about help and support you may require.

What will happen to the results of the research?

The findings of this research will be presented in a short report and made available to all study participants. A detailed report of the research will form part of a PhD thesis, which will be available at the University of Sheffield's library. Please note that individual participants will not be identified in any report or publication from this research.

Who has ethically reviewed the research?

The University of Sheffield's Research Ethics Committee has approved the research

Contact for further information

Ashfaque Talpur, PhD student, School of Nursing and Midwifery, University of Sheffield, Barber House Annexe, 3a Clarkehouse Road, Sheffield, S10 2LA; Work Number: 07756128944; Email: ashfaque.talpur@sheffield.ac.uk

Some useful numbers:

Action on Elder Abuse: 08088088141

Sheffield Safeguarding Adults: 01142736870

Age UK: 08001692081

NHS services: 111

Thank you taking time to read this information sheet. You will be provided with a copy of this information sheet and a signed and dated copy of the consent form to keep. A second copy will be kept for research project records.

Appendix 21:

Data management plan (DMP) for PhD study

Title of Research	Understanding Elder Mistreatment in Pakistani who are living in the UK: A Constructivist Grounded Theory Study
Principal Investigators	Ashfaque Talpur
Supervisors	Dr Tony Ryan and Dr Sharron Hinchliff
Institution	The University of Sheffield
Proposed duration of the research	20 th December 2016 – 19 December 2019

The data storage, use, disclosure or destroying will comply with the requirement of Data Protection Act 1998 and information governance policies of the University of Sheffield.

This DMP is written using DMPOnline tool from the Digital Curation Center and the plan is reviewed by Research Data Management (RDM), University of Sheffield.

Data Collection:

The researcher intends to collect qualitative data. The data will be comprised of transcribed audio recordings of about 40 in-depth individual interviews and two focus group discussions with research participants and taking observation/reflection notes. Field data will be consisting of digital audio recordings, paper documents such as consent forms, and field notes. Digital audio recording device (Olympus LS-P1) will be used to collect/record data with the permission of the research participants. Digital recordings will be in WAV (Waveform Audio Format) and will be uploaded to password-protected computers within the University of Sheffield for transcriptions. Audio files will be transcribed verbatim and checked for accuracy, and then original audio files will be deleted. Professional transcribers will also be used to do some transcribing if needed. Audio files transcribed by transcribers will be deleted once PI has checked and satisfied. All transcriptions will be anonymized. All the transcription will be in MS word, and they will be categorized and coded using MS Excel or NVivo or Quirko format. The decision around format is based on researcher's expertise in the softwares. The data files will be stored in a format accepted by the UK Data Archive for deposited data. Acceptable format for sharing, reuse, and preservation for qualitative/textual data will be used such as RTF, TXT, DOC/DOCX, and HTML. Data will be organized in three folders; each for individual interviews, focus group discussions, and observation/reflection notes. Data file names will be kept brief and version numbering in file names will be used to indicate file reversion or editing. Data will be full documented, and definitions of key terms or variables will be indexed to aid secondary users/supervisory team understand the data well, if there are confusions.

Ethics and legal compliance:

The information sheet explaining the purpose, approach, and dissemination of the research, and accompanying consent forms will be used to ensure informed consent is obtained from research participants to permit long-term preservation and sharing of the anonymised data.

A clear verbal explanation will also be provided to each interviewee and focus group participant.

Storage and Backup:

The researcher will use Google Drive space (provided by university) for the storage, backup and access of the data. Google Drive has unlimited storage and can only be accessed with user/researcher logging in. In addition to this, the PI has requested space in Standard Research Storage (SRS) that will be used to store research data. SRS is free, 10GB data storage facility by the university, which is centrally managed by CiCS where data is kept secure and is backed up to protect against disasters and failures, for example, if data is accidentally deleted or corrupted.

If PI request is declined for SRS space, PI will use University Filestore, allocated to students and staffs. Filestore is also unlimited storage space that is managed by CICS and it is secured and backed up regularly.

Selection and Preservation:

The raw data of audio files of focus group discussions and individual interviews will be destroyed once transcribed and checked for accuracy. Transcription will be fully anonymised and therefore where consent has been given, will be appropriate for sharing. To enable sharing and long-term access, data and associated documentation will be archived in ORDA (Online Research Data) repository. ORDA is a repository for managing and sharing University of Sheffield research data. The digital research data in ORDA will be preserved for about 5 years. The researcher has already opened an account in the repository with the project name. Data in ORDA is openly accessibly to anyone under CC-BY license.

Data Sharing:

Data generated through this project will form part of PhD thesis, which will be available at the University of Sheffield's library and at White Rose Research Online. Digital data of this research will be deposited in ORDA therefore it will be openly accessible to anyone under a CC-BY license. ORDA issues DOI for each dataset therefore identifying dataset will be easier for secondary users. Full set of data will be made available after the completion of the project. An embargo period will also be introduced following discussion with supervisors. However, if requested, the datasets will be made available by the PIs so long as the request does not interfere with the publication, compromise IPR, or precede data analysis.

Primary Researcher, Ashfaque Talpur, will be overall responsible for the implementation of the Data Management Plan.

Appendix 22:

Risk Assessment Plan (RAP) of the study

Hazard	Who might be harmed and How?	Control measures	Further action necessary	Action By / person responsible
Face to face interview	<p>1. Researcher: Data collection at unfamiliar location, particularly at participants home, may lead to risk to physical injury or psychological harm to the researcher.</p>	<ul style="list-style-type: none"> • Interviews will be held in public spaces/safe environment (university building or stakeholders premises). However, there are chances that some interviews will be conducted at participants home, if participant preferred. Therefore, the safety checker/supervisory team will have key information (about interview time, date, and location) available to assist if researcher calls for help. • Pre-programmed numbers of safety checkers will be stored in researcher's/ interviewers phone for speed dial. • Researcher will not share personal contact details i.e. personal mobile no., home number or home email with research participants. • The researcher will gather as much information in advance as possible about the characteristic of participants, their housing and living circumstance. • The interviewer will abandon the interview and leave the premise if felt threatened. 	<p>1. Before and after the interview, the interviewers will drop a text/phone to safety checkers about their safety.</p> <p>2. A code word will be agreed with research team to signify when help is needed e.g. in case a conversation requesting assistance is being overheard.</p> <p>3. If an interviewer reported that s/he is in immediate danger, safety checker will report to police.</p>	AT & TR/SH
	<p>2. Participants: Participants could be upset and suffer psychological effects</p>	<ul style="list-style-type: none"> • In the information sheet and before the conduct of interview, the participants will be explained what type of questions will be asked and that they do not have to answer questions they do not wish to and that they can stop the interview at any 		AT

		<p>time. Participant's wishes to terminate the interviews will be respected.</p> <ul style="list-style-type: none"> Participant will be offered post interview talk by researcher if they want/required. Beside this, researcher will provide numbers of support services that can be used to counsel distressed participants. 		
	<p>3. Participants: Participants could be concerned about the confidentiality of interview.</p>	<ul style="list-style-type: none"> Participants will be informed of limits to confidentiality in participant information sheet. Interviews will be arranged at participants convenience place, time, and date. Researcher will make a pre interview call with participant to confirm participant is happy to continue with interview. This is also to help participant, who will be having interview at home, to confirm that the home is safe for the conduct of interview i.e. there is no one they do not want to be at the interview time. 	<ul style="list-style-type: none"> A sealed envelope will be used to ensure physical safety of participant's information documents such as consent forms. Research documents (consent forms) will be locked in safe cabinet 	AT
	<p>4. Participants: Sensitive issues i.e. Gender</p>	<ul style="list-style-type: none"> If a participant has preference for gender, the PI will gender-match the interview 		AT
	<p>5. Participants: Participant safety in case of disclosure of abuse or abuse by family/other during the interview.</p>	<p>It will be ensured to conduct interview only when it is safe following above-mentioned precautions. There is Plan of action in case of disclosure of abuse by participant that include;</p> <ol style="list-style-type: none"> I. Inquiring participant if they can act for themselves to report abuse and advise them that no body should live with abuse and who to contact in case of elder abuse II. If they are unable to act for themselves and/or want the researcher to act, the researcher will discuss the case with 		AT & TR/SH

		<p>supervisory team and Sheffield Safeguarding Adults and/or Action on Elder Abuse charity for advise/support/actions, once agreed the researcher will complete Safeguarding Adult concern form (attached) and will send it to Sheffield Safeguarding Adults and/or Action on Elder Abuse</p> <p>III. If there is an immediate danger to participants life, the immediate interventions will be taken that will include reporting incident to police and safeguarding authorities.</p>		
Focus groups	<p>Participants: Maintenance of confidentiality</p>	<ul style="list-style-type: none"> • In the participant information sheet it will be explained what are the purposes of study and what question to expect, and limits to confidentiality. • Beside this, before the start of focus groups, all participants will be explained about the ground rules of focus group (Appendix focus group) 		AT/ FG facilitator
Travel risk to location of research project	<p>Researcher / Interviewer Theft or loss of ID, cash, valuables, physical/ verbal threat/ abuse, psychological harm</p>	<p>Researcher/interviewer will be advised to consider arriving early to familiarise self with physical environment/area, local amenities, and public spaces. Field site consideration will be undertaken including reliability of public transport, taxis, safety of car parking</p> <p>Researcher / interviewer will be advised to keep enough money (not less not more) to be able to pay taxi if required.</p> <p>Emergency contact number will be pre-programmed in researcher/ interviews phone to make call in case need help.</p>	Counselling service for the researcher within the University of Sheffield if required	AT/ interviewer

AT – Ashfaque Talpur; TR – Tony Ryan; SH – Sharron Hinchliff

Appendix 23:

Safeguarding Adults Concern form

Section 1 – detail of adult at risk		
Name of adult		
Address of adult		
Date of birth or Age		
Contract number		
Section 2 – Researchers details		
Name		
Contact phone number		
Name of organization		
Role in organization		
Section 3 – detail of concern		
Detail what you have been told that make you believe the adult is being abused or is at risk of abuse.		
Section 4 – Abuse type(s)* – please tick as many as you feel applies		
Physical	Psychological	Financial
Sexual	Neglect	Other
Section 5 – Sharing the concerns		
Sheffield Safeguarding Adults	Action on Elder Abuse	
Email : adultaccess@sheffield.gcsx.gov.uk	enquiries@elderabuse.org.uk	
Office Number: 0114 2736870	080 8808 8141	
Adult access Number: 0114 2734908		
Keep a copy of this form for your records		

*See back of the form for the operations definitions of the types of abuse

Note: This is a modified version of existing form developed by Sheffield Safeguarding Adult Office.

Appendix 24:

List of conference papers, research papers and poster presentations from the thesis

Research paper:

- Talpur, A. A., Ryan, T., Ali, P., and Hinchliff, S. (2018) Elder mistreatment in South Asian communities: a review of the literature. *The Journal of Adult Protection*. Vol 20, No 2/6, pp 193-206

Conference paper:

- Talpur, A. A., Ryan, T., and Ali., (2017) Understanding and addressing elder abuse in ethnic minorities of majority populations: A theoretical model paper. *Critical Medical Anthropology Workshop*, Mexico

Poster presentation:

- Talpur, A. A., Ryan, T., and Ali., (2016) Evaluating the prevalence of elder abuse in population-based studies: A review of the literature. *Royal College of Nursing and British Geriatric Society*. March 14, 2016
- Talpur, A. A., Ryan, T., and Ali., (2015) Person Centred Care for Black and Minority Ethnic elder in Care Homes of England. A Review of the literature. *International Nursing Home Research Conference* Toulouse, France.