Professional Perceptions of Microaggressions and Verbal or Emotional Abuse Toward Aging Women: An Interpretive Phenomenological Analysis

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Professional Perceptions of Microaggressions and Verbal or Emotional Abuse Toward Aging Women: An Interpretive Phenomenological Analysis

Abstract
This purpose of this study was to gain an understanding of the phenomenon of microaggressions and verbal and/or emotional abuse occurrence(s) toward aging women through the perceptions of trusted professionals. Using seven participants from diverse regions of the United States, interviews capturing rich data from the lived experiences of Aging Life Care Association (ALCA) experts, an interpretive phenomenological analysis was used to describe the meaning of ALCA professionals’ experiences and perceptions regarding abuse occurrence(s) from their involvement or observations of those most marginalized or oppressed population, aging women. Five themes emerged from this study: (a) insidious transactions, (b) definition interpretation, (c) trauma, (d) dignity, and (e) advocacy. This study’s ALCA experts believed microaggressions and verbal or emotional abuse recognition is important, and they advocate for aging women clients as a means to reduce this abuse burden. Recommendations include examining this study’s emerging themes for further knowledge and requiring a Medicare policy change to specifically fund the development of comprehensive training programs to build awareness and advocacy skills to combat microaggression and verbal or emotional abuse toward aging women.

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Professional Perceptions of Microaggressions and Verbal or Emotional Abuse Toward Aging Women: An Interpretive Phenomenological Analysis

By

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Submitted in partial fulfillment of the requirements for the degree Ed.D. in Executive Leadership

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Dedication

This work is dedicated to not just one, or a few, but to all who have held close to their hearts a want for social justice, truth, and cultural change for those most vulnerable. This dissertation is dedicated to everyone who touched my life. Thank you to those who bravely told me their story. I was honored to gather your truth, and to learn and think about how healing begins. This journey assisted me in reaching my goal of reducing human suffering and building wellness. This dissertation allows me ethical contemplation and future freedom to contribute, connect, and bring hopeful solutions.

My thank you will never be enough to those who helped me move forward. I owe a debt of tremendous gratitude for your patience and belief in my work, so I may shine my light into the world: David Evanoski at #32, Haley Evanoski, Nicholas Evanoski, Helen Kozina, Lynn Fedorchak, and Susan Hyatt; a special thank you to Dr. Cynthia P. Smith, my committee member; and Dr. C. Michael Robinson, my committee chair; my mentors who held steady with me, Dr. Barbara Ganzel and Dr. Pamela Newland; my faithful accountability partners, Veneilya Harden and Michelle Stewart; my amazing editor, Sharon Ryan; and to my dedicated colleagues of Syracuse Cohort 5, Shannon Babbie, David Brown, Carol Charles, Nancy Daoust, Andy Drozd, Missy Greene, Jessica Harris, Rachel Hendricks, Eliezer Hernandez, Aisha Huntley, Dominick Lisi, Chol-Awan Majok, Rhoda Overstreet-Wilson, and Cindy Stevens: You all graciously gave wisdom, kindness, and vision.

Keep your voice. Shine your light. Hold steadfast—you have permission.
Biographical Sketch

Kim Kozina-Evanoski, Owner and CEO of Care Manage For All LLC, created an innovative care management service covering 14 counties in Upstate New York, USA for reducing human suffering and building wellness in daily living. The LLC is known for “doing what no one else will do” for palliative care and trauma-informed excellence. Kim Kozina-Evanoski is nationally certified as a Care Manager and has Advanced Professional status as an Aging Life Care Expert. Before establishing the LLC in 2011, she worked in healthcare, social work, public administration, education, and care management. She completed the New York University’s Silver Social Work Leadership Fellowship in Palliative and End-of-Life Care, becoming nationally recognized as a Social Work Leader for improving palliative care. She is a Co-Founder of The Memory Maker Project, an innovative cultural arts access program. She teaches at Keuka College, Binghamton University, and has created a national Care Management Fellowship. Ms. Kozina-Evanoski received her Bachelor of Science degree in Applied Social Science from Binghamton University, and a Master of Social Work degree and Master of Public Administration degree from Marywood University. She came to St. John Fisher College in 2017 and began her doctoral studies in the Ed.D. Program in Executive Leadership. Kim Kozina-Evanoski pursued her research on professional perceptions of microaggressions and verbal or emotional abuse toward aging women under the direction of Dr. C. Michael Robinson and Dr. Cynthia Smith and received the Ed.D. degree in 2020.
Abstract

This purpose of this study was to gain an understanding of the phenomenon of microaggressions and verbal and/or emotional abuse occurrence(s) toward aging women through the perceptions of trusted professionals. Using seven participants from diverse regions of the United States, interviews capturing rich data from the lived experiences of Aging Life Care Association (ALCA) experts, an interpretive phenomenological analysis was used to describe the meaning of ALCA professionals’ experiences and perceptions regarding abuse occurrence(s) from their involvement or observations of those most marginalized or oppressed population, aging women. Five themes emerged from this study: (a) insidious transactions, (b) definition interpretation, (c) trauma, (d) dignity, and (e) advocacy. This study’s ALCA experts believed microaggressions and verbal or emotional abuse recognition is important, and they advocate for aging women clients as a means to reduce this abuse burden. Recommendations include examining this study’s emerging themes for further knowledge and requiring a Medicare policy change to specifically fund the development of comprehensive training programs to build awareness and advocacy skills to combat microaggression and verbal or emotional abuse toward aging women.
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Chapter 1: Introduction

The U.S. Bureau of Labor Statistics (2018) stated that 41.3 million people provide unpaid eldercare to 16% of the civilian population. The 26% of citizens engaging in unpaid eldercare spend an average of 2.8 hours, on any given day, providing care. Nationally, these unpaid eldercare providers are aged 15 years and older. Of the 41.3 million eldercare providers, the majority (56%) are women (U.S. Bureau of Labor Statistics, 2018) who assist over 7.7 million older adults (Wolff, Spillman, Freedman, & Kasper, 2016). The U.S. Bureau of Labor Statistics (2018) report defines unpaid providers of care as follows:

Eldercare providers are individuals who provide unpaid care to someone age 65 or older who needs help because of a condition related to aging. This care can be provided to household or non-household members, as well as persons living in retirement homes or assisted care facilities. Eldercare can involve a range of care activities, such as assisting with grooming, preparing meals, and providing transportation. Eldercare also can involve providing companionship or being available to assist when help is needed, and thus it can be associated with nearly any activity. (p. 1)

According to a Pew Research Center survey, most eldercare providers (88%) state that helping their aging parents is a rewarding experience (Parker & Menasce Horowitz, 2015). However, family caregivers who provide substantial healthcare assistance express significant emotional difficulty as well as using available supportive services less (25%)
in conjunction with helping their aging parents (Wolff et al., 2016). Further, the 2015 Pew Center survey states that approximately one-third (32%) of adults assisting with care tasks report that helping an aging parent is stressful (Parker & Menasce Horowitz, 2015). According to Wettstein and Zulkarnain (2017), future eldercare providers (17%) will end up giving large monthly time commitments (approximately 77 hours per month) to their parents for care. Time for care commitments will be demanding on their lives.

The demands of being a caregiver or eldercare provider can manifest in mental, emotional, physical, and financial stresses. Caregivers, who often feel void of choice when the need arises to participate in a primary caregiving role, are more likely to report negative impacts (57%) as a result of providing care. Additionally, these caregivers will continue to experience these negative effects well into the future (National Alliance for Caregiving & AARP Public Policy institute [NAC & AARP], 2015). Caring for a seriously ill family member creates additional stressors, which are caused by a high-burdened care situation (NAC & AARP, 2015) that poses the risk of one losing his or her job (Menasce Horowitz, Parker, Graf, & Livingston, 2017). Caregiver stress and negative experiences may lead to adverse treatment of those aging adults who are receiving care. This adverse treatment is known as elder abuse. Elder abuse can lead to increased psychological distress and geriatric syndromes of aging individuals, which may pose as complex health issues. Dong, Chen, Chang, and Simon (2013) found that these health issues are independently associated with premature morbidity and mortality.

The World Health Organization (WHO, 2002) adopted the most recognized definition of elder abuse, which states, “Elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of
trust which causes harm or distress to an older person” (WHO, 2002, p. 3). Elder mistreatment can come in the form of microaggressions. Microaggressions are defined as subtle behaviors or verbal indignities that communicate negative messages. Microaggressions have been acknowledged as a form of abuse that is linked to psychological distress and trauma (Fleischer, 2017; Gonzales, Davidoff, DeLuca, & Yanos, 2015; Owen, Tao, & Rodolfa, 2010; Ross-Sheriff, 2012). Burnes et al. (2015) found emotional abuse to be the most prevalent of abuses, followed closely by physical abuse and neglect. The intertwining of multiple forms of abuse is called polyvictimization. Microaggressions and verbal or emotional mistreatment are included as forms of polyvictimization, which significantly affects aging individuals, especially in their later years. The working definition of polyvictimization, retrieved from the Ramsey-Klawsnik et al. (2014) national forum on later life, states:

Polyvictimization in later life occurs when a person age 60 or older is harmed through multiple co-occurring or sequential types of elder abuse by one or more perpetrators, or when an older adult experiences one type of abuse perpetrated by multiple others with whom the older adult has a personal, professional or care recipient relationship in which there is a societal expectation of trust. Perpetrators of polyvictimization in later life include individuals with special access to older adults such as: intimate partners; other family members; fiduciaries; paid or unpaid care or service providers, resident(s) or service recipients in care settings. (p. 5)

Late-life polyvictimization trends show higher amounts of abuse, coupled with the lack of interventions (Fearing et al., 2017). A recent systematic review of community-
based interventions for elder abuse and neglect indicates that intervention research is limited (Yon, Mikton, Gassoumis, & Wilber, 2017). In 2009, Ploeg, Fear, Hutchison, MacMillan, and Bolan posited that insufficient evidence to support any intervention relating to elder abuse targeting clients, perpetrators, or healthcare professionals existed. Elder mistreatment predictions reveal increasing mortality risks stemming from poorer physical and psychological health (Wong & Waite, 2017). Fearing et al. (2017) predicted that insufficient interventions of preventing elder abuse will lead to elder mistreatment potentially reaching epidemic levels. For every single case of elder abuse that becomes revealed, there are likely 23 additional cases that remain unexposed, hidden, and unreported (Lachs & Berman, 2011).

When factoring in gender, elder abuse rates are higher than originally thought. As of 2017, it was estimated that 68 million, or one in six, aging women experience some form of abuse worldwide (Yon et al., 2017). An aging woman is defined as being 65 years and older (Orimo et al., 2006). At any age, women suffer higher rates of interpersonal violence, verbal abuse, and emotional abuse throughout their lifespan than their male counterparts. These forms of abuse are a consistent trend when comparing elder women to elderly men (Hamby, Smith, Mitchell, Turner, & Smith, 2016; Mouton et al., 2004; Yon et al., 2017). A report by Lachs and Berman (2011) revealed that almost two-thirds of the study participants who self-reported being victims of elder abuse were women. Abuse of these postmenopausal women did not diminish as age increased nor did the serious threat to their health or well-being (Hamby et al., 2016; Mouton et al., 2004).

Abuse varies and includes physical, verbal or psychological, emotional, sexual, and financial forms. Abuse can also mirror as intentional or unintentional neglect (Luoma
et al., 2011; WHO, 2002). As demonstrated in a study across five countries in a multinational survey by Luoma et al. (2011), emotional abuse tends to be the most commonly reported form of abuse among aging women. The study revealed that 23.6% of women (or one in four women in the study) reported experiences of emotional abuse (Luoma et al., 2011).

Historically, there has been little understanding of the cause of verbal or emotional abuse toward aging women (Baker et al., 2009; Fearing et al., 2017; Lin & Giles, 2013; Mouton et al., 2004; Ross-Sheriff, 2012; Yan & Brownell, 2015; Yon et al., 2017). Women outlive their male counterparts; statistics report females ages 65 to 69 outnumber males by 0.7 million. One million more females outnumber males in the 75 to 79 age group; and in the age group of 85 and over, 1.9 million more females than males comprise that sector of the population (U.S. Census Bureau, 2014). Socioeconomic detriments may challenge women. Of particular concern is the vulnerability of cognitive impairment reducing aging women’s financial capacity to take care of daily bills or other financial needs, hence increasing the risk of financial exploitation (Deane, 2018; Lachs & Berman, 2011). The certainty of known higher risk factors, such as poverty, lack of social support, and cognitive impairment, has led to increasing the understanding of aging women’s mistreatment (Amstadter et al., 2010; Comijs, Smit, Pot, Bouter, & Cees Jonker, 1999; Lachs & Berman, 2011; Lin & Brown, 2012).

**Problem Statement**

Elder abuse is a public health issue. Five million Americans are affected each year by elder abuse, causing injury, suffering, and exploitation (U.S. Department of Justice [USDOJ], n.d.). Aging women suffer higher mortality risks, which is due to interpersonal
violence, verbal abuse, and emotional abuse throughout their lifespan (Baker et al., 2009; Dong et al., 2013; Fearing et al., 2017; Lin & Giles, 2013; Mouton et al., 2004; Yan & Brownell, 2015; Yon et al., 2017). Unmarried, widowed or divorced, and longer-living aging women can be further marginalized by socioeconomic determinants by having higher risk factors of poverty or low social support (Amstadter et al., 2010; Brownell, 2016; Comijs et al., 1999; Dong et al., 2013; Lin & Brown, 2012; O’Connor & Kelson, 2018).

Stakeholders from all United States’ sectors are developing initiatives to respond to the impact on older individuals’ health, finances, and safety (USDOJ, n.d.). Stakeholders, such as eldercare professionals or care managers, are known as trusted advocates and listeners to their clients’ needs (Horne & Ortiz, 2017; Ortiz & Horne, 2013; USDOJ, n.d.). Eldercare professionals respond appropriately in their communities to urgent injuries that are impacting aging individuals’ health, finances, and safety, with the client’s best interests first, and without any political or financial ties to businesses, organizations, and government entities (ALCA, 2018; USDOJ, n.d.).

Deane (2018) found that the U.S. Senate Special Committee on Aging’s cost estimates of elder abuse are into the billions of dollars. Funds for aftermath treatment, government services interventions, financial and home losses through financial abuse, or theft of aging individuals’ assets, are not only an escalating serious national issue in 2017. Academics, businesses, and eldercare professionals who are concerned with the impact of victims’ human suffering are aligning to the need for strategic planning because little data is currently available (USDOJ, n.d.).
Victims of microaggressions and various forms of verbal or emotional abuse may share their experiences with a trusted professional or stakeholder (USDOJ, n.d.). Trusted stakeholders such as eldercare professionals, who provide care to aging women clients within their services, can provide their perceptions regarding the occurrence(s) of microaggressions, which include micro assaults, micro insults, micro invalidation, or verbal abuse. Those microaggressions can also include eldercare professionals’ women clients being the victims of uncontrolled anger, hollering, mocking or name calling, ignoring, threatening, bullying, and fear-inducing language.

At the time of this study, there were no empirical studies that exist on ALCA professionals’ perceptions about their attitudes toward aging adults nor their perceptions of ageist barriers toward quality eldercare in or outside facility care (Reyna, Goodwin, & Ferrari, 2007). Various studies exist on the issues of ageism and microaggression studies of women and caregivers, but there is no empirical literature stemming from studies on perceptions of care managers, specifically ALCA professionals, for this population of aging women.

**Theoretical Rationale**

The theoretical intent of this study was to identify and develop the feasibility of a relationship between microaggressions and verbal or emotional abuse toward aging women through the lens of cumulative advantage/disadvantage (CAD) theory. Theorist, Dannefer (1987) conveyed CAD’s historic origin as being influenced by the cumulative advantage research of Price (1976) and the influence of Merton’s (1968) essay that describes the notable occurrence of the wealthy gaining more wealth while the poor become poorer over time (Entwisle, Alexander, & Olson, 2001). Dannefer’s (1987)
insight into diversity and inequality came from his research on life course of inequality and poverty in old age, which addresses cultural and gender disparities. It was at this point that Dannefer (2003) linked CAD with age.

Dannefer (2003) defined CAD as the systemic tendency, or point of entry, for interindividual divergence or cohort activity in a given characteristic, such as money, health, or status, with the passage of time or aging. CAD can be defined by common phrases such as *the rich get richer; the poor get poorer* (Entwisle et al., 2001). It highlights interindividual divergence or how sets of individuals are ranked against one another. While CAD recognizes rank among cohorts of people, CAD also takes into consideration individual differences and actions between people within those cohorts. Specifically, CAD regarding the aging is concerned with age-specific individual differences. These age-specific individual differences are in such areas as health or cognitive functioning. These differences relate to fairness in the distribution of resources in healthcare, social security benefits based on gender, and on the death of a spouse, as well as in opportunities in earnings over the years, job stability, and access to healthcare (Dannefer, 2003).

CAD’s perspective in the field of gerontology contributes to the emergence of distinct themes. These distinct themes can include a *pension or savings* as financial stability, *mobility* as the ability to afford a housing move, *gender* in very old age, and *independence in aging*, when viewing problems of diversity and inequality among aging individuals (Dannefer, 2003; Settersten, 2017).

The CAD theoretical lens can assist in exploring studies of elder mistreatment in the context of verbal, emotional, or psychological abuse and by broadening the term
microaggressions that are experienced by aging women. As such, the CAD theory may assist researchers in understanding the eldercare manager’s perspective of microaggressions and verbal, emotional, or psychological abuse toward aging women (Dannefer, 2003).

Statement of Purpose

The purpose of this study was to gain an understanding of the phenomenon of microaggressions and verbal or emotional abuse occurrence(s) toward aging women through the perceptions of trusted professionals providing eldercare services.

Research Question

The research question that guided this study is from the perspective of an ALCA professional, asking, How do ALCA professionals perceive the occurrence(s) of microaggressions and verbal or emotional abuse toward aging women clients?

Potential Significance of the Study

Pillemer, Connolly, Breckman, Spreng, and Lachs (2015) stated the need for an elder mistreatment knowledge base, a comprehensive network of elder mistreatment services, and training opportunities, as well as a coordinated policy approach to reducing elder mistreatment. Pillemer et al. (2015) posited that research, service, and policy in a global capacity of a worldwide health issue should impact both aging women, as individuals, as well as impacting those professionals and stakeholders who assist in aging women’s care and well-being.

Significance for individual women. Throughout and beyond the baby boomer generation, women are expected to significantly outlive their male counterparts (USDOJ, n.d.). Given that women are about two-thirds of the total elder abuse victims (Lachs &
Berman, 2011), with aging women suffering from a life course of inequality and poverty, changes in how aging women are financially supported in their care, through their individual Medicare and Medicaid reimbursement policies, to prevent and mitigate elder abuse, may pose a significant problem (USDOJ, n.d.). For example, financial support may include the reimbursement for actions designed to screen, detect, intervene, and prevent elder abuse, using care managers (USDOJ, n.d.).

Significance for stakeholders, caregivers, and eldercare professionals.
Pillemer et al. (2015), in a priorities statement to a United States White House Conference on Aging, estimated an overall prevalence rate of elder mistreatment of approximately 10% in the United States, translating the number to approximately 5,600,000 elder mistreatment victims, ages 60 and over, nationwide. Pillemer et al. (2015) stated that elder mistreatment is widespread, so much so, that professionals who serve older adults are likely to encounter elder abuse. By creating a comprehensive network of elder mistreatment services, coupled with the provision of professional best-practices training opportunities with organizations, aging women may benefit (Pillemer et al., 2015). Trained professionals who are knowledgeable about elders’ day-to-day challenges may help alleviate the suffering from a life course of inequality and poverty (Dannefer, 2003).

Significance for society as a worldwide public health issue. Elder abuse is a public health issue worldwide for aging women (Mouton et al., 2004; Teaster & Hall, 2018; Yon et al., 2017). Research provides information contributing to the use of evidence-based practices with effective interventions (Teaster & Hall, 2018). Research can assist in helping indicate specific barriers to reporting abuses to help curb elder abuse
(Teaster & Hall, 2018). Pillemer et al. (2015) believed that research is needed to coordinate policy approaches to reduce elder mistreatment and to expand and coordinate a collection of elder abuse data. Effective intervention studies may divert later life polyvictimization or abuse trends, leading to fewer concerns of elder mistreatment such as verbal, physical, or emotional—a combination of two or more abuses—having the potential of reaching to a widespread problem (Fearing et al., 2017). For example, “The Elder Justice Roadmap” (USDOJ, n.d.) encouraged ways to identify elder abuse.

Using practice initiatives is a way to improve quality of care in hospitals for victims of elder mistreatment where interventions in emergency department (ED) can create vulnerable elder protection teams. Rosen et al. (2018) posited that ED teams can be built and studied as a mobilized model of best practices to identify elder abuse.

**Significance for research.** Although there is a body of research focused on elder abuse (Baker et al., 2009; Mouton et al., 2004; Yon et al., 2017), only since the beginning of the 21st century did a body of research focus specifically on aging women. Also, only since the year 2000 has ALCA professionals formed and developed a professional role. Within the existing body of research (Horne & Ortiz, 2017; Ortiz & Horne, 2013), only a few studies have focused on ALCA professionals’ role as assessment and advocacy expert resources. There are no visible studies exploring the occurrence(s) of microaggressions and verbal or emotional abuse of aging women in ALCA professionals’ services that explore the phenomenon from the perspective of an ALCA professional. Additionally, no studies exist of the phenomenon of elder abuse utilizing an interpretive phenomenological analysis (IPA) with an ALCA professional.
The hope is that the findings from this study will contribute to the body of knowledge on the occurrence(s) of microaggressions and verbal or emotional abuse of aging women in an ALCA professional’s service. Stakeholders, ALCA members, funders, consultants, and other practitioners may find this study helpful as they consider how to support aging women, especially aging women from at-risk populations, such as those with past self-acknowledged trauma or poly-victimized women, very aged women, or women in the midst of financial hardship. Through exploring the experiences of a small group of ALCA members who engaged in supporting aging women, the new learning obtained from this study should provide insights to understand more about why the occurrence(s) of microaggressions and verbal or emotional abuse of aging women in an ALCA professional’s service is happening. This new learning may also assist in ensuring that elder mistreatment is addressing aging women’s societal need for more specific and dedicated supports. Aging women may also gain more resources for a growing retired baby-boomer population that will continue to bring a demand for these services.

Chapter Summary

Chapter 1 provided an overview of the phenomenon of microaggressions and verbal or emotional abuse applied to aging women as well as the need to understand the mistreatment and violence toward aging women. Chapter 1 also explored the theoretical construct of CAD theory as it relates to aging. Elder abuse is a worldwide public health issue for aging women (Mouton et al., 2004; Teaster & Hall, 2018; Yon et al., 2017). Research proves that the aging women population is susceptible, from a life course perspective, to experience inequality and poverty. The purpose of this study was to
understand the reported amount of mistreatment and violence, in the form of microaggressions and verbal, emotional, and psychological abuse, against aging women through the perception of ALCA professionals.

Chapter 2 explores the review of the empirical literature. Following the review of the literature, the research design and methodology are discussed in Chapter 3. The results of the research are disseminated in Chapter 4, and Chapter 5 provides a discussion of the findings and recommendations based on the analysis of the data collected.
Chapter 2: Review of the Literature

Introduction and Purpose

The review of the empirical literature examines the impact of outcomes for aging women’s overall safety, mortality, and well-being. This review was achieved by extrapolating the data on this subpopulation from other studies that were focused on larger populations (e.g., studies on women, studies on elderhood, studies on abusive practices). These five research areas are identified and explored in this chapter:

(a) professional perceptions studies on culture, work role, and attitudes toward aging adults; (b) microaggression studies on women as a vulnerable group, with special analysis of aging women; (c) elder abuse studies on the prevalence of abuse and its impact on older women; (d) ageism studies on abusive, discriminatory practices toward aging women; and (e) ageist communication studies on vulnerable aging groups. The review focuses on aging women in relation to public health issues, safety from mistreatment, and social and psychological well-being.

Review of the Literature

Professional perceptions. The review of the literature is first explored through the professional perceptions of eldercare professionals’ work roles. This exploration also includes personal aging anxiety and attitudes toward aging adults. The professional perceptions include professional culture and professional work role and attitudes toward aging adults.
**Professional culture.** According to Gendron, Inker, and Welleford (2018), professional perceptions of aging are strongly shaped by an internalized message wherein aging means disease and decline versus a youth-related message that values intervention and curative treatment. Attempts to deny age or any appearance of aging is a value attributed to youth. Because of such perceptions, Gendron et al. (2018) discussed professional culture and professional perceptions being riddled with subtle but normalized negative attitudes of aging. Everyday ageism can be challenging to study due in part to the transmission of ageist sentiments in daily discourse with midlife professionals who lead the aging network.

Gendron et al. (2018) studied ageist language by using a qualitative discourse analysis of video recordings to analyze 15 video fragments that comprised the recorded sessions of the 2015 White House Conference on Aging (WHCOA) from providers who served older adults, such as those in higher education, research, policy and governing bodies, advocacy organizations, private businesses, and not-for-profit organizations. Gendron et al. (2018) further reported that these professional providers represented a range of occupations and disciplines including gerontology, education, finance, civil service, business, administration, therapeutic practitioners, social service, and travel and leisure experts.

The Gendron et al. (2018) study results note that approximately 26 instances were captured of ageist statements that included utilizing personal age, aging, or an age-related characteristic negatively regarding oneself or others (micro ageism); statements expressing global negative opinions or beliefs about aging and older adults based on group membership (macro ageism); and lastly, through a theoretical pathway
representing the dynamic process by which ageist statements were expressed and reinforced (relational ageism). With the consequences of ageist practice this significant, Gendron et al. (2018) believed further investigation regarding the communication of ageism within the professional culture of aging services is essential.

**Professional work role and attitudes toward aging adults.** Reyna et al. (2007) performed a study in which all the data were obtained from care facilities for older adults in Tasmania, Australia. Participants comprised 225 adult caregivers (182 women and 43 men) who assisted older adults at five residential care sites. The mean age of participants was 48.9 years old ($SD = 14.19$). Most participants were of European descent (88.4% White; <2% each of Aboriginal, African-decent, and race unspecified; 7% did not indicate race) and had at least some high school/college education (61.9%). Participants reported working at the facilities for an average of 50.16 months ($SD = 66.45$), assisting residents who were, on average, 78.8 years old ($SD = 11.2$). According to Reyna et al. (2007), the results of this study compared two prevailing strategies for reducing ageist attitudes among caregivers—contact with older adults and education. The study’s results indicated that neither contact variable had any significant association with stereotypes of older adults, and daily contact in the context of long-term care did not have the promising effects on prejudice often associated with regular, meaningful contact (Reyna et al., 2007). Further, the contact between clients and care providers did not meet certain conditions necessary for contact to reduce prejudice, such as equal status, interdependence, and shared goals (Reyna et al., 2007).

According to the Reyna et al. (2007), professionals have contact with aging individuals during patients’ times of sickness, frailty, and impairment. Importantly, these
frailties are physical and cognitive. Contact during impairment confirms the biomedical message that aging individuals are vulnerable, infirm, or dependent on others. These messages can challenge these professionals’ perceptions during their daily professional work roles, and the messages can create anxiety and attitudes regarding those professionals becoming elderly themselves.

Although the Reyna et al. (2007) study touches on professional perceptions within one’s work role within a facility care, there is not an empirical study with care managers’ nor ALCA professionals’ perceptions. Empirical literature validates the phenomenon of elder abuse. However, a gap in the literature as to how eldercare managers, specifically, ALCA professionals, attitudes and perceptions of aging exists; and although there are two further studies exploring ALCA professionals’ work role (Horne & Ortiz, 2017; Ortiz & Horne, 2013), these studies do not address ALCA professionals’ perceptions. Currently, there are no empirical studies that exist on ALCA professionals’ perceptions about their attitudes toward aging adults nor their perceptions of ageist barriers toward quality eldercare in or outside facility care (Reyna et al., 2007). Various studies exist on the issues of ageism and microaggression studies on women and caregivers, but there is no empirical literature stemming from studies on perceptions of care managers, specifically ALCA professionals, for this population of aging women.

**Microaggression studies on women.** Sue et al. (2007) defined the term microaggression as negative or demeaning communication toward another person or persons who is/are associated with a perceived vulnerable social group. Sue et al. (2007) discussed a group of researchers’ perspectives by describing and analyzing how racism, in the form of racial microaggression, is particularly problematic for therapists to
identify. As such, this group of researchers proposed a taxonomy of racial microaggressions with potential implications for practice, education and training, and research and used the counseling/therapy process to illustrate how racial microaggressions can impair the therapeutic alliance. Up to the time of the Sue et al. (2007) study, there was no conceptual or theoretical model of racial microaggressions proposed to explain the impact of these microaggressions on the therapeutic process.

The Sue et al. (2007) study further discussed how microaggressions can be defined in the subcategories of micro assaults (name calling or other forms of conscious and deliberate discriminatory actions), micro insults (rudeness or insensitivity or subtle snubs), micro invalidation (communication that excludes, negates, or nullifies feelings), and attributional ambiguity (interpreting feedback that seems negative or discriminatory). Although Goldsen et al. (2017), Gonzales, Davidoff, Nadal, and Yanos (2014), Gonzales et al. (2015), Heintz, DeMucha, Deguzman, and Softa (2013), Sterzing, Gartner, Woodford, and Fisher (2017), and Watson and Corrigan (2001) researched vulnerable social groups who felt oppressed, had a negative label, or were vulnerable social groups having stigma placed upon them, very little current research gives perceptions or explanations of microaggressions impacting aging women. Studies do discuss oppression or stigma through patronizing speech (Corwin, 2017; Draper, 2005) and an assumption of inferiority by the perpetrator by rejection or being silenced, marginalized, and objectified (Gonzales et al., 2014; Gonzales et al., 2015; Watson & Corrigan, 2001). For some individuals, it is being a person of color who is stereotyped (Sue et al., 2007); or of women who experience psychological distress or stigma as a patient (Heintz et al., 2013). For some people, they feel the lack of a safe environment to address their needs, such as
physical complaints in a healthcare setting (Sterzing et al., 2017). Then again, a person can feel the stress of a group’s signature identity that has a negative impact or oppresses that person (Goldsen et al., 2017). Research giving an explanation of microaggressions impacting aging women is available. However, researchers have discussed broadening the definition of microaggressions to include all types of abuse and the relationship abuse has regarding the impact of trauma on individuals.

**Broadened term and inclusivity.** The review of the literature discusses microaggression as a term broadened to include verbal abuse and psychological distress, patronizing speech, financial exploitation, and poverty as applied to older adult singleness or widowhood stereotyping. Additionally, studies have allowed the term microaggression to be broadened to include diversity characteristics beyond race and ethnicity and may include acts against individuals with mental or physical disabilities (Ross-Sheriff, 2012). Negative themes of discrimination, prejudice, oppression, and exploitation describe the hostility, negative slights and insults, and derogatory comments or gestures toward vulnerable social groups (Patrick, Tucker, & Matsui, 2018; Yon et al., 2017), ability status (Ross-Sheriff, 2012), and age (Corwin, 2017).

Gender inequality across a lifespan was explored by Patrick et al. (2018), using data cited through multiple sources, including many government agencies. As reported, for example, 33 million women and girls received their health coverage from Medicaid under the Title X Family Planning Program in 2016. The program served more than 4 million people, 89% of whom were women. The Supplemental Nutrition Assistance Program (SNAP), previously called Food Stamps, were supplied to more than 311,400 people 65 and older, including nearly 185,000 older women—more than two in five
who were older women of color. Most program recipient or beneficiary data came from the individual programs’ latest annual reports or from the most recently published data tables available, and with reliance on U.S. Census Bureau 2017 Current Population Survey estimates or analyses, which were conducted by other organizations for program and demographic information.

Patrick et al. (2018) stated that women are more likely than men to face economic insecurity at all stages of life. Women suffer the cumulative effects of a lifetime of gender pay gap; ongoing employment discrimination; overrepresentation in low-wage jobs; educational disparities; difficulty accessing affordable, comprehensive healthcare; and women have greater responsibilities for unpaid caregiving (Yon et al., 2017); and, as such, consistent and long-term exposure to microaggressions can have a sustained negative impact on individuals (Fleischer, 2017).

**Trauma.** Fleischer (2017) explained that microaggressions toward individuals can manifest into psychological trauma in two ways: shock trauma and strain trauma. Shock trauma is an acute experience that refers to a horrific external or internal event that stimulates the mind to an unbearable degree, resulting in a person feeling intensely distressed (Fleischer, 2017). An example of shock trauma would be the shock of being intensely bullied or threatened by the use of a derogatory name that triggers bad memories prior to an event. Strain trauma is a chronic low-level trauma experience having a cumulative negative effect over time (Fleischer, 2017). An example of strain trauma would be hearing a derogatory comment daily for 2 months. Fleischer (2017) indicated that for some individuals, this chronic exposure of discrimination can lead to post-traumatic stress disorder (PTSD), which produces significant negative outcomes.
such as loss of attendance to work or life events because high amounts of stress, fear, or anxiety can cause immobility.

**Elder abuse.** Elder abuse is defined as an intentional act or failure to act by a care partner or another person in a relationship that involves an expectation of trust and that causes or creates a serious risk of harm to an aging adult who is 65 years or older (Hall, Karch, & Crosby, 2016; Orimo et al., 2006). Elder abuse also includes the phenomenon of creating chronic health conditions over time, polyvictimization, as well as emotional and psychological distress and trauma. Failure to report, or underreporting of these phenomena, further exacerbates elder victimization over the life course.

Elder abuse studies validate that aging women who experience abuse are more at risk for serious health threats (Baker et al., 2009; Mouton et al., 2004; Yon et al., 2017). Baker et al. reported from their 2009 retrospective analysis that community-dwelling, middle-aged and older women, who reported prior-year physical, verbal, or both types of abuse, had significantly higher adjusted mortality risk than women who did not report abuse. Poor social supports, as well poor socioeconomic status, validate the CAD perspective that poorer aging women who continue to endure abuse may hold more mortality risk. Baker et al. (2009) reported 160,670 community-dwelling women, ages 50 to 79 at baseline, enrolled in one of two major Women’s Health Initiative (WHI) study components, and these women responded to those baseline abuse questions. The 1994-1998 observational study enrollment was 593,676 ($N$) with a 90-month average follow-up. The 1993-1998 clinical trial enrollment was 568,132 ($N$) with a 96-month average follow-up (Baker et al., 2009). The health threats posing higher adjusted mortality risk included a higher likelihood of chronic care medical problems, such as diabetes (7.3%
abuse versus 4.3% non-abuse); cardiovascular issues including congestive heart failure (12.2% abuse versus 6.9% non-abuse); and cerebrovascular stroke accidents (3.5% abuse versus 1.3% non-abuse). All of these diseases are associated with physical and verbal abuse and an overall higher mortality risk (Baker et al., 2009). Further, according to Baker et al. (2009), verbally abused women are more likely to experience migraines and inflammatory bowel disease than women who have no abuse or who are only physically abused. Additionally, there is greater risk for cardiovascular death in the verbal abuse group.

The Mouton et al. (2004) study, having a cohort of 91,749 women, ages 50 to 79 years, from the WHI study, included physical and verbal abuse outcomes that were self-reported. In this 3-year prevalence study, predictors of physical and verbal abuse among post-menopausal women were examined. Mouton et al. (2004) stated the baseline results were: 11.1% reported abuse sometime during the prior year, 2.1% reported physical abuse only, 89.1% reported verbal abuse only, and 8.8% reported both physical and verbal abuse. The study’s baseline prevalence was associated with service occupations, lower incomes, and living alone (Mouton et al., 2004). At the 3-year follow-up, 5.0% of the women reported new abuse, 2.8% reported physical abuse only, 92.6% reported verbal abuse only, and 4.7% reported both physical and verbal abuse.

The Yon et al. (2017) systematic review and meta-analysis study brought forth concerns around the higher prevalence in psychological (verbal) abuse (11.8%) and neglect (4.1%) with an overall combined prevalence of elder abuse being approximately one in seven (14.1%) older women in the study. Through the Yon et al. (2017) global systematic review, a meta-analysis of 50 past-year abuse prevalence studies (out of 104
full-text screenings and 38,544 references retrieved for abstract review) between years 2002 and 2015 were collected. The Yon et al. (2017) global systematic review was used to gather data to determine the extent of abuse against women 60 years of age and older. Yon et al. (2017) further suggested that the risk of all types of abuse are of particular concern with aging women who reported factors of poor social support and poor socioeconomic status.

Wong and Waite (2017) tested a stress process theory using nationally representative, longitudinal data from 2,261 older adults in the 2005-2016 National Social Life Health and Aging Project that had three study waves ranging from 2005 through 2016. From the 2,261 respondents, with data in both study waves, the makeup of the sample was an average age of 73 years, and a little over half of the sample (52.10%) was female. The majority of the sample was White (70.77%), and most respondents were married (57.05%); although a substantial proportion were widowed (26.32%). The Wong and Waite study found that verbal abuse is related to a decline in psychological health because of anxiety and loneliness. In addition, there is a decline in physical health because of additional chronic care needs that include daily help, such as bathing or dressing. The decline in psychological health was related to the verbal abuse seen in the participants even 5 years after the verbal abuse. Wong and Waite (2017) reported that elder mistreatment in the form of verbal abuse predicts further physical and psychological health later in life. Polyvictimization, emotional and psychological distress, and trauma further exploit aging women.

*Polyvictimization.* Aging adults suffering from many forms of abuse, which includes psychological distress or micro assault, is called polyvictimization (Teaster,
When physical abuse toward aging adults, such as pinching, slapping, and shaking, or more physically harmful forms of abuse, such as repeated assault rituals, neglecting physical care needs, or sexual victimization, psychological harm often follows (Hamby et al., 2016; Hanrahan, Burgess, & Gerolama, 2005; Roberto, 2017; Yon et al., 2017). Although little is known regarding the scope of the problem, physical and sexual mistreatment has significant emotional and psychological consequences for its victims.

Hanrahan et al. (2005) conducted a convenience sampling method study consisting of 125 cases of female elder sexual abuse victims who were 60 years of age and older. This data was collected using the Comprehensive Sexual Assault Assessment Tool (CSAAT), which was submitted to a panel of experts for review. Although the CSAAT lacked specificity for the studied cohort, the study contributed critical information. In particular, the cases reviewed by the experts became the stimulus for discussion about the unique characteristics of sexually victimized older adults. This discussion was foundational to creating the groundwork for a conceptual framework. The findings of the Hanrahan et al. (2005) study may be valuable toward educating health care professionals about elder sexual abuse and the psychological trauma outcomes of such abuse including the exacerbation of comorbid conditions and the death of victimized elders (Hanrahan et al., 2005).

**Emotional and psychological distress with trauma.** Research shows emerging themes around verbal abuse in the form of psychological distress (verbal and emotional) and microaggressions in the form of micro insults and micro invalidations toward older women (Baker et al., 2009; Yan & Brownell, 2015). Verbal abuse has been subcategorized as humiliation, coercion, bullying, being ignored or marginalized, or the...
perpetrator displays verbal aggressiveness or micro assaults toward an individual. Severe and significant psychological and emotional trauma, which includes ongoing verbal abuse toward aging women, can exist throughout the lifespan of the individuals (Dong et al., 2013; O’Connor & Kelson, 2018). For example, the mixed-method study conducted by O’Connor and Kelson (2018) explored baby boomer-aged adults’ experiences accessing an emotional health program (EHP) in a community-based seniors’ center. The data generated included client-based surveys ($n = 118$), in-depth qualitative interviews ($n = 20$) with client users and professionally trained counselors ($n = 2$), and a focus group with a peer support service worker ($n = 14$). The survey data also included a demographic profile. The O’Connor and Kelson (2018) study’s average client of the EHP was White, female, of the baby boomer age (1946-1964), low-income, living alone, and not partnered. One key finding of the study suggested the emotional health program as a preventative strategy to address familial abuse. In the case of one of the participants, the complexity is shown of adult children being emotionally abusive to acquire needed housing or financial support from their aging mother (O’Connor & Kelson, 2018). The use of such micro insults, micro assaults, and micro invalidation by abusers are the types of emotional abuse that can cause psychological distress as well as traumatize aging women who are faced with familial abuse (O’Connor & Kelson, 2018; Sue et al., 2007).

Other research links the association of psychological and emotional distress to social disconnectedness and isolation, through elder mistreatment or neglect, to a correlation of poor health status in self-related health studies (Amstadter et al., 2010; Beaulaurier, Seff, & Newman, 2008; Cornwell & Waite, 2009; Cullati, Rousseaux, Gabadinho, Courvoisier, & Burton-Jeangros, 2014). Correlations to social isolation, elder
mistreatment, and neglect are tied to reductions in morbidity, mortality, and well-being (Suen, Gendron, & Gough, 2017).

Dong et al. (2013) reported in a systematic review that the most prevalent psychological consequences of elder abuse were depression, anxiety, and post-traumatic disorders. The independent variables of depression, anxiety, trauma, and loneliness, which cause psychological distress, are key risk factors that are associated with elder abuse (Dong et al., 2013). The systematic review notes from Dong et al. (2013) indicate that elder abuse and psychological distress, or micro assaults, are geriatric syndromes that are associated with premature illness and death, although research around psychological distress and elder abuse relationships is little known. Similar to Dong et al. (2013), other researchers have acknowledged emotional mistreatment as the highest percentage of abuse toward aging women with victims reporting chronic verbal aggression or micro assaults (emotional or psychological mistreatment) as high as 53.2% (Comijs et al., 1999) and 76.3% (Mouton et al., 2004).

**Underreporting.** The current estimate of elder abuse is one in six women, worldwide (Yon et al., 2017). However, researchers anticipate that actual rates are higher due to the failure to report such mistreatment to authorities or agencies (Acierno et al., 2010; Baker et al., 2009; Mouton et al., 2004). Understanding that the perpetrator is generally a relative or close relation to the victim, such as a longtime neighbor, can create complexity toward the resolution of such a situation. Reporting the abuse becomes very difficult when considering the possible risk factors of an aging woman that may include physical frailty, compromised mental health, isolation, or poverty (De Donder et al., 2016). An aging woman self-reporting abuse is further complicated when the aging
woman’s relationship to the perpetrator includes domestic violence along with the elder abuse (Beaulaurier et al., 2008; Newman, Seff, Beaulaurier, & Palmer, 2013). Researchers agree that significant study needs to be completed to understand underreported elder abuse and to develop effective interventions to reduce or eliminate polyabuse among aging adults (Acierno et al., 2010; Baker et al., 2009; Hamby et al., 2016; Mouton et al., 2004; Ramsey-Klawnik, 2017).

**Ageism.** The review of the literature more fully discusses public health issues and chronic social problems relating to microaggressions of aging women in areas such as the workplace, with healthcare, and the widespread age discrimination through media and advertising as well as the aging women being unemployed and financially unstable. Ageism is a specific microaggressive behavior in which prejudice and/or discrimination is based upon an individual’s age. Butler (1969) termed the phrase ageism as another form of bigotry; however, when compared to sexism and racism, there has been little research on ageism since the term was first introduced (Nelson, 2016). Additionally, ageism is not understood by the public nor among researchers themselves (Gendron, Inker, & Welleford., 2017; Nelson, 2016). Further, some researchers have concerns regarding how age is subjectively defined, constructed, and analyzed, and thereby the body of research, itself, perpetuates the dominant public view that old and aging are bad (Gendron et al., 2017, 2018; National Academies of Sciences, Engineering, and Medicine [NASEM], 2018).

For aging women, Nelson (2016) and other researchers (Chrisler, Barney, & Palatino, 2016; Palmore, 1997; Palmore, Branch, & Harris, 2016) expressed that given the negative stereotypes, a double jeopardy—being guilty twice—exists when ageism and
sexism intersect (e.g., lonely widow and mean old lady). Prejudices showing ageism (e.g., negative jokes of aging women and/or women with gray hair and wrinkles) also are ingrained in the culture through implicit bias (NASEM, 2018). This double jeopardy affects aging women in the difficult form from forced early retirement (Macunovich, 2012) to the economic consequences of aging minority women widowhood (Angel, Jimenez, & Angel, 2007). The Health and Retirement Study Survey Research Center (1992, 2000) was used to assess the effects of widowhood on the household incomes and assets of non-Hispanic White, Black, and Hispanic women who were 51 years of age or older at baseline ($N = 4,544$). The Angel et al. (2007) study discussed marital disruption, including the widowhood of women of all racial and ethnic groups, which results in a substantial decline in household income and assets. These and other risk factors may exacerbate the incredible economic consequences of widowhood for older minority women (Angel et al., 2007); or when combined with issues of longevity and ageism, extended employment needs would reduce or delay the propensity of poverty in these aging women (Angel et al., 2007). These factors may increase psychological abuse, workplace and employment issues, coupled with media and personal image misperceptions, health issues, and societal prejudice.

**Psychological abuse.** Ageism and women’s longevity pose a risk of mistreatment and poverty, with one in four aging women reporting psychological abuse, which may cause emotional or psychological trauma (Mouton et al., 2004; Robbins, 2015; Yon et al., 2017). The reported psychological abuse of aging women leads to negative impacts on their financial stability, on their security in housing, on their health, on their employment,
on their mental health, and on their overall well-being (Nelson, 2016; Palmore, 1999). Workplace and employment ageism are a growing concern impacting aging women.

**Workplace and employment.** The NASEM (2018) proceedings documents that ageism in the workplace, in the form of micro assaults, micro insults, and micro invalidations, is a growing concern. Silicon Valley’s high technology communities reveal that young adults are undergoing plastic surgery to conceal their age to avoid workplace ageism and to keep certain jobs longer. The studies of Abrams, Swift, and Drury (2016), Angel et al. (2007), and Macunovich (2012) discussed the impact of implicit age biases affecting many aging women who are forced into retirement or excluded from jobs based on age discrimination and negative stereotypes. These age-implicit biases cause financial hardship and older-aged poverty (Abrams et al., 2016; Angel et al., 2007; Macunovich, 2012). Although studies do not specifically address the terminology of workplace gender microaggressions toward aging women, aging women employment research shows sexism and ageism in the forms of early retirement and reported discriminatory practices (Abrams et al., 2016; Angel et al., 2007; Macunovich, 2012). Researchers have expressed the need to further understand the negative impact ageism has on later-life hiring, employment practices, and workplace environments (Basford, Offermann, & Behrend, 2014; HelpAge International and the Center for Financial Inclusion at Accion, 2015). In addition to job related ageism, media and personal image for women also perpetuate ageism.

**Media and personal image.** Studies like Ayalon and Gewirtz-Meydan (2017) and Gendron et al. (2018) discuss negative age stereotypes in media as perpetuating ageism. Ayalon and Gewirtz-Meydan (2017), after evaluating 39 websites, found 29 out of 39
websites used negative connotations of aging adults, such as to question the sincerity of aging adults in relationships or evaluate aging women’s personal images as objectified, or made invisible, based on physical appearances and attractiveness. Gendron et al. (2018), through a qualitative discourse analysis of a White House Conference on Aging video, studied aging professionals discussing aging adults’ issues. Gendron et al. (2018) identified 26 instances of perpetuated ageism pervasive in the cultural messages.

Discriminating and negative messages have been also found in social media such as in the analysis of Facebook’s group descriptions (Levy, Chung, Bedford, & Navrazhina, 2014). Of the 84 groups investigated, which totaled 25,489 members, Facebook descriptions revealed that 74% criticized aging adults, 27% infantilized aging adults, and 37% supported banning aging adults from public activities such as shopping. Levy et al. (2014) discussed Facebook’s Community Standards, which are used as a guide to acceptable content, not including age as a discriminatory factor relating to hate speech violations toward aging adults.

Gendron, Welleford, Inker, and White (2016) supported the idea that research has noticed a tendency to criticize, infantilize, patronize, and advocate for the exclusion of aging adults. Other types of verbal abuse, micro insults, and psychological distress coming from internalized ageism is part of the concept that aging people are different, old is negative, and young is positive (Gendron et al., 2016). Other studies support the premise that when society places importance primarily on youth and beauty, society further aids the perpetuation of negative age stereotypes as well as imposing consequences on the positive sense of aging (Chrisler et al., 2016; Nussbaum, Pitts, Huber, Raup Krieger, & Ohs, 2005; Palmore et al., 2016). Ageism interferes with healthy
aging, prompt medical treatment, and how practitioners handle aging adult assessments (Chrisler et al., 2016; NASEM, 2018; Nelson, 2016; Palmore et al., 2016). As such, ageism impacts aging women’s health and treatment.

**Health.** According to Chrisler et al. (2016), aging women seeking healthcare concerns may not be screened immediately, are considered too frail for certain treatments, or may have symptoms of a disease that looks age justified. Therefore, medical providers decide if the disease or the aging patient is necessarily in need of medical intervention. Aging women addressing healthcare concerns with a provider on screening for sexually transmitted disease or depression may be dismissed. Providers may think that aging women are not sexually active nor need medication for depression (Chrisler et al., 2016; Nussbaum et al., 2005). The request may yield discriminatory results, such as dismissing the need for a test or medication, until the provider is repeatedly asked over multiple visits (Chrisler et al., 2016; Nussbaum et al., 2005). Nussbaum et al. (2005) suggested practitioner bias toward aging women tends to result in under-treatment or over-treatment in healthcare. Palmore et al. (2016) spoke of a widespread belief that illness and ailments are normal in aging, which prevents adequate treatment. Chrisler et al. (2016) reported, in her review of the literature on ageism and women’s health, practitioner bias influences treatment assessment. For example, more or less medication is recommended based on mental health or memory loss behaviors in aging. Practitioner bias holds a cumulative burden for aging female patients. Such ageist stereotypes impact aging adults’ physical and mental health by influencing treatment decisions (Chrisler et al., 2016). As a result, Chrisler et al. (2016) suggested changes in
policy as well as more research on ageist behaviors and the outcomes reported, as a way to improve aging women’s health and well-being.

**Outcomes reported in ageism.** Studies addressing ageism through discriminative behaviors (Robbins, 2015) can manifest in the form of internalized microaggressions (Gendron et al., 2016) with examples being a peer group age bias, or oppression (Gendron et al., 2016), such as an aging woman not finding employment; or complex prejudices (Cary, Chasteen, & Remedios, 2017) involving both negative and positive stereotypes such as the aging adult is perceived to be incompetent or the aging adult does not want help when the perpetrator insists. Cary et al. (2017) discussed benevolent and hostile ageism as predictors of the competence and warmth perceptions of aging adults. The Cary et al. (2017) study explained that participants testing high on benevolent ageism perceived aging adults as warm hearted, whereas those testing high on hostile ageism viewed aging adults as not warm hearted. Aging adults viewed as low in competence and high in warmth tended to experience protective or benevolent prejudice (Cary et al., 2017). Aging adults who were viewed as low in competence and low in warmth tended to experience disrespectful or hostile prejudice (Cary et al., 2017).

**Ageist communication.** Ageist communication is a behavioral and language-based discrimination described as patronizing, demeaning, or condescending speech. Nelson (2005) and Nussbaum et al. (2005) purported that ageist communication and ageist language are culturally pervasive, leading to the consequences of prejudice and discrimination toward aging individuals. Nelson (2005), in his literature review, highlighted the existing empirical and theoretical work by researchers in gerontology, psychology, communication, and related fields on understanding the origins and
consequences of stereotyping and prejudicing. Nelson’s (2005) research further implicates that individuals automatically make decisions and categorize each other in society by social perception. For example, an automatic decision is made on an aging individual’s social status when an aging adult has gray or white hair. Depending on the society’s attitude toward aging, individuals’ perceptions can be both positive and negative. Such a perception can affect social and health outcomes toward such traits as gray or white hair that categorize an individual as an aging adult. Negative age stereotyping (Palmore, 1999; Palmore et al., 2016), such as feeling ugly or not youthful, encourages many aging adults to buy skin products dedicated to hiding the physical signs of aging because of social perception (Nelson, 2005). Other negative prejudice includes viewing aging individuals as being sick or chronically ill; having mental decline or mental illness, such as Alzheimer’s disease; being powerless, weak, or useless, as in being retired, living in poverty, or losing the ability to be financially stable; and/or having depression, anxiety, or isolation (Palmore, 1999; Palmore et al., 2016). According to Draper’s (2005) discussion of patronizing speech toward aging adults, students’ perception of aging adults was influenced by the professional education and modeling of behaviors, hence creating a link between the prevalence of ageist attitudes, automatic decisions, and categorization. Ageist communication can appear in verbal and nonverbal communication in the form(s) of elderspeak, patronizing speech, and behavior tactics, which all warrant additional advocacy and research.

_Elderspeak._ With the further broadening of terms, studies include the form of negative stereotyping and patronizing ageist language called elderspeak. Younger adults use elderspeak to address aging adults with speech accommodations that include baby-
talk, infantilism of speech by producing shorter sentences, and using simpler words or adding repetition (Lombardi et al., 2014; Williams, Perkhounkova, Herman, & Bossen, 2016). Researchers corroborate on how elderspeak, used by staff, produces resistance to care or negative outcomes, such as increased dependency, when additional attention or assistance is not needed (Corwin, 2017; Lagacé, Tanguay, Lavallée, Laplante, & Robichaud, 2012; Lombardi et al., 2014; Williams, Kemper, & Hummert, 1995; 2003). For instance, aging adults self-reported that demeaning or condescending speech contributed to low self-esteem and depression, and the ageist communication, elderspeak, undermines a sense of self and lends to perceived dependence (Williams, Kemper, & Hummert, 2004). Corwin (2017) reported, after examining 100 hours of audio and video recordings on the interactions of aging adults and their caregivers, that individuals with cognitive decline were shown to be more resistive to care by responding with further cognitive decline and social isolation when confronted with ageist communications defined as baby talk or elderspeak.

**Patronizing speech.** Palmore et al. (2016) described patronizing speech as using a condescending or perceived disrespectful tone to an aging adult. Researchers agree that patronizing speech is a form of verbal abuse or micro insult toward aging adults (Draper, 2005; Hummert & Shaner, 1994; Lagacé et al., 2012; Lombardi et al., 2014).

The Lagacé et al. (2012) study explored the extent to which institutionalized elders perceive daily communication with caregivers as being ageist, as well as the impact of such perceptions on quality of life in the facility and coping strategies used by elders. A total of 33 in-depth, semi-structured interviews were conducted with elders living in long-term care facilities in the province of Quebec. The qualitative and
quantitative results of the data analyses suggest that communication with caregivers is, indeed, perceived as ageist by the majority of elders, and that such perceptions diminish the perceived quality of life in the facility. Furthermore, most elders seem to cope with ageism by accommodating caregivers, a strategy that may ironically reinforce patterns of ageist communication (Lagacé et al., 2012).

Through studying how staff address elders in facility-based care, patronizing speech can be as simple as calling an aging woman by her first name, or calling her “sweetie,” “cutie,” or “honey” rather than dignifying her through the use of a title such as Mrs. or Ms. accompanied with her last name when addressed by staff (Palmore et al., 2016). Other patronizing speech forms produce a loss of self-esteem and dignity. These include speaking loudly when an aging adult does not have a hearing issue, simplifying or repeating information many times with the idea an aging person will not first understand what was said, and offering or forcing unwanted help, such as a helper pushing the wheelchair to the dining hall without asking the aging adult, who normally physically manages alone (Palmore et al., 2016).

**Behavior tactics.** The use of controlling speech or tactics of ignoring is a means of psychological distress for any aging adult, with aging women also carrying the burden of sexism (Cary et al., 2017; Lagacé et al., 2012; Nussbaum et al., 2015). Aging women feel demoralized and marginalized by bigotry, sexism, and ageism (Nussbaum et al., 2015). Most problematic are non-intimate individuals who provide services such as healthcare workers or counselors (Nussbaum et al., 2005). Negative environments and ageist communication behavioral tactics, or micro invalidations, such as insincere flattery saying *wonderfully done* or *aren’t you sharp today* diminish social well-being (Palmore
et al., 2016). As a result, there is a negative stereotyping of perceived incompetence (Cary et al., 2017). Further, there is stigma that occurs in interactions between aging adults, treatment providers, and staff who assist in care (Chrisler et al., 2016). Ageist stereotypes emphasize negative characteristics and aspects of aging especially affecting older aging adults. To this point, ageist communication studies have not addressed the psychological distresses of patronizing speech, controlling speech, and the use of ignoring microaggressions, more specifically, micro insults or micro invalidations. Gendron et al. (2016) found that few aging studies bridge the gap to include microaggressions as a term describing verbal abuse as ageist communication, which is a form of language-based age discrimination. Throughout the literature, researchers have agreed that more microaggression studies are needed for this emerging concept (Nobels, Vandeviver, Beaulieu, Lemmens, & Keygnaert, 2018; Sohi et al., 2015; Stambaugh & Ford, 2015; Sue et al., 2007).

Advocacy and research call. Microaggressions can contribute to a sense of social oppression, dehumanization, and exploitation in marginalized groups. Research in understanding the impact of at-risk groups could negate further detrimental outcomes and negative consequences such as poverty and social isolation. Additionally, microaggressions negatively impact other health disparities in marginalized groups, as noted with chronically ill, aging women (Ortiz & Horne, 2013), and individuals facing gender-identity issues (Goldsen et al., 2017). Current research indicates the need for studies on the implications of well-being (Dong et al., 2013) and collective action (Sohi et al., 2015), but Ortiz and Horne (2013) recommended that additional studies are needed to determine higher quality of life through better healthcare treatments and stable daily
The results of microaggressions show an overall higher discrimination toward women (Sue et al., 2007). Application of microaggressions can be argued to affect women of any age. With respect to vulnerable aging women, researchers concur there is a need for further study and advocacy (Nobels et al., 2018; Sohi et al., 2015; Stambaugh & Ford, 2015; Sue et al., 2007). Further, advocacy can be impacted by the language and communication that leaders proport for providing a sense of certainty given that microaggressions can contribute to a sense of social oppression, dehumanization, and exploitation of aging women.

**Language, communication, and leadership.** Corley and Wedeking (2014) discussed the importance of certainty in language under their study’s concept of legal decision makers increasing the likelihood of a favorable response from other legal and social entities. By using a multinomial logit model of the impact of certainty on lower court compliance through the 2001 and 2007 Linguistic Inquiry and Word Count Dictionary, Corley and Wedeking found that opinions with a higher level of certainty in authoritative language are more likely to be treated positively by other legal entities. Corley and Wedeking proposed that their theory was based on the certainty expressed in language that is applicable to many different legal contexts. The theory Corley and Wedeking (2014) grounded in psychology and legal advocacy suggests that expressing certainty enhances the persuasiveness of a message; and although Corley and Wedeking (2014) discussed certainty through the study of legal language and legal advocacy, the practice of advocacy in the context of other social entities (Schegloff, 1997) have an additional place in advocacy or leadership language to necessitate the persuasiveness of
the message to defend against social oppression, dehumanization, and exploitation of any marginalized group—including microaggressions toward aging women.

Chapter Summary

As women suffer higher interpersonal violence, verbal abuse, and emotional abuse throughout their lifetimes, identification and review of the current research literature was performed to understand the cause or attitude around emotional mistreatment and violence in the areas of: (a) microaggressions and trauma; (b) elder abuse in the context of polyvictimization, psychological distress, and underreporting; (c) ageism in the context of psychological abuse, as applied to the workplace, media, health, and outcomes reported; and (d) ageist communication speech and behavior tactics.

Studies using the topic and terms of microaggressions and verbal abuse toward aging women specifically were not found during this literature search, nor has mistreatment and violence of older women been adequately represented in the research relating to addressing a microaggression viewpoint. A new urgency for more research on the mistreatment of aging women has developed with the high surge of longer-living, retired women baby boomers, who not only are outliving their male counterparts but who are known to be at higher risk of poverty (Christ & Gronniger, 2018) and poor social support (Cornwell & Waite, 2009) as this population ages. The impact of this realization has become a growing public, social, economic, and health issue (Cubanski, Koma, Damico, & Neuman, 2018; Teaster & Hall, 2018).

Chapter 3 discusses the research design and methodology for this research.
Chapter 3: Research Design Methodology

Introduction

Elder abuse is a global public health issue (Yan, 2019). Aging women experiencing elder abuse have higher mortality risks because of interpersonal violence, verbal abuse, and emotional abuse throughout their lifetimes (Baker et al., 2009; Dong et al., 2013; Fearing et al., 2017; Lin & Giles, 2013; Mouton et al., 2004; Yan & Brownell, 2015; Yon et al., 2017). Postmenopausal women suffer higher interpersonal violence, verbal abuse, emotional abuse, and consistent abuse exposure throughout their lifetimes (Hamby et al., 2016; Mouton et al., 2004, Yon et al., 2017). The demands of being a caregiver or eldercare provider can manifest in mental, emotional, physical, and financial stresses (NAC & AARP, 2015). Caregiver stress and negative experiences may lead to the adverse treatment or elder abuse of aging adults receiving care. Elder abuse has various forms: physical, verbal, or psychological/emotional; sexual; and financial, including intentional or unintentional neglect (Luoma et al., 2011; WHO, 2002). Emotional abuse tends to be the most commonly reported form of abuse among aging women (Luoma et al., 2011). Historically, there has been little understanding of the cause of verbal or emotional abuse toward aging women (Baker et al., 2009; Fearing et al., 2017; Lin & Giles, 2013; Mouton et al., 2004; Ross-Sheriff, 2012; Yan & Brownell, 2015; Yon et al., 2017). Eldercare professionals, such as care managers (USDOJ, 2014), are known as trusted advocates and listeners to their client’s needs (ALCA, 2018; Horne & Ortiz, 2017; Ortiz & Horne, 2013).
This research study endeavored to gain an understanding of the phenomenon regarding microaggressions and verbal or emotional abuse occurrence(s) toward aging women through the perceptions of trusted eldercare professionals who provide care management services to this population. Through exploring the experiences of a small group of ALCA experts, who engaged in supporting aging women, the new information obtained may provide insights, not only regarding occurrence(s) of microaggressions and verbal abuse toward aging women, but also in suggesting how to tackle elder mistreatment that is specific to aging women’s needs. The research question that guided this study was: How do ALCA professionals perceive the occurrence(s) of microaggressions and verbal or emotional abuse toward aging women clients?

A qualitative inquiry using the IPA method was chosen after various methodological approaches were explored, and the qualitative inquiry was based on the research question above. Qualitative inquiry seeks to describe and clarify the human experience as it appears in an individual’s life (Polkinghorne, 2005). The study’s primary goal was to explore the meaning that ALCA professionals assign to their experiences with microaggressions or verbal abuse toward their aging women clients.

To explore the perceptions of ALCA professionals regarding occurrence(s) of microaggressions and verbal or emotional abuse toward their female clients, a research design needed exploration and formation. Qualitative inquiry is an effort to give voice to participants; therefore, this study adopted a phenomenological approach so an understanding of the experiences of ALCA professionals could be queried (Creswell, 2013; Glesne, 1999). According to Creswell (2013), the application of qualitative research is needed when the topic is relatively new, and when important aspects of the
phenomenon are unknown. Qualitative inquiry allowed the researcher the opportunity to establish the meaning of a phenomenon from the perspective of the research participants. The researcher must be immersed in the lived experience (Saldaña, 2009). Qualitative inquiry provided more abundant opportunities for gathering and assessing, in language-based meanings, what the research participant valued, believed, and thought (Saldaña, 2009). A phenomenological research design was used in this study to allow the researcher to explore shared experiences within the ALCA profession relating to client experiences in the clinical field (Marshall & Rossman, 1995).

The qualitative method of inquiry was an appropriate way to gain insight into the phenomenon (Creswell, 2013, 2014; Glesne, 1999). The methodology used for this study was IPA. IPA is aimed at giving detailed exploration of how participants make sense of their personal and social world (Smith & Osborn, 2007). Larkin and Thompson (2012) defined IPA as a method used in qualitative analysis with a particular psychological focus on how people make sense of their experiences. IPA allowed the researcher to gather first-person, detailed and reflective reasoning from the research participants (Larkin & Thompson, 2012). Furthermore, Larkin and Thompson (2012) suggested that successful IPA studies capture and reflect upon the essential beliefs and concerns of the research participants. The two components, giving voice and making sense, take a substantial amount of time and effort by the researcher (Larkin & Thompson, 2012), because it is a dynamic process where the researcher plays an active role (Smith & Osborn, 2007). The researcher’s objective was to try to make sense of the participants’ worlds through interpretive activity to develop an inside perspective (Conrad, 1987).
IPA requires open research questions that focus on the experiences of the participants in different contexts, with the intent that the interview questions would explore those experiences (Larkin & Thompson, 2012). IPA emphasizes that studying different people reveals something about the experience of each individual involved, which allows the researcher to gain detailed information about the entire research participant group.

For the purpose of this study, six to eight participants were the optimal number (Smith, Flowers, & Larkin, 2009). Rich detailed descriptions of how the research participants experienced a phenomenon drove the answer to the research question (Pietkiewicz & Smith, 2014). As the aim of this current study was to explore how ALCA professionals perceive the occurrence(s) of microaggressions or verbal abuse toward aging women clients, IPA was thought to be an appropriate analytical tool to understand the particular instances of the participants’ lived experience. The researcher actively participated in the process (Smith & Eatough, 2006) through understanding and interpreting these participants’ lived experiences. The researcher made sense of the participants’ narratives—who made sense of their experiences—to apply an inductive interpretation approach by using a dual interpretation process that involved both the participant and the researcher (Gee, 2011) for this IPA study.

**Research Context**

The context for this IPA study was based on a purposeful sampling process consistent to IPA. This study, using IPA, aimed to find a closely defined group of participants for whom the research question would have relevance and personal significance (Smith & Osborn, 2003). This study included a homogenous sample. The
homogenous group comprised participants from ALCA, an international organization initially formed in 1985 in the United States as the National Association of Professional Geriatric Care Managers (NAPGCM). In May of 2015, this international association began operating under a new name called the ALCA (Aging Life Care Association). Members are called ALCA Professionals. The membership count was 1,783 in 2017, consisting mostly of social workers and nurses who are business owners, who have a minimum of a master’s degree, and who have over 2 years of supervised experience in a geriatric care setting. To qualify for the Advanced Professional status in the ALCA, approved certifications must be acquired and maintained for Care Manager Certified (CMC), Certified Case Manager (CCM), Certified Advanced Social Work Case Manager (C-ASWCM), and Certified Social Work Case Manager (C-SWCM). ALCA members must maintain advanced professional education as a requirement for recertification and membership status. ALCA members are given access to specifically tailored, best-practices resources that optimize clinical, business, and ethical performance in the growing field of aging life-care, geriatric-care management. ALCA professional development opportunities through webinars, conferences, and publications are offered year-round to the members. In conjunction with association professional development opportunities, ALCA members use private or group mentoring or supervision within the advanced-practiced ALCA experts inside the membership umbrella. The ALCA CEO and board of directors were asked by the researcher to approve (Appendix A) email access to the ALCA members who agreed to participate in the phenomenological interviews for this study (ALCA, 2018).
**Research Participants**

The ALCA professional, also known as a geriatric care manager, is a health and human services specialist who guides and advocates for families caring for older relatives or disabled adults (ALCA, 2018). The ALCA professional is educated and experienced in any of several fields relating to aging life-care, geriatric-care management, including, but not limited to, nursing, gerontology, social work, or psychology, with a specialized focus on eldercare (ALCA, 2018).

The ALCA professional assists clients in attaining their clients’ maximum functional potential, such as obtaining and maintaining healthcare, to be able to continue to live in better health in the clients’ own homes. The ALCA professional encourages the clients’ independence while addressing safety and security concerns. ALCA professionals can address a broad range of issues relating to the well-being of their clients, such as housing, health, or a coordination of services, including home healthcare and meal delivery, so aging adults can maintain independent living. The ALCA professionals chosen for this study had many different experiences, and the participants lived throughout the United States. The ALCA professionals chosen for this study aligned with the membership criteria that includes required self-oversight in the professionals’ commitment to follow a code of ethics as part of the membership standards (ALCA, 2018).

Creswell (2013) recommended phenomenological studies use five to 25 participants. IPA studies require small sample sizes. The basis of this study was on the quality, rather than the quantity, of the data that permitted the development of insightful analysis (Larkin & Thompson, 2012). The appropriate numbers of participants can vary.
according to the aims, level, context, time, and resources of the researcher (Smith et al., 2009).

IPA samples are generally reasonably homogenous when participants tend to have an understanding of the topic (Larkin & Thompson, 2012). For this study, the sample size of this reasonably homogenous group was seven participants. In order to collect data from the participants, the requirement was to gather a sample. This IPA study used purposeful sampling that involved identifying and selecting participants who were knowledgeable or experienced with the phenomenon of this study based on the judgment of the researcher (Creswell & Plano Clark, 2011). Purposeful sampling was a way of identifying and selecting the ALCA professionals who were knowledgeable with the phenomenon of this study.

The participants were recruited by responding to the ALCA list serve posts as voluntary participants (Appendix B). The participants were also ALCA professionals in good standing with at least 3 years of experience, and these participants had up-to-date, approved certifications in care management.

**Data Collection Instruments**

Upon approval from the IRB at St. John Fisher College (Appendix C), identification of potential research participants commenced. The researcher called the interested participants who had contacted her through email and who had verbally reviewed the prequalification criteria for participation under the interview protocol (Appendix D). Upon meeting the criteria, interested volunteer participants were chosen for the study and asked to participate. Following the agreement to volunteer, the participants were sent information confirming the date set for the interview using a
follow-up email to the participant selected (Appendix E), which included a digital letter confirming the voluntary interview date (Appendix F), an information sheet (Appendix G) including the participant’s informed consent form (Appendix H).

In detail, IPA analyzes how participants make sense of a particular phenomenon in their world. Therefore, IPA requires a flexible data collection instrument. In this IPA study, collected data was from personal accounts, diaries, and semi-structured interviews (Smith & Osborn, 2007). The researcher, in the structure of each study participants’ interview, allowed the data collection instrument to be flexible, which helped reduced researcher bias.

For this study, the use of semi-structured interviewing questions allowed the researcher and the participants to engage in open dialogues regarding their experiences. MODIFYING initial questions, in the light of the participants’ responses to the researcher, can allow for probing interesting or important subject material that emerges during the interviews (Smith & Osborn, 2007). With the semi-structured interview process, the researcher had a set of questions with an interview protocol (Appendix D), where the protocol (guide) would not dictate the interview process (Smith & Osborn, 2007). The interview protocol directed the conducting of the semi-structured interviews within the IPA study. For this study, the researcher established rapport by following the participants’ interests or concerns. Once the participants were comfortable with the researcher’s rapport, the ordering of the questions was flexible.

The advantages of using semi-structured interviewing in this study was to facilitate a flexible connection via empathy to produce rich data. Use of an interview protocol assisted the researcher in thinking about what the interview would cover. For
this study, an interview schedule helped the researcher to be more confident as well as to concentrate on what the participants were saying (Smith & Osborn 2007). In creating this study’s protocol schedule, the researcher determined how to conduct the overall interview, including the broad range of issues the interview would cover. Topics were in the most appropriate sequence with the most sensitive topics left until later in the interview to allow the participants with time to become relaxed and comfortable. Further, the researcher thought of possible probes and prompts that could follow from answers to some of the questions (Smith & Osborn, 2007).

After creating the interview protocol, the researcher constructed questions, starting with the most general question, to enable the participant to talk about the subject. When a participant was having difficulty, the researcher moved to the prompt, which was more specific. A successful interview included questions and answers at both general and more specific levels (Smith & Osborn, 2007).

Specifications for participating in this study included an unstructured English-speaking interview timeframe of 60 minutes in each participant’s natural environment through an online digital audio platform. The interview modality consisted of a digital audio platform called WebEx. Time was designated to obtain follow-up contact information at the end of the first interview meeting. Once the interview was transcribed, the researcher provided each participant their transcription as a member check of the original interview via email to provide feedback to ensure that the researcher had an accurate understanding of what the participant had shared.

A research notebook was used to capture field notes, reflective memos, as well as to serve as an audit trail for data analysis. Consistent with IPA research, the researcher
took field notes immediately following the interview to help contextualize the interview material and as a means of reflection upon the researcher’s impressions of the interaction with the participants (Smith et al., 2009). Field notes were completed directly following each interview to capture any thoughts or questions that surfaced.

**Data Collection and Analysis**

After the semi-structured interview process was complete, the researcher listened to the interviews from the recorded and transcribed interviews (Smith & Osborn, 2007). For IPA, the level of transcription is generally at the semantic level, meaning the researcher needs to see all the words spoken, including pauses, laughs, and other characteristics, that are worth recording. The researcher allocated adequate hours of transcription time for each interview (Smith & Osborn, 2007), given that transcription is labor intensive, and as well, the researcher used a private transcription service called Temi (Temi, 2020). The procedure used for data analysis of this IPA study was a recording of the interview, so the researcher could listen carefully to the responses and probe for new questions during the interview. The recordings were then transcribed word for word, the researcher reviewed the transcripts, and the transcripts were given to the participants for their review and approval, which is also known as member checking (Hycner, 1985; Vogt, Gardner, Haefele, & Vogt, 2014). The researcher, within the transcription process, looked for significant themes that emerged from the semi-structured interview process.

To analyze the data, the researcher spent extensive time with the data, looking for themes, looking through the transcripts several times, and annotating significant information received from the research participants (Smith & Osborn, 2007).
researcher started the first stage of analysis in IPA by reading and rereading the
transcripts to become as familiar as possible with the materials (Smith & Osborn, 2007).
Initial notes were transformed into short phrases that captured the text quality. The themes moved the responses to a slightly higher level of abstraction and invoked more psychological terminology (Smith & Osborn, 2007). This process of notes being transformed into themes happened throughout the full transcripts (Hycner, 1985). To further assist the researcher, a qualitative research software program, Quirkos (2020), was used to map out data as emergent themes provided connections. The Quirkos (2020) data mapping software program allowed the researcher to access richer data for analysis by looking repeatedly through the data to reposition and code the analyzed data into further color-coded maps, allowing for a visualization of the connections to the emerging themes. This data mapping allowed for the development of spreadsheets with specific coded data sets. The researcher found value in the use of the coding software when analyzing the data in a more comprehensive way.

Once the emergent themes were found and listed, the researcher looked for connections. The initial list was in chronological order by the sequence with which the themes came from transcripts. The next step involved more logical and theoretical ordering, where the researcher tried to interpret and make sense of the connections between the emerging themes. The researcher “sat with” the connections, further examining, reexamining, and understanding the data through how the study participants provided the data, and by reviewing those connections by rereading the study participants’ transcripts. Some of the themes clustered together, and some themes
emerged as a category within a system of classifications under certain concepts (Smith & Osborn, 2007).

In summary, the data analysis included transcription and member checking, open line-by-line coding through reading and rereading (first stage), initial noting, developing emergent themes, identification of connections, analysis sequencing, and identification of patterns. During the development of the emergent themes in IPA (codes), the data analysis involved inductive and emergent coding, in vivo coding, and a priori coding. After the first level of coding, axial coding was used for the second level of data analysis, followed by selective coding, which produced categories, then the categories yielded the final themes.

**Chapter Summary**

This chapter, Chapter 3, described the qualitative method of inquiry used for this phenomenological study, giving purpose and meaning to ALCA professionals’ perceptions of the occurrence(s) of microaggressions and verbal or emotional abuse toward their aging women clients. To gain insight into the phenomenon needed for this study, the qualitative method of an IPA was used (Creswell, 2013; Glesne, 1999; Smith & Osborn, 2007). An overview of IPA design was presented as well as the research context, participants, instruments, and the data analysis process.

The findings of this study are presented in Chapter 4. In the Chapter 5, the implications of the findings and recommendations are shared. The final chapter will also summarize the study, reiterate the significance of the study, discuss limitations of the study, and provide recommendations for future research.
Chapter 4: Results

Introduction

Elder abuse is a global public health issue (Yan, 2019). Aging women who experience elder abuse suffer higher mortality risks due to interpersonal violence, verbal abuse, and emotional abuse throughout their lifetimes (Baker et al., 2009; Dong et al., 2013; Fearing et al., 2017; Lin & Giles, 2013; Mouton et al., 2004; Yan & Brownell, 2015; Yon et al., 2017). Emotional abuse tends to be the most commonly reported form of abuse among aging women (Luoma et al., 2011).

The literature supports that there is an acknowledged need for further understanding of the cause of verbal or emotional abuse toward aging women (Baker et al., 2009; Fearing et al., 2017; Lin & Giles, 2013; Mouton et al., 2004; Ross-Sheriff, 2012; Yan & Brownell, 2015; Yon et al., 2017). And while there is growing research on elder abuse toward aging women, there is little to no existing literature on the specific experiences or perceptions of the stakeholders, such as ALCA experts, who are known as trusted advocates and listeners to their clients’ needs (ALCA, 2018; Horne & Ortiz, 2017; Ortiz & Horne, 2013).

This chapter presents an analysis of the qualitative data gathered through the interviews with seven ALCA experts. The purpose of this IPA study was to explore the lived experience of ALCA experts and the meaning that these experts assigned to their experiences with microaggressions and verbal or emotional abuse occurrence(s) toward aging women.
The research goal was to gain insights into the understanding of the phenomenon regarding microaggressions and verbal or emotional abuse occurrence(s) toward aging women through the perceptions of trusted stakeholders, identified for this study as ALCA experts, who provide professional care services. The following research question guided this study: *How do ALCA professionals perceive the occurrence(s) of microaggressions and verbal or emotional abuse toward aging women clients?*

An IPA qualitative inquiry was completed after exploring various research methods as well as how the inquiry connected to the research question noted above. The primary goal of IPA is to investigate and uncover how an individual makes sense of their experiences (Larkin & Thompson, 2012). An IPA approach provided detailed descriptions of how ALCA professionals perceived the occurrence(s) of microaggressions and verbal or emotional abuse toward aging women clients.

**Data Analysis and Findings**

This section provides an overview of the results of the data analysis. This section further gives the findings including the identification of the themes that emerged, which are described and supported.

**Data analysis.** A homogenous sample of seven U.S. ALCA experts, with shared experiences of the phenomenon of interest, participated in this study. These participants practiced in California, Florida, Georgia, Michigan, New York, Pennsylvania, and the District of Columbia at the time of the interviews (Clarke, 2009). These participants represented a culturally diverse sample that included mixed genders; diverse backgrounds in race; diverse socioeconomic status and they represented rural, suburban, and city settings. The participants met the prequalifying criteria for study participation and
identified as engaging in the phenomenon of interest—the perceptions of an occurrence(s) of microaggressions and verbal or emotional abuse toward aging women. Interviews were conducted with each of the ALCA experts through a secure online audio recording platform and member checking was performed for study integrity. The data analysis process focused on both the details of each participant’s experience of the phenomenon and the shared experiences of the phenomenon by each of the study participants. Besides using manual data analysis, a qualitative data analysis software program called Quirkos (2020) was beneficial for gaining an insightful, visual, and intuitive perspective in managing, analyzing, and exploring this IPA qualitative research.

Findings. By the researcher’s analysis in interpreting the study participants’ responses, and by identification of patterns, five themes emerged: (a) insidious transactions, where microaggressions are negative interactions against aging women; (b) definition interpretation, where microaggressions and verbal or emotional abuse are intertwined; (c) trauma, where higher vulnerabilities in aging women lead to a higher amount of microaggressions and verbal or emotional abuse that traumatize; (d) dignity, where recurring microaggressions and verbal or emotional abuse violate aging women’s human dignity and human rights; and (e) advocacy, where support is an essential tool to use against microaggressions and verbal or emotional abuse toward aging women. Also, a varied definition of microaggression and verbal or emotional abuse terminology emerged from the study participants that provided a foundation for how each participant understood the research question: How do ALCA professionals perceive the occurrence(s) of microaggressions and verbal or emotional abuse toward aging women clients?
The population for this study was seven ALCA experts who self-identified as engaging in the phenomenon of interest, by having professional perceptions of the occurrence(s) of microaggressions and verbal or emotional abuse toward aging women, which was based on a definition provided by the researcher. For the purpose of this study, a *microaggression* was defined as verbal indignities that communicate negative messages that have been a more recently acknowledged form of abuse linked to psychological distress and trauma. For the purpose of this study, *verbal or emotional abuse* was defined as uncontrolled anger, hollering, mocking or name-calling, ignoring, threatening, bullying, and fear-induced language.

The examination of the findings began with each participant’s definition of microaggressions and verbal or emotional abuse. The study participants defined microaggressions and verbal or emotional abuse in many ways. These definitions were essential to understand as each participant specifically defined microaggressions and verbal or emotional abuse through client stories, personal observations, interactions, and transactions. During the interviews, the participants shared their particular definition of microaggressions and verbal or emotional abuse by their perceptions of their aging women clients’ experiences. The meaning that the participants assigned to their experiences was influenced by these particular definitions of microaggressions and verbal or emotional abuse.

Understanding each participants’ definition of microaggressions and verbal or emotional abuse set the foundation for understanding the meaning that each participant assigned to their experience with microaggressions and verbal or emotional abuse. All seven study participants self-identified as observing or experiencing microaggressions.
and verbal or emotional abuse toward aging women and experiencing the phenomenon through their perceptions of aging women clients’ experiences with the following statements.

The definition and word use relating to how Participant 1 stated that microaggressions toward aging women “happen a lot” where clients’ experienced people “talking over and around them.” This participant expressed this type of experience as one of the most traumatic microaggressions, having “serious and impactful” negative outcomes on aging women. Participant 1 experienced the phenomenon while watching verbal confrontations produce fear, sadness, and helplessness in aging women. Participant 1, adding sadly, that microaggressions “happen a lot” when people “push them out of the way” because aging women “can’t hear or are not fast enough” in their responses or interactions. This participant expressed that clients’ experiences of microaggressions, and verbal or emotional abuse have a painful impact with negative transactional communication, meaning relating to the conduct of an exchange in business or work relationship occurring with both families and professional.

The definition and word use relating to how Participant 2 expressed microaggressions toward aging women were as the “exclusionary kind of conversations where there is a lot of, she, she, she” used, “like the patient isn’t even in the room.” Further, Participant 2 addressed her discovery that the type of microaggression and verbal or emotional abuse happens when a client is dealing with “financial exploitation where the bullying person uses, you know, whatever angry language” or “manipulative language” where the abuser scares the aging woman. Participant 2 expressed that this was her perception of her observations with clients’ experiences of microaggressions and
verbal or emotional abuse. She could feel her aging woman client’s fear and she, herself, felt fearful for her client in that situation.

The definition and word use relating to how Participant 3 stated microaggressions toward an aging woman were “when she got a lot of pressure from her family member,” and when “the family member began to call her at least three times a week in the evening and began to frighten her.” Participant 3’s perception was of the aging woman client feeling emotionally upset by interactions that seemed frightening, causing “emotional pain” and “anxiety.” Using a dismayed tone, this ALCA expert expressed how the emotionally upset aging woman client should not have had to experience what she did as “it was unnecessary.” The family member (abuser) was “interfering and making her feel really upset and more worried than she needed to be.”

The definition and word use relating to how Participant 4 expressed microaggressions and verbal or emotional abuse toward aging women showed “dismissiveness” where care staff were “too busy” to notice an aging woman’s bodily needs. The very vulnerable aging women were “invisible” or “lied to” as just a “body in a hospital gown.” Using a distressed tone, this ALCA expert expressed such observations of microaggressions and verbal or emotional abuse were a “tragic reflection” in the medical field where care is “barbaric” by the “lack of insensitivity” occurring by “no feeding, being untouched, and ignoring.” These “non-dignities” were traumatic microaggressions that produced “latent trauma.” In the client’s circumstances, Participant 4 expressed, the dormant past trauma exposure awakened by other recent repeated or prolonged painful experiences or verbal indignities affecting the aging woman client. In one such example of keeping the aging woman client in an adult
“onesie,” Participant 4 stated, in an angry tone, without toileting every 2 hours, as agreed by the facility, “was a form of abuse and a dismissal of a human being,” as “she’s an aged woman who could not speak for herself” and she “couldn’t report.” These incidents observed by this ALCA expert held forth the perception of aging women clients’ experiences of microaggressions and verbal or emotional abuse.

The definition and word use relating to how Participant 5 expressed, through a voice that held distinctive unhappiness, microaggressions were aging women being “infantilized where they are made to look child-like” in their appearance, such as using hairstyles that children would wear, groomed on an aging woman. This participant indicated the microaggressions toward aging women can take the form of “cultural misunderstanding by the sender.” Such a case would be when addressing aging women by her first name without permission. This action, stated by this ALCA expert, could be perceived as a microaggression. Further, this participant expressed these incidents were perceptions of her aging women clients’ experiences of microaggressions and verbal or emotional abuse when transactional communication was observed with care staff or professionals who may bring different cultural perceptions to their care.

The definition and word use relating to how Participant 6 stated that microaggressions and verbal or emotional abuse toward aging women were based on “societal structures” that could “ignore” the need for physical and psychological caring as well as “withholding care” to meet the needs of the care provider or because of facility policy. Aging women, from an “abilities” standpoint, may endure risky transactions, such as fumbling with money because of arthritic hands, and where a person in society must wait for money to be counted or dropped because of poor dexterity, hence the cashier not
meeting their “timed work transactions,” causing microaggressions toward the aging woman through a show of impatience, eye-rolling, or harshly returning the change to the aging woman’s hand. This ALCA expert expressed, in a concerned tone, this perception of the aging women clients’ experiences of microaggressions and verbal or emotional abuse was observed in transactional communication with the aging women clients being assisted by working people on a daily basis in shopping areas, facility care, and other community-service settings.

The definition and word use relating to how Participant 7 expressed microaggressions and verbal or emotional abuse toward aging women could be seen with interpersonal violence where there was name-calling, like “dithering” or “dumb.” Participant 7 acknowledged that even when the aging woman was distressed by such harassment of an aggression, the client felt, in her generation, that she had “no voice” to protect herself. Further, this ALCA expert expressed in sad frustration, when the ability for an aging woman to provide certain personal care diminished, statements by the care staff saying, “well, she can do it herself” still is part of the microaggression. This participant believed verbal indignities happened to an aging woman client when help was truly needed, and the care staff decided to ignore or not give the proper care.

There were some similarities in the definitions provided by the participants, but there was no singular definition of microaggression/s and verbal or emotional abuse that emerged from the study. As summarized in Table 4.1, this was an unanticipated finding around the definitions, as each study participant’s definition of microaggressions and verbal or emotional abuse varied.
All the study participants stated the end results of the microaggressions and verbal or emotional abuse toward their aging women clients produced some form of trauma (being upset, showing pain or a type of suffering, noticeably becoming disturbed, shocked, or agitated) for those clients. Although this was the study participants’ perceptions of their aging women clients’ experiences, these study participants’ felt personally upset for their clients by describing emotional pain and interpersonal violence toward their aging women clients.

Table 4.1

Summary of Participant Definition for Microaggressions and Verbal or Emotional Abuse

<table>
<thead>
<tr>
<th>Participant</th>
<th>Definition</th>
<th>Word Use for Microaggressions and Verbal or Emotional Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant 1</td>
<td>serious and impactful</td>
<td>Verbal confrontations; hollering; timed, forced interactions/reactions; interpersonal violence; emotional pain; trauma</td>
</tr>
<tr>
<td>Participant 2</td>
<td>exclusionary conversations</td>
<td>Elder abuse; financial and verbal exploitation; being a pronoun; cultural differences; trauma</td>
</tr>
<tr>
<td>Participant 3</td>
<td>emotional upset</td>
<td>Harassment; pressure causing emotional pain; threatening; aggression; interpersonal violence; trauma</td>
</tr>
<tr>
<td>Participant 4</td>
<td>human dismissal</td>
<td>Dismissive; latent trauma; overt ignoring; lack of sensitivity; lying; warehoused; invisible; emotional pain</td>
</tr>
<tr>
<td>Participant 5</td>
<td>cultural misunderstanding</td>
<td>Infantilization; fear of retribution; being a pronoun; trauma; cultural differences</td>
</tr>
<tr>
<td>Participant 6</td>
<td>abilities insensitivity</td>
<td>Risky transactions; ignoring; withholding care; timed, forced interactions/reactions; cultural differences; trauma</td>
</tr>
<tr>
<td>Participant 7</td>
<td>verbal indignity</td>
<td>Cringing; harassment; distress; no voice; fear-induced language; bullying; interpersonal violence; trauma; verbal indignities</td>
</tr>
</tbody>
</table>

Further, the definition and word use related to how the study participants described the aging women being a nonentity, such as being a pronoun (using forms of “she” or “her” in place of the person’s name), and of their aging women clients’ reacting to harassment (pestering, persecuting, agitating). Many of the study participants
expressed their own distress by experiencing the phenomenon of watching timed, forced interactions/reactions (e.g., saying to an aging woman that “you can put an X here, don’t worry about writing your name” making the aged woman into a nonentity), which reduces an aging woman’s dignity and sense of identity, giving further meaning to microaggressions and verbal or emotional abuse that emerged from the study.

Understanding each participant’s definition of microaggressions and verbal or emotional abuse provided the context for examining the five themes that emerged from the study. The five themes outlined and discussed in detail in the next section represent the unique meanings that the participants assigned to microaggressions and verbal or emotional abuse as well as the shared experiences across the study participants.

**Insidious transactions: Microaggressions are negative interactions against aging women.** All the study participants indicated that verbal indignities, or the existence of microaggressions, were real. All seven ALCA experts observed microaggressions as an ongoing problem. There were many types of microaggressions witnessed. These participants gave meaning to the types of microaggressions that Sue et al. (2007) described in their research, such as *micro assault* (name calling or other forms of conscious and deliberate discriminatory actions), *micro invalidation* (communication that excludes, negates, or nullifies feelings), *micro insult* (rudeness or insensitivity or subtle snubs), and *micro invisibility* (disregarded presence).

All the participants reported microaggressions as a micro assault (name calling or other forms of conscious and deliberate discriminatory actions). One participant sadly expressed there was ongoing harm to her aging woman client in the form of an inflexible facility policy that caused a micro assault every morning to her client stating,
Why are they also coming by to wake her up at 5:00 a.m., to check her blood sugar and take her GERD medicine, [when she is] exhausted and half asleep, when she doesn’t get up to eat her breakfast until 8 or 9 in the morning? (P7)

This ALCA expert explained that medical care was to be checked right before breakfast, and it did not benefit the client 3 to 4 hours before her meal.

Another ALCA expert, with dismay, reported a micro assault observed of an aging woman client’s emotional struggle in an acute care setting, when a healthcare professional said, “okay, we’re not going to move you. And then, three people shoved her into the other bed, you know, and she screams again.”

Two out of the seven study participants both expressed micro assaults that came out as frustrations and impatience toward their aging women clients. One participant gave the following significant scenarios

The elderly woman, let’s say, is complaining about her orange juice. So, they put the orange juice glass down kind of heavy . . . maybe they’re complaining that their food is cold, so then they [workers] heat it up extra hot or something. Or the worker does not want to disturb an aging woman client because she finally stopped chanting so the worker chooses to forget to bring them their medicine then, you know, “I could just say I forgot that day.” (P6)

Another ALCA expert reported a micro assault by a family member when she heard a person on the phone saying to an aging woman client, “You’re an idiot. This doesn’t make sense. Look at that mistake you made.” The participant stated, “I don't know how many years ago it was” but this family member was “just continually bringing
that up” and was “harassing her” so “she then becomes very upset.” With an upset tone, this ALCA expert stated, “It’s hurting her,” this micro assault by the family member.

Another participant, in a summation when it came to micro assaults toward aging women clients, said,

This could really upset a person and would cause distress . . . especially if you are ignoring or, you know, kind of that micro assault, where you’re asked in a very rushed way and the person just walks away before you can respond or hear fully what is said to you. (P4)

The study participants reported microaggressions as micro invalidations (communication that excludes, negates, or nullifies feelings). One frustrated participant stated a common story that the other study participants had described:

People act like my aging woman client, like the patient isn’t even in the room, and I wonder why they exclude them instead of asking them, “is it okay if I tell her what you know happened,” or “can I describe what you told me you were feeling,” so you can address the aging woman client’s need. (P2)

Another scenario was expressed by an exasperated sounding ALCA expert, where

The family member will speak up and say, “oh mom or oh dad, I don’t know why you’re choosing that; you never liked it before, so the family member would choose over that aging adult, right in front of them. (P1)

One study participant stated an observed facility staff incident of staff “Speaking, using a pronoun, when the person, the older aging loved-one female, is present.” Another ALCA expert expressed “a staff member will talk about them [aging woman client] as if they’re not [there], and sometimes in a demeaning way.”
One participant expressed observing aging women clients’ microaggressions as micro invalidations by the way the aging women clients were being dismissed. Expressed in a slightly angry tone, this participant stated,

I do feel that women tend to get the brunt of the dismissiveness . . . these small things [micro invalidations], they actually jump out—at least as a practitioner myself, that it’s hard to quantify that in a sense until you start breaking it down [in]to words that make sense, like [a] micro invalidation that I have observed.

(P4)

Another dismayed participant further stated, “It’s just awful. I mean, they’re warehoused and all of these microaggressions or micro invalidations, they just, they compound upon each other and create what is essentially an absolute non-dignified aging process for those who are subject to it.”

The study participants reported microaggressions as a micro insult (rudeness or insensitivity or subtle snubs). A participant expressed micro insults happen by not understanding aging women, and in particular, the cultural information around aging women of color. This ALCA expert stated, “for example, in some communities, an older African American woman does not want to be addressed as girl, that is considered rude and a micro insult.” Individuals working with aging women of color, and who are void of cultural competency, may call an aging woman by her first name “and that is considered offensive [or is a micro insult] to be addressed by your first name without permission.”

Another study participant with a little disbelief in her voice reported,

I think a lot of times the way I see it in a doctor’s office can be a patronizing conversation where I’ve actually had to escort people and say, “can we please talk
over here? I think this would be a better place to talk,” you know, so I removed them from the situation so that they won’t be further aggressing upon the person as they act insensitive [with] how they are speaking about [client’s name]. (P7)

The study participants reported microaggressions as micro invisibility (disregarded presence), where their aging women clients were ignored or treated as nonentities in the room. One slightly agitated-sounding ALCA expert discussed micro invisibility with an incident regarding more frail, higher aged women clients having the microaggression of micro invisibility, “You know, especially the more frail, older women; they can’t move as quickly, you know, so they tend to be pushed out of the way sometimes, you know, not maybe even intentionally.” This ALCA expert continued with a further microaggression of micro invisibility by reporting, “Hearing; hearing is a huge issue,” because “an elderly woman not hearing immediately gives the impression that they’re cognitively impaired, making the professional think he should talk to me.”

The study participants expressed two recurring situations of microaggression used in health- and facility-based care settings with medical providers and facility-based care staff where micro assault and micro invalidation became serious barriers to their aging women clients’ care and health. Three out of the seven participants talked about situations of microaggression used in health care settings with medical providers. One participant stated in a frustrated tone:

So, let’s start talking to an elderly woman and she can’t hear them. And she’s saying, “Well, I’m sorry Dr., What was that Sir? Sorry, sir, what was that like?” And then you [medical provider] just stop talking to them because they can’t hear you or you think that they’re not understanding. So, you [medical provider] don’t
say anything anymore. Right. You just go about your business and that happens. Oh, so hearing issues also seem to have a play into or even reading and if they [aging women clients] can’t read fast enough for something, you know they’re [through helping the aging woman client with the form]. If you’re [medical provider] throwing forms, you know, [in front of aging woman clients], I’ve seen social workers, I’ve seen, taught, I know nurses, you’re like “just sign.” [Just] sign, sign and they [aging women clients] don’t seem to be, you know, they don’t seem to be catching on quick enough or knowing where to sign or if they’re [aging women clients] signing their name too slow. Right. You [medical provider] don’t want to, they can’t see or they’ve [aging women clients] got Parkinson’s and they’re [slow], you know, you see like, you know, they’re trying to pull the paper out from them while they’re still writing their because they [medical provider] want to put the next one underneath and they’re in a hurry. (P1)

One ALCA expert provided the example of an aging woman client stating,

I have to stop looking at the doctor. Like, I literally have to put my head down and write notes, or I have to look at the patient while the doctor is talking to me. Hmm. So, he moves his head [to look at and address my aging woman client]. (P2)

Another ALCA expert provided this example of a situation of microaggression used in a health care setting with a medical provider for her aging woman client stating,

I think a lot of times the way I see it in a doctor’s office can be a patronizing conversation of, “well, she doesn’t know better or she’s not going to follow through anyway there, so I [doctor] decide this.” There’s some of these kinds of
ways [transactional decisions are made]. Sometimes a male doctor will talk this way about a female patient. That’s definitely how I see those conversations as microaggressions. (P7)

The study participants told about microaggressions being used in facility-based care settings. Medical providers and facility-based care staff used micro assaults and micro invalidations that became serious barriers to their aging women clients’ care and health. Three out of the seven ALCA experts talked of situations where their aging woman clients were placed in distressing and unsafe situations. One of these experts gave a typical example that collectively expressed when professionals or facility care staff lack understanding about abilities, such as hearing:

If you don’t have much interaction with elderly women who have hearing and dexterity problems, then you know, you [professionals or facility care staff] don’t really, you don’t really know about it and so, it’s nothing, and it’s new to you, so, you don’t know how to accommodate, and then we [professionals or facility care staff] are not addressing aging women needs by our lack of education or understanding. (P6)

In summary of this first theme, insidious transactions, the study participants described many forms of microaggressions that were considered deceptive in nature, subtle in negative or demeaning transactions, and underhanded by the way the transactions played out with the professionals and the aging women. These ALCA experts provided personal narratives with a continuous acknowledgment that microaggressions are real in aging women’s lives. These experienced experts observed this phenomenon as a serious, ongoing problem.
Definition interpretation: Microaggressions and verbal abuse were intertwined and interchanged by the study participants. There was an intertwined, interdependent relationship between microaggressions and verbal or emotional abuse when the study participants shared their stories or discussed how they perceived their aging women clients’ experiences with microaggressions and verbal or emotional abuse. As seen in Table 4.1, terms used by the study participants, such as “verbal indignities,” “exploitation,” “verbal confrontation,” “avoiding” care, “bullying,” “ignoring,” “manipulation,” and “withholding care,” were used as both microaggressions and as verbal or emotional abuse, and sometimes these acts moved to polyvictimization, where the physically aging women clients were affected. The study participants moved through their stories, sometimes defining microaggressions as verbal or emotional abuse; at other times, the study participants defined verbal or emotional abuse as a microaggression.

For three out of five of the study participants, bullying was an active process of verbal indignities mixed with verbal abuse by family members, other facility residents, and even the caregiving staff. In the bullying process, verbal abuse was heard by these ALCA experts as well as by the aging women clients. These concerned and angry experts told how peoples’ words were threatening to their aging women clients and how behaviors were scaring the care managers, themselves. One ALCA expert expressed a situation around a bullying incident that occurred with her aging woman client:

So, we had this whole [peer group] bullying her because she said that she didn’t [pay anything], and with memory loss, that is what she thought, but it was not true, and physical altercations actually happened because of this bullying of someone [aging woman client] who had significant memory loss. (P7)
Two study participants expressed great concern around ignoring, avoiding, and withholding care. These two ACLA experts did not always know how to consider the above actions of ignoring or avoiding. Should they lean more toward a microaggression or more toward verbal or emotional abuse when you see ignoring, avoiding or withholding care? One of the two ALCA experts stated the:

Caregiver was, instead of redirecting and using skills that, you know, she should have learned working in a memory care unit, she was getting frustrated and, you know, parted, kind of avoiding this person or, you know, putting her back to this person or ignoring them or talking with the other staff. (P6)

The ALCA expert further stated, with a slightly protective voice:

That type of neglect is the type that I mentioned about withholding and then ignoring and then not providing care. I think that is the most damaging because that hits somebody in their, you know, in their core, in their soul. (P6)

One study participant reported her aging woman client by ability limitations. This ALCA expert unhappily explained her aging woman client was physically suffering from being ignored. This below example of withheld care in an acute care setting of a hospital demonstrated the complexity of care treatment when hospital staff would not feed her client. This expert discussed the intertwined nature of microaggressions and verbal or emotional abuse by trying to figure out if a lack of care is a microaggression or if it is emotional abuse toward her aging woman client:

They would’ve put a tray in front of her and then collected the tray untouched an hour later without making any attempt to make sure that she got some nutrition in her. You know, again, I was there to make sure that that happened. And then I
was able to get a caregiver to sit with her in the room for her own safety. The hospital said they have sitters—they never materialized in this hospital system that I’m familiar with. I mean, sitters supposedly exist, and I’ve never seen one materialize. So, once again, we’re talking about resources and what people can afford, and what happens when you cannot afford the support that you need. (P4)

Two out of the seven study participants denied verbal or emotional abuse, stating only microaggressions were present. These same study participants discussed fear-induced language (defined as verbal abuse) and fear of retribution (defined as verbal abuse) being difficult abuse experiences for their aging women clients. Although when asked about the specific use of verbal abuse, one of the participants stated at one point, “I can’t remember any incident of that. Never. [contemplative sound] Well, sorry.” This expert further expressed she had not fully thought about microaggressions and verbal or emotional abuse as separate, identified types of abuse leading to someone feeling seriously harmed or being traumatized:

Well, to be honest, I hadn’t really thought of it until you, until this research project, and I read, you know, the introduction because I think we’re so focused on elder abuse and whatever the exploitation, the financial, the physical, the yelling, what families can do that, you know, [contemplative sound] using the term microaggressions, right? Some of the other stuff [microaggressions and verbal abuse] seems kind of mild. You’re not really paying it all that much attention to it. You know it’s happening; you do things to correct it. But, you know, in the scheme, we’re all focused on the bigger picture of elder abuse. Yeah. I’m going to say, frankly, I hadn’t even thought about it until today, sadly. (P2)
Further, another ALCA expert stated, “I have not observed that [verbal abuse] in over 20 years in my practice,” though with further deliberation, the expert went on to discuss her perceptions that exhibited an intertwined, interdependent relationship between microaggressions and verbal or emotional abuse. Although this expert acknowledged trauma could happen in an aging woman client’s care, this participant actively (spoke contemplatively, as if processing her words) was working on understanding her definitions of microaggression and verbal abuse. For example, the following is about one study participant’s discussion about defining a *declamatory style of care* as a microaggression or not, or even as verbal abuse toward aging women when the aging woman client perceived the interaction as abusive treatment:

> I think . . . traumatizing, because the caregiver did not recognize or understand and recognize the woman’s cognitive level or advanced dementia. Let me put it that way. A frustration. Um, impatience. I think that’s another microaggression. So “hurry up,” you know. Um, I don’t know where these fit, but I have witnessed what would appear to one observer as a microaggression, may, in fact, not be intended as such because of the cultural difference in communicating between the caregiver who may be international and the care receiver who is not international. Cultural alum. Yeah. In certain cultural traditions, non-American, there’s what I call a declamatory style of care. So, it is “sit down,” “turn around,” “stand up,” “go sit.” It’s declamatory; there’s never a “please Mrs. Jones, please turn around and, and have a seat instead.” It’s *sit down*, not intended to be disrespectful. I often observed that and do some coaching to the caregiver who is international and comes from a community where that cultural tradition, you know, as a parent,
that kind of style of giving an instruction, not softening it. Whoa. It sounds harsh or received as harsh. . . . And that’s a big one in my view. And in my observation and in practice. No, I hadn’t thought of that as a microaggression, but I, I think it [declamatory statement] is received as something that doesn’t feel good. So therefore, I think it’s valid, you know? (P5)

In this theme of definition interpretation, the study participants’ scenarios provided a belief in the existence, complexity, and intertwined nature of microaggressions and verbal or emotional abuse. The intertwined nature of the situations further challenged the study participants to gain a greater personal understanding of the complexity of microaggression use and verbal or emotional abuse communication toward aging women. The study participants used the terms of microaggressions and verbal or emotional abuse interchangeably, making the definition interpretation complex and challenging. Many of these study participants were trying to understand their definitions, then label them correctly.

Trauma: Higher vulnerabilities in aging women lead to higher microaggressions and verbal or emotional abuse that traumatize. The study participants described how higher vulnerabilities in aging women lead to a higher number of microaggressions and verbal or emotional abuse. These participants realized vulnerable aging women with such issues as memory loss, physical/health needs, interpersonal violence, or emotional pain, were being subjected to microaggressions and verbal or emotional abuse, which would cause them emotional distress and trauma. Past or repeated unresolved trauma placed further emotional distress on these vulnerable aging women. A participant who expressed disbelief and anger described a situation of a
hospitalized aging woman client with severe memory loss, who expressed physical pain, fear, and distress, causing her to suffer microaggressions and verbal or emotional abuse by the healthcare workers’ actions.

Each time that they poked or prodded her, she screamed, and yell to stop. She innately wanted to protect [her]self, and yet could not. I felt that part of why she was treated the way she was treated was because she was essentially invisible to the providers who were offering care. She was a body. She was someone who couldn’t report about herself. “Honey, it’s okay, honey. Oh, honey, I won’t do that to you again. Okay, honey.” And yet [they did] in the end. It was false because they were continuing to do things to her. I would say that what I perceived as dismissiveness and abrasiveness was a result of her not being valued as someone who deserved more dignity in her care. (P4)

The concept of higher vulnerabilities, such as an aging woman with memory loss meant higher microaggressions; such as when staff would be chronically lying to a patient about painfully touching her. The abuse comes when a care professional believes it is okay to manhandle an aging woman patient because she will possibly forget being forcefully held down against her will for medical care. These abuses traumatize and re-traumatize vulnerable aging women.

A further example of a trauma incident is described by the following story from a participant who expressed disbelief, frustration, and slight anger on how further emotional distress was placed on her vulnerable aging woman client when obtaining services in a hospital setting.
I had a client who was admitted to the hospital; she was a brand-new client. Her adult caregiver was out of state, and I show up to the hospital. And they have her in restraints because she was going through alcohol withdrawal, and she would try to get up, and she had fallen down the stairs after drinking too many beers and broken her neck. And so, they had her in restraints, literally, had her hands tied down. And, you know, that was really shocking. I said, “well, why is she in restraints?” Well, she keeps trying to get up, and we can’t, you know, we can’t monitor her; we can’t watch her. And instead of, “have you, told the adult caregiver this, and have you offered you know, companionship care? Have you said anything about getting a caregiver in here to sit with her? Do you know that she’s a long-time alcoholic,” you know? So of course, you know, they hadn’t even thought about, or maybe they had, maybe they had thought about it, but hadn’t communicated getting a caregiver in there to help so that she didn’t have these restraints on her wrist. So, you know, I facilitated that. Got the caregiver in. She had 24/7 care with her to help her from, you know, this fall risks that she posed. And then also, you know, with] the alcohol withdrawals, you need certain medications, and you need some oversight for that. You can’t just, you know, go into that [treatment without supports]. So, I think, in that case, they should’ve seen how much alcohol was in her system though. That’s a thing. So, withdrawn. What’s holding that care, you know, that medical care with the alcohol and then withholding the option of the caregivers, which they should have known. (P6)
Past or repeated unresolved trauma can place further emotional distress on vulnerable aging women. Described by the following story from a participant, the adult child became abusive to the vulnerable aging woman client causing trauma:

I was over at a client’s house, right? It was, it was one in the afternoon, and her [adult child] called. Now there’s a lot of family dynamics with his family. So, I happened to go over to the house, and [adult child was on the phone] was over there talking with my client, perfectly having a chat session. Like we always do, [and she was in] good spirits, good mood. Almost immediately her tone changed. I could hear as she was hard of hearing. She had the control up. She didn’t ask me to leave the room. So, I didn’t, so I could hear the conversation. I could hear what was [said], on one hand the [adult child] started to lay in on her about different things, about her not remembering. And then it got very, very colorful with the language toward mother. And so, I’m hearing this, as I’m sitting across the table, you could just tell by her reaction how she was, you know, and she was trying to calm [adult child] down. [The adult child] just kept getting loud, more [and] more aggressive. So, she just hung up on [adult child] finally. And she should have. I was giving her signs, you know, I was, without interrupting her. I wasn’t verbally saying . . . hang up, hang up the phone, ’cause I can hear exactly what [adult child] was saying. And of course, after that, you know, she apologized to me for having to hear that. So, so we talked about it [the call] for a while afterwards. And she was affected even afterwards. In fact, probably for the rest of her life. There was a separation after [from the aging woman client’s adult child]. She was really afraid to answer the phone. She’s afraid to because she didn’t know what she was
going to expect on the other end. This is her [adult child]. You can imagine what emotional effect that had on her. (P1)

Another participant shared a perception with a sense of grief and agitation when telling of a client story where past or repeated unresolved trauma placed further emotional distress on a vulnerable aging woman:

We then reached a point where her [sibling] decided that he needed to know everything about her money because he had a conversation with her and she wasn’t clear, and he was afraid that she was developing dementia, and he was going to step in. He was not her financial power of attorney, and I had been specifically told by my client that I could not share her financial information with her [adult children] or anyone else in her family. Not that she didn’t have good relationships with them, she just didn’t think they needed to know, and she didn’t want anyone telling her what to do with her money or how to manage her money. So, while the daily money manager, my client, and myself all got along just fine, we got, she got a lot of pressure from her [sibling] about planning for the future, she [was] making sure she [client] didn’t run out of money. I did my best to assure her she could have 24/7 care for the next 10 years, and she wouldn’t run out of money, and she would still be living in her home. [The sibling] then began to call her at least three times a week in the evening and began to frighten her. I would get calls saying, “I’m worried about my money. They’re trying to tell me what to do. I don’t understand why this is happening.” She became, started having anxiety over it. Her dementia started to get worse; understand, this is my perspective. She then at, one point, just came apart and was requiring a geriatric
psych admission. So, she went from caregiver to needing some assistance to needing an admission to a geriatric psych unit. (P3)

In summary, on the theme of trauma, the study participants’ narratives described how higher vulnerabilities in aging women lead to a higher amount of microaggressions and verbal or emotional abuse; and there was the realization by most participants that these recurring abuses caused emotional distress and trauma. These ALCA experts also validated microaggressions and verbal or emotional abuse patterns being linked to re-triggering psychological distress and trauma in their aging women clients’ experiences.

**Dignity: Recurrences violate human dignity and human rights.** Recognition by the study participants that recurring microaggressions and verbal or emotional abuse violate aging women’s human dignity—financial exploitation, facility-centered care, infantilization, memory loss vulnerability, physical altercation, and unmet physical and health needs—many of these abuse types are also human rights violations. A participant shared the following story of an aging woman with no memory loss receiving care in a facility-centered care placement. The aging women client—every day for 2 months—had a recurrent issue where the facility staff consistently ignored offering help or assistance to the aging woman client with her personal hygiene. The ALCA expert spoke to the recurring dignity violation:

They [family] told me yesterday that they just found out that since her placement in the facility, which was about 2 months ago, they have not bathed her. And to me, that’s an aggression. The 97-year-old said, “Oh, it’s fine. I go to the sink and I do everything at the sink.” It’s fine from her wheelchair, mind you. It’s not fine. And, again, you know, just that, that in and of itself, to me again represents a
complete and utter lack of care, which can certainly reflect the status of the staff in that facility, which is not a good facility. There’s not enough staff, and the staff that is there has no interest in doing the work that they’re tasked with. I mean, again, it’s, it’s an aggression even to think that someone would be denied their own hygiene. I mean, it’s just, it’s inexcusable. (P4)

A frustrated-sounding account by one participant told of a common scenario experienced by many of the study participants when working with staff at facility-centered care locations. Facility staff consistently talked about the aging woman clients as if they could not hear or participate in any decision-making. This ALCA expert discussed how staff violated the recognition of personhood. And further, this expert expressed this human dignity issue as happening on a recurring basis:

Sometimes these facilities are talking about a person right in front of them as if they can’t take in anything that’s being said. And these people are not disabled, but in their memory, but they’re not deaf. You know, they’re right there. And a staff member will talk about them as if they’re not, and sometimes in a demeaning way. That makes me cringe. And that happens unfortunately quite a bit. And some of them are just very focused on their task as opposed to their surroundings, they’re not seeing the surroundings and saying, “oops, I think I should take this aside” . . . and I’ve actually had to escort people [staff members] and say, “Can we please talk over here? I think this would be a better place to talk, you know,” so I removed them [staff member] from the situation so that they won’t be further aggressing upon the person [client] who’s there. (P7)
Other study participants shared the same concerns, though in varied scenarios, about recurring microaggressions and verbal or emotional abuse that violate aging women’s human dignity and human rights, especially when there is memory loss and physical abilities vulnerability. One participant discussed her frustration of recurring issues of aging woman clients’ privacy rights and dignity. The participant gave this narrative of staff in personal care who took photos without asking the aging woman client’s permission:

Oh, another microaggression. I was just thinking—it’s the photographing that goes on, but the person generally isn’t aware that their photographs are now available, you know, on the Internet or whatever. I don’t like photographs. I don’t like hearing she, she is cooperative. She did this, I actually redirect immediately. Or I try to include the older adult. I try to model for the caregiver, but honestly, when I’m in a new home with a new worker, I, say no [to all photos]. (P2)

In a sad manner, another participant shared another story of an aging woman client, with memory loss, losing her physical functioning, and how receiving care in a facility-centered care placement took her dignity away by forced clothing use. This ALCA expert discussed the recurring problem of the aging woman client’s hygiene care being ignored by the facility staff when a specified care plan order was put in place:

We went through a period of where her dementia, she was in decline, and she’s in a memory care unit, which presumably can address the needs of these clients, these residents as they come up. I, this was particularly painful to, to be a part of. When she became incontinent, they systematically took everything away from her that she could use to keep herself clean, because she didn’t know how to anymore,
and ultimately [they] put her in a onesie, a jumper that could only be on zipped from the back. So, she essentially was put in, in a body suit that she couldn’t get out of. And the agreement was that they would toilet her every 2 hours and that agreement was not kept by the facility. And so, again, I felt like it was a form of abuse and dismissal of a human being by virtue of the fact that she’s an aged woman who could not speak for herself. (P4)

In discussing the theme of dignity, there was recognition by the study participants that recurring microaggressions and verbal or emotional abuse violate aging women’s human dignity, and these abuse types are a human rights violation. Study participants shared narratives about the recurring problems of facility staff and other professionals that cause non-dignities toward their aging women clients.

Advocacy: Advocacy is an essential tool. There was a focus on the use of advocacy as an essential tool to use against microaggressions and verbal or emotional abuse toward aging women. The study participants acknowledged their role as an advocate being vital in assisting the aging women. One participant fully stated, “I say that as your advocate.” Another ALCA expert stated, “I was in a position of having to defend her wishes and defend my position and what I had been doing. I was very willing.”

Further, another ALCA expert told of an advocacy situation where an aging woman was being harassed by another professional, “If you do that, if he calls her again, and if he harasses her again, because she took it as harassment, I said, “if you harass her again, I will call the local bar association on him.”

In particular, the participants in this study provided insight where coaching, modeling, and educating were an essential part of their role as an advocate, especially in
building awareness of microaggressions and verbal or emotional abuse toward aging women or in empowering aging women clients. One participant stated that “I do some coaching to the caregiver,” while another ALCA expert stated, “I try to model for the caregiver.” Another expert expressed, “I empower my clients to speak up. If you don’t know, you can’t hear them, I tell them [“speak up”], I coached them before we go into these appointments.” From another participant, she expressed a perception regarding how advocacy sometimes needed to work in complex places and situations for aging women clients:

From our perspective, I think we try, since we’re involved as an advocate to constantly be, you know, where we can fight our battle. We fight the battle; and where we can soothe, we, soothe; and where we can educate, we educate. But there are times where, sometimes, you just hear it, and you have to talk to the female person afterwards and say, “I know that guy was not nice, but we got what we needed out of him, and we’re going to try to find someone to replace him if we can.” (P7)

These study participants expressed the role of advocacy as an essential tool used against microaggressions and verbal or emotional abuse toward aging women. These ALCA experts acknowledged that advocacy functions as an innate part of their role. The following participant expressed how she, and other study participants, acknowledged their advocacy role:

As an Aging Life Care Manager, we are advocates. And I think part of who we are innately is, you know, born advocates. This is why we are attracted to this field. And I think that some of that has to do with the fact that, in general, our
society as a whole, [is] so siloed from people with disabilities. It seems like only if you’ve been around people with disabilities, elderly, or, you know, even younger, you gained that sensitivity. (P6)

The study participants, by their discussion and narratives of the advocacy theme, believed advocacy is an essential tool to use against microaggressions and verbal or emotional abuse toward aging women. These study participants also acknowledged their role as an advocate being vital in assisting aging women clients. Many of the study participants provided coaching, modeling, and educating as an essential part of their role as an advocate. These study participants believed in building awareness of microaggressions and verbal or emotional abuse toward aging women or in empowering their aging women clients to fight against abuses.

**Summary of Results**

This IPA study explored the lived experiences of seven ALCA experts and, specifically, applied an interpretive analysis to these professionals’ experiences and perceptions of their aging women clients’ experiences of the occurrence(s) of microaggressions and verbal or emotional abuse to answer the guiding research question of this study: *How do ALCA professionals perceive the occurrence(s) of microaggressions and verbal or emotional abuse toward aging women clients?*

The results shown in Table 4.2 of the researcher’s data analysis of the interpreted study participants’ responses yielded five themes: (a) insidious transactions, where microaggressions are negative interactions against aging women; (b) definition interpretation, where microaggressions and verbal or emotional abuse are intertwined; (c) trauma, where higher vulnerabilities in aging women lead to a higher amount of
microaggressions and verbal or emotional abuse that traumatize; (d) dignity, where recurring microaggressions and verbal or emotional abuse violate aging women's human dignity and human rights; and (e) advocacy, where support is an essential tool to use against microaggressions and verbal or emotional abuse toward aging women.

Table 4.3 shows the relationships of the study’s five themes. The first theme of insidious transactions relates to the study’s findings from the study participants’ responses having a better understanding of the professional perceptions of the occurrence(s) of microaggressions and verbal or emotional abuse. Specifically, these participants had a better understanding of the activities that were consistent with the definition interpretation that defines microaggressions and verbal or emotional abuse, so that they tended to contemplate, process, and be more aware of the importance of identifying and understanding microaggressions and verbal or emotional abuse toward aging women clients. All the study participants told stories, giving further meaning of the end results of the theme of trauma where microaggressions and verbal or emotional abuse toward vulnerable aging women produced some form of trauma. Also, the study participants described the theme of dignity as recurrences of microaggressions and verbal or emotional abuse toward aging women and violating their human rights and human dignity, further causing emotional pain or trauma. The study participants provided an understanding of the advocacy theme by intellectually interacting with the previous themes of insidious transactions, definition interpretation, trauma, and dignity. The study participants believed that microaggressions and verbal or emotional abuse recognition holds important connections for reducing incidents of non-dignities and trauma, and

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where the study participants’ actions of advocating or coaching other care providers was consistent with supporting that belief.

Table 4.2

*Summary of Themes*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
<th>Essences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insidious Transactions</td>
<td>Microaggressions are negative interactions against aging women</td>
<td>There was a repeated acknowledgment by participants that microaggressions are real in aging women's lives, and they observe this phenomenon as an ongoing problem.</td>
</tr>
<tr>
<td>Definition Interpretation</td>
<td>Microaggressions and verbal abuse examples are intertwined</td>
<td>Participants described situations as well as used definitions of microaggressions and verbal or emotional abuse interchangeably as if an intertwined phenomenon.</td>
</tr>
<tr>
<td>Trauma</td>
<td>Higher vulnerabilities in aging women lead to a higher amount of microaggressions and verbal or emotional abuse that traumatize</td>
<td>Participants described how higher vulnerabilities in aging women lead to a higher amount of microaggressions and verbal or emotional abuse. There was the realization these abuses, and recurring abuses, cause emotional distress and trauma.</td>
</tr>
<tr>
<td>Dignity</td>
<td>Recurrences violate human dignity and human rights</td>
<td>There was recognition by participants that re-occuring microaggressions and verbal or emotional abuse violate aging women's human dignity, and these abuse types are a human rights violation.</td>
</tr>
<tr>
<td>Advocacy</td>
<td>Advocacy is an essential tool</td>
<td>There was a focus on the use of advocacy as an essential tool to use against microaggressions and verbal or emotional abuse toward aging women. Participants acknowledged their role as an advocate being vital in assisting aging women.</td>
</tr>
<tr>
<td>Theme</td>
<td>Participant Number</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------------------</td>
<td></td>
</tr>
<tr>
<td><strong>INSIDIOUS TRANSACTIONS: microaggressions are negative interactions against aging women</strong></td>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>Micro assault (name calling or deliberate discriminatory action)</td>
<td>X X X X X X X</td>
<td></td>
</tr>
<tr>
<td>“Micro invalidation (communication that excludes, negates, or nullifies feeling)”</td>
<td>X X X X X X X</td>
<td></td>
</tr>
<tr>
<td>Micro insult (rudeness, insensitivity, or subtle snubs)</td>
<td>X X X X X X X</td>
<td></td>
</tr>
<tr>
<td>“Micro invisibility (forgotten, ignored; you are a pronoun)”</td>
<td>X X X X X</td>
<td></td>
</tr>
<tr>
<td>Situational: medical provider</td>
<td>X X X</td>
<td></td>
</tr>
<tr>
<td>Situational: facility care staff</td>
<td>X X X</td>
<td></td>
</tr>
<tr>
<td><strong>DEFINITION INTERPRETATION: microaggressions and verbal abuse are intertwined</strong></td>
<td>X X X X X</td>
<td></td>
</tr>
<tr>
<td><strong>TRAUMA: higher vulnerabilities mean higher microaggressions and abuse that traumatizes</strong></td>
<td>X X X</td>
<td></td>
</tr>
<tr>
<td><strong>DIGNITY: recurrences violate human dignity and human rights</strong></td>
<td>X X X</td>
<td></td>
</tr>
<tr>
<td>Financial exploitation</td>
<td>X X X</td>
<td></td>
</tr>
<tr>
<td>Facility centered care</td>
<td>X X X</td>
<td></td>
</tr>
<tr>
<td>Infantilization</td>
<td>X X X</td>
<td></td>
</tr>
<tr>
<td>Memory loss vulnerability</td>
<td>X X X X X X X</td>
<td></td>
</tr>
<tr>
<td>Physical altercation</td>
<td>X X X</td>
<td></td>
</tr>
<tr>
<td>Unmet needs (physical/health)</td>
<td>X X X</td>
<td></td>
</tr>
<tr>
<td><strong>ADVOCACY: advocacy is an essential tool</strong></td>
<td>X X X X X</td>
<td></td>
</tr>
<tr>
<td>Coaching, modeling, and educating</td>
<td>X X</td>
<td></td>
</tr>
</tbody>
</table>
Chapter 5 provides the implications for the findings and makes recommendations. The chapter also summarizes the study, reiterates the significance of the study, discusses the limitations of the study, and provides recommendations for future research.
Chapter 5: Discussion

Introduction

Elder abuse is a global public health issue (Yan, 2019). Aging women experience elder abuse and suffer higher mortality risks due to interpersonal violence, verbal abuse, and emotional abuse throughout their lifetimes (Baker et al., 2009; Dong et al., 2013; Fearing et al., 2017; Lin & Giles, 2013; Mouton et al., 2004; Yan & Brownell, 2015; Yon et al., 2017). Emotional abuse tends to be the most commonly reported form of abuse among aging women (Luoma et al., 2011). For this study, microaggression was defined by the researcher as verbal indignities communicating negative messages. A microaggression has been more recently acknowledged as a form of abuse that is linked to psychological distress and trauma (Fleischer, 2017; Gonzales et al., 2015; Owen et al., 2010; Ross-Sheriff, 2012). For the purpose of this study, verbal or emotional abuse was defined as uncontrolled anger, hollering, mocking or name-calling, ignoring, threatening, bullying, and fear-inducing language.

The purpose of this IPA study was to explore the lived experiences of ALCA experts and the meaning that they assigned to their experience with microaggressions and verbal or emotional abuse occurrence(s) toward aging women. The following research question guided the study: How do ALCA professionals perceive the occurrence(s) of microaggressions and verbal or emotional abuse toward aging women clients?

The first phase of the research process involved identifying a range of participants as directed by IPA protocol, which was a small group of ALCA experts who self-
identified as having engaged in professional perceptions of the occurrence(s) of microaggressions and verbal or emotional abuse toward aging women, as defined by the researcher. The second phase of the research process included a series of semi-structured interviews with seven participants who were selected based on their potential to contribute to the understanding of the phenomenon and the research problem. Data analysis included transcriptions, reading and rereading, initial noting, developing emergent themes, identifying connections, sequence analyzing, and identifying patterns. The following themes emerged: (a) insidious transactions, (b) definition interpretation, (c) trauma, (d) dignity, and (e) advocacy.

The final chapter of this study connects the themes identified in the literature regarding microaggressions and verbal or emotional abuse occurrence(s) toward aging women. Also, the chapter proposes the implications of this study’s findings to professional practice and the expansion of knowledge on microaggressions and verbal or emotional abuse occurrence(s) toward aging women. The chapter provides recommendations to ALCA experts, to care management with aging professionals and their leaders, to ALCA board of directors, to policymakers, and to community stakeholders for improved practice. The chapter also details the limitations of this study and the recommendations for future research.

Implications of Findings

In this study, seven ALCA experts were asked to share various experiences with microaggressions and verbal or emotional abuse occurrence(s) toward aging women and assign meaning to those experiences. During the identification of patterns, five themes emerged from the data. Varied definitions of microaggressions and verbal or emotional
abuse also emerged from the study participants that provided a foundation for how each participant understood the research question.

**Defining microaggressions and verbal or emotional abuse.** In this study, an important finding emerged. Although all the participants self-identified as engaging in professional perceptions of aging women’s experiences of the occurrence(s) of microaggressions and verbal or emotional abuse based on the definition provided by the researcher, when asked how they defined microaggressions and verbal or emotional abuse, several definitions emerged. Sue et al. (2007) defined the term microaggression as negative or demeaning communication toward another person or persons who were associated with a perceived vulnerable social group. For the purpose of this study, a microaggression was defined by the researcher as verbal indignities communicating negative messages, more recently being an acknowledged form of abuse linked to psychological distress and trauma. This study confirmed the research showing emerging themes around verbal abuse in the form of psychological (verbal and emotional) distress (Baker et al., 2009; Yan & Brownell, 2015) and microaggressions in the forms of micro insults, micro assaults, and micro invalidations toward aging women.

Verbal abuse was subcategorized as humiliation, coercion, bullying, being ignored or marginalized, or when a perpetrator displays verbal aggressiveness or micro assaults toward an individual. Severe and significant psychological and emotional trauma, which includes ongoing verbal abuse toward aging women, can exist throughout the lifespan of the individuals (Dong et al., 2013; O’Connor & Kelson, 2018). For this study, verbal or emotional abuse included uncontrolled anger, hollering, mocking or
name-calling, ignoring, threatening, bullying, and fear-induced language toward the aging woman.

These ALCA experts indicated they were engaged in the professional perceptions of their aging women clients’ experiences of the occurrence(s) of microaggressions and verbal or emotional abuse at varying degrees, and the range in definitions of microaggressions and verbal or emotional abuse was significant. All the study participants told stories, giving further meaning, of the end results where microaggressions and verbal or emotional abuse toward aging women produced some form of trauma. These participants described cultural differences, emotional pain, and interpersonal violence as evidence of participants gaining further meaning and understanding of their aging women clients’ experiences of microaggressions and verbal or emotional abuse that emerged from the study. These study participants further described their aging woman clients’ being a pronoun (use of the words “she” or “her”), suffering harassment, and receiving timed, forced interactions, with the ALCA experts detecting a further indicator of microaggressions and verbal or emotional abuse that emerged from the study. This study confirms the research findings of Teaster (2017), where there are many forms of abuse, which includes psychological distress and microaggressions in the forms of micro insults, micro assaults, and micro invalidations that affect aging women.

These study participants self-identified as engaging in professional perceptions of their aging women clients’ experiences of occurrence(s) of microaggressions and verbal or emotional abuse; however, their experiences varied significantly. These findings indicate a need to establish common language in using microaggressions and verbal or
emotional abuse within organizations and professional disciplines, specifically toward the aging population, with all key stakeholders. When stakeholders can share an understanding of what microaggressions and verbal or emotional abuse means across professional disciplines and organizations, the same language is spoken with all. Establishing a common language also sets a foundation and provides clarity about what microaggressions and verbal or emotional abuse are, and are not, toward the aging population. A common language also provides a framework for discussing the scope and specific activities that the professional disciplines and organizations will undertake for all, but especially the more vulnerable, aging women.

This study confirms the findings of Baker et al. (2009), Dong et al. (2013), O’Connor and Kelson (2018), Sue et al. (2007), and Yan and Brownell (2015) that ALCA experts are engaging in professional perceptions of their aging women clients’ experiences of occurrence(s) of microaggressions and verbal or emotional abuse. These ALCA experts were engaging in activities that are consistent with the definitions of microaggressions and verbal or emotional abuse. However, these participants were not categorizing these activities as microaggressions and verbal or emotional abuse, nor was there a common language set to provide a foundation and clarity about what microaggressions and verbal or emotional abuse are, or are not, toward the aging population.

This research found that the study’s ALCA experts, who were engaging in more understanding of the professional perceptions of the occurrence(s) of microaggressions and verbal or emotional abuse and, specifically, activities that are consistent with the definition of microaggressions and verbal or emotional abuse, were more aware of the
importance of identifying and understanding microaggressions and verbal or emotional abuse toward aging women. These participants believed that microaggressions and verbal or emotional abuse recognition is important, and their actions as experts (advocating or coaching care providers) are consistent with supporting that belief.

Understanding how the study participants defined microaggressions and verbal or emotional abuse provided the context for exploring what microaggressions and verbal or emotional abuse meant to these ALCA experts. The study participants assigned meaning to their aging women clients’ experiences with microaggressions and verbal or emotional abuse. These experiences were shaped by the ALCA experts’ individual definitions and, collectively, some of the study’s ALCA experts agreed, and some of the study’s ALCA experts were not in agreement, regarding those definitions.

Theory of CAD. In this study, the theory of CAD (cumulative advantage/disadvantage) served as the theoretical framework for understanding ALCA experts’ assigned meaning to their experience with microaggressions and verbal or emotional abuse. The theory helps conceptualize the research findings. When applying the theory of CAD to the study participants’ experiences with microaggressions and verbal or emotional abuse, Dannefer (2003) addressed aging women suffering from a life course of inequality and poverty by how society is structured. Dannefer’s (1987) insight into diversity and inequality came from his research on life courses of inequality and poverty in old age, which addresses cultural and gender disparities. It was at this point that Dannefer (2003) linked CAD with age. CAD highlights interindividual divergence or how sets of individuals are ranked against one another (Dannefer, 2003).
This study’s ALCA experts’ attitudes about microaggressions and verbal or emotional abuse were consistent with CAD theory. Therefore, CAD may have influenced how the study participants assigned meaning to their perceptions of their aging women clients’ experience with microaggressions and verbal or emotional abuse. Specifically, CAD in aging is concerned with age-specific individual differences such as health or cognitive functioning processes. These differences relate to fairness in the distribution of resources in healthcare, social security benefits based on gender, the death of a spouse being widowhood, and in opportunities for earnings over the years, job stability, and access to healthcare (Dannefer, 2003).

The degree to which the study participants understood their experience with microaggressions and verbal or emotional abuse is consistent with CAD theory. The researcher took particular notice of the study participants’ acknowledgement of cumulative disadvantage facing their aging woman clients by their experiences. These ALCA experts, through the CAD theory lens, who believed their experiences with microaggressions and verbal or emotional abuse may need greater attention, will engage in advocacy. Conversely, the study’s ALCA experts who believed their experiences with microaggressions and verbal or emotional abuse were not affected by the CAD theory lens will give less attention to advocacy engagement. CAD’s distinct themes can include such examples as a financial stability, the ability to afford a housing move, gender in very old age, and independence in aging, when viewing problems of diversity and inequality among aging individuals (Dannefer, 2003; Settersten, 2017). The CAD theoretical lens assists in exploring studies of elder mistreatment in the context of verbal, emotional, or psychological abuse by broadening the term of the microaggressions experienced by
aging women. These ALCA experts expressed advocacy as an essential tool, through the CAD lens, regarding microaggressions and verbal or emotional abuse, where coaching, modeling, and educating can play a role in reducing such microaggressions and verbal or emotional abuse.

The findings present an opportunity for ALCA experts, who are an interdisciplinary association of leaders in the field of care management, to focus on how their understanding of microaggressions and verbal or emotional abuse impacts the extent to which they are thinking about, talking about, and engaging in discussions within their professional disciplines and organizations. This conscious leadership knowledge of their own character, feelings, motives, and desires to learn about microaggressions and verbal or emotional abuse toward aging women is central to this study’s ALCA experts’ self-awareness and intention to engage in advocacy. These ALCA experts have the ability to become champions in changing outcomes for those most vulnerable, aging women.

Because studies of professionals’ attitudes about microaggressions and verbal or emotional abuse are not occurring, examining the shared experiences of a group of ALCA experts, who are engaged in finding the meaning of microaggressions and verbal or emotional abuse through the lens of CAD theory, provides an additional layer of new understanding. These participants acknowledged the importance of understanding microaggressions and verbal or emotional abuse toward aging women by providing new insight into the beliefs influencing the intention to engage in finding meaning when microaggressions and verbal or emotional abuse affect aging women clients.

**Themes.** In addition to a varied definition of microaggressions and verbal or emotional abuse, five themes emerged from the meaning that the participants assigned to
their experiences with microaggressions and verbal or emotional abuse toward aging women. The themes provide a foundation regarding how each participant understood the research question of: How do ALCA professionals perceive the occurrence(s) of microaggressions and verbal or emotional abuse toward aging women clients? The emerged themes are: (a) insidious transactions, (b) definition interpretation, (c) trauma, (d) dignity, and (e) advocacy.

**Insidious transactions: Microaggressions are negative interactions against aging women.** As the study participants explored their experiences with microaggressions and verbal or emotional abuse in aging women’s lives, microaggressions became very real. Microaggressions have been broadened to include acts against individuals with mental or physical disabilities (Ross-Sheriff, 2012), which includes aging women. This study’s ALCA experts observed microaggressions as an ongoing problem through many types of observed microaggressions. Further, these ALCA experts gave meaning to the many types of microaggressions, which include micro assault, micro invalidation, micro insult, and micro invisibility. These ALCA experts expressed concern over two recurring situations of microaggression used in health- and facility-based care settings with medical providers and facility-based care staff.

This study’s findings align with the research on practitioner bias holding a cumulative burden for aging women patients. Such ageist stereotypes impact aging adults’ physical and mental health by influencing treatment decisions (Chrisler et al., 2016). If practitioners, like ALCA experts, can acknowledge their belief in the existence of microaggressions and arrive at an accepted definition, there may be greater intention to
engage in understanding the many types of microaggressions in health, facility-based, and community care.

**Definition interpretation: Microaggressions and verbal or emotional abuse are intertwined.** This concept of microaggressions and verbal or emotional abuse being intertwined was the second finding that emerged as a shared experience of the ALCA experts finding meaning with microaggressions and verbal or emotional abuse toward aging women. There was an intertwined, interdependent relationship between microaggressions and verbal or emotional abuse when these participants shared their stories or discussed how these ALCA experts perceived microaggressions and verbal or emotional abuse. Burnes et al. (2015) found emotional abuse to be the most prevalent of abuses, followed closely by physical abuse and neglect. Microaggressions and verbal mistreatment are included as forms of polyvictimization, which significantly affects aging individuals later in life.

The terms verbal indignities, exploitation, verbal confrontation, bullying, ignoring, and manipulation were used as both a microaggression and as verbal or emotional abuse in this study. These participants moved through their stories, sometimes defining microaggressions as verbal or emotional abuse. The ALCA experts also flipped their thoughts, defining verbal or emotional abuse as a microaggression. To this point, ageist communication studies have not addressed the psychological distresses and the use of terms such as *ignoring* as a microaggression. Gendron et al. (2016) found that few aging studies bridge the argument to include microaggressions as a term describing verbal abuse as ageist communication, which is a form of language-based age discrimination.
Two out of the seven study participants denied verbal or emotional abuse, stating only microaggressions were present. However, these two experts did discuss fear-inducing language and the fear of retribution being difficult for their aging women clients. For the ALCA experts who acknowledged their belief in the existence, complexity, and intertwined nature of microaggressions and verbal or emotional abuse, there may be a greater intention to engage in understanding these complexities of negative or demeaning verbal indignities (Sue et al., 2007).

**Trauma: Higher vulnerabilities mean higher microaggressions and verbal or emotional abuse that traumatize.** The concept of higher vulnerabilities means higher microaggressions and verbal or emotional abuse that traumatize was the third finding that emerged as a shared experience of the ALCA experts finding meaning with microaggressions and verbal or emotional abuse. This study’s findings support microaggressions being acknowledged as a form of abuse that is linked to psychological distress and trauma (Fleischer, 2017; Gonzales et al., 2015; Owen et al., 2012). This study’s ALCA experts described how higher vulnerabilities in aging women lead to a higher amount of microaggressions and verbal or emotional abuse. All of the study’s participants realized that vulnerable, aging women who exhibit memory loss, physical/health needs, interpersonal violence, or emotional pain also display emotional distress and trauma from microaggressions and verbal or emotional abuse. Past or repeated unresolved trauma places further emotional distress on vulnerable aging women, as described by all the study participants telling of painful emotional distresses that their aging women clients endured. Similar to Dong et al. (2013), this study concurs with other researchers who acknowledged emotional mistreatment as the highest percentage of
abuse toward aging women, with victims reporting chronic verbal aggression or micro assaults as high as 53.2% (Comijs et al., 1999) and 76.3% (Mouton et al., 2004).

In this study, the case example where a participant told of her observations watching a hospitalized aging woman with severe memory loss being poked and prodded by medical personnel, where her aging woman client screamed, asked, and yelled for medical personnel to stop, aligns with reports of chronic verbal aggressions that traumatize or re-traumatize vulnerable aging individuals. As with this ALCA expert, another participant expressed that part of why her vulnerable aging woman client was treated poorly was because her client was essentially invisible to the providers who were providing care. As stated in research, most problematic is the non-intimate individuals who provide non-intimate services, such as with healthcare workers or counselors (Nussbaum et al., 2005).

Additionally, this participant expressed her distress that her aging woman client was just a body in a bed. Facility workers provided care in a non-intimate way in an uncompassionate technical robot-like fashion that does not serve as high-quality care (Nussbaum et al., 2005). A participant stated that her client was “someone who couldn’t report about herself,” having cognitive impairment. This study confirms the certainty of known higher risk factors, such as poverty, lack of social support, and cognitive impairment, has led to the need for increasing the understanding of aging women’s mistreatment (Amstadter et al., 2010; Comijs et al., 1999; Lachs & Berman, 2011; Lin & Brown, 2012). In addition, this participant validated, as well as did the other study’s ALCA experts, that aging women clients with higher vulnerabilities meant higher microaggressions and verbal or emotional abuse that traumatize through the use of
dismissiveness and abrasiveness, which was the result of this participant’s aging woman client not being valued as someone who deserved more dignity in her care.

**Dignity: Recurrences violate human dignity and human rights.** The concept where the microaggression and verbal or emotional abuse recurrences violate human dignity and human rights was the fourth finding that emerged as a shared experience of the ALCA experts finding meaning with microaggressions and verbal or emotional abuse. This study’s findings are consistent with the research on the abuse of postmenopausal women, which did not diminish as age increased and was a serious threat to these women’s health and well-being (Hamby et al., 2016; Mouton et al., 2004). In this study, there was recognition by the study’s ALCA experts that recurring microaggressions and verbal or emotional abuse violate aging women’s human dignity, as witnessed as financial exploitation, facility-centered care that ignored or withheld care, infantilization, memory loss vulnerability, physical altercation, and unmet physical or health needs—many of these abuse types are also human rights violations. A participant shared a story of a very aged woman, who was intact cognitively, receiving care in a facility-centered care placement who was not physically bathed for 2 months after her placement in the facility. Like the other study participants, the variety of recurrences of microaggressions and verbal or emotional abuse violated their aged woman client’s dignity and human rights.

Because of these human rights violations, there is a need to increase a competent workforce with the training and skills so that human rights violations will be reduced and there will be accountability toward aging women’s dignity and well-being (ALCA, 2018; Wideman, 2012). This study’s ALCA experts acknowledged their desire and intention to
have their aging women clients treated with human dignity. This understanding is a significant step in acknowledging the recurrences of microaggressions and verbal or emotional abuses that violate aging women’s dignity and human rights. This study’s ALCA experts expressed the need to understand aging women’s mistreatment in order to help stop these human rights violations.

Advocacy: Advocacy is an essential tool. The concept of advocacy being an essential tool was the fifth finding that emerged as a shared experience of these participants finding meaning with microaggressions and verbal or emotional abuse. This study’s ALCA experts acknowledged their role as an advocate, with this advocacy role being vital in assisting aging women. The results of this study are consistent with researchers who concurred that there is a need for further advocacy and research, such as the studies of microaggressions and verbal or emotional abuse and the use of advocacy (Nobels et al., 2018; Sohi et al., 2015; Stambaugh & Ford, 2015; Sue et al., 2007).

Although Nobels et al. (2018) discussed, specifically, the fight against sexual assault of older women, the message of the Nobels et al. (2018) study resonates when discussing advocacy for any type of aging women abuse: “We urgently call for increased attention to older women in research, policies, and health practices” (p. 1).

Two out of the seven study participants indicated that coaching, modeling, and educating were an essential part of their role as an advocate, especially in building awareness of microaggressions and verbal or emotional abuse toward aging women. If this study’s ALCA experts are focused on the use of advocacy, and if they are being intentional about coaching, modeling, and educating, there can be demonstrated evidence of finding an understanding of why microaggressions and verbal or emotional abuse
violate aging women’s human rights (Dannefer, 2003; Pillemer et al., 2015). By providing professional training opportunities with best practices through organizations, such as ALCA, aging women, who are suffering from a life course of inequality and poverty and where their human rights have been violated, may benefit by having more trained professionals who are knowledgeable regarding their day-to-day challenges (Dannefer, 2003; Pillemer et al., 2015). For ALCA experts, finding the meaning of microaggressions and verbal or emotional abuse involves a long-term approach that can influence a sustainable commitment toward further study of microaggressions and verbal or emotional abuse toward aging women and the need to use advocacy as an essential tool.

**Summary of the implications of the findings.** These study ALCA experts were engaged in finding the meaning of microaggressions and verbal or emotional abuse toward aging women and were focused on acknowledging microaggressions as being real in aging women’s lives. All the study participants observed microaggressions and verbal or emotional abuse as an ongoing societal problem, and these ALCA experts were grappling with the concept of microaggressions and verbal or emotional abuse being intertwined. This study’s participants recognized there was a significant complexity with microaggression and verbal or emotional abuse toward aging women. These ALCA expert realized that for vulnerable aging women with memory loss, physical/health needs, interpersonal violence, or emotional pain, microaggressions and verbal or emotional abuse cause additional emotional distress and trauma. This study’s participants validated and acknowledged that aging women with higher vulnerabilities experience higher microaggressions and verbal or emotional abuse that traumatize, and the variety of
recurrences of microaggressions and verbal or emotional abuse violated aging women’s dignity and human rights, and that the ALCA experts’ role was to be advocates in assisting aging women against experiences of microaggressions and verbal or emotional abuse.

The findings presented here are in agreement with other researchers (Baker et al., 2009; Fearing et al., 2017; Fleischer, 2017; Gonzales et al., 2015; Lin & Giles, 2013; Mouton et al., 2004; Owen, Tao, & Rodolfa, 2010; Pillemer et al., 2015; Ross-Sheriff, 2012; Yan & Brownell, 2015; Yon et al., 2017). Further, several researchers (Chrisler et al., 2016; Gendron et al., 2017, 2018; NASEM, 2018; Nelson, 2016; Palmore, 1997; Palmore et al., 2016) influenced this study’s findings. The findings of this study are the shared experience of self-awareness and exploration by all the study’s ALCA experts. These participants were candid and expressive when sharing professional experiences and perceptions regarding their clients’ occurrences of microaggressions and verbal or emotional abuse.

This study discovered an unanticipated finding relating to the definition knowledge. Consistent with IPA research, the sample for this study included a homogenous sample of individuals with shared experiences of a phenomenon of interest. A purposeful sample of seven ALCA experts within the United States was selected based upon their shared experience of finding the meaning of their experiences with microaggressions and verbal or emotional abuse toward aging women. These homogeneous participants’ responses were not as homogeneous as first perceived. The study participants self-identified as having engaged in experiences with microaggressions and verbal or emotional abuse toward aging women as defined by the researcher.
However, their interpretation of the definition of microaggressions and verbal or emotional abuse varied. As noted in the findings, microaggressions and verbal or emotional abuse were defined significantly differently by the participants, creating different foundations of understanding for exploring their experience with microaggressions and verbal or emotional abuse.

The meaning that these study participants assigned to their perceptions of aging women’s experiences with microaggressions and verbal or emotional abuse were personal, exploratory for some participants, and profound for other participants. Identifying the existence of verbal abuse and the complexity and intertwined nature of microaggressions and verbal or emotional abuse was challenging to these participants who were trying to gain a greater understanding of the complexity of the phenomenon. Through the given meaning of microaggressions and verbal or emotional abuse, assigned by these study participants, are the elements of control, fear, outside influences, and their own biases and attitude toward their experiences with microaggressions and verbal or emotional abuse toward aging women. Insights gained from this study’s ALCA experts regarding their shared experiences may be useful to other ALCA experts and care providers who acknowledge the importance of understanding microaggressions and verbal or emotional abuse toward aging women but who have yet to engage in the behavior.

The researcher noted the participants’ professional stress as these ALCA experts expressed frustration regarding inadequate healthcare systems. This stress also included an internal struggle when the participants thought about recurring microaggressions and verbal or emotional abuse that violate aging women’s human dignity and human rights.
This was especially evident when there was an increase in client vulnerability originating from a decline of physical abilities or memory loss. The researcher further noted the topic of microaggressions, and verbal or emotional abuse was often a difficult conversation, but these ALCA experts expressed their time given to the researcher was well spent by the information they garnered from the dialog.

These participants expressed a belief that advocacy is an essential tool to use against microaggressions and verbal or emotional abuse toward aging women. These study participants believed the use of advocacy assisted in culturally changing society’s behavior toward aging women. Some of the study participants discussed using coaching, education, and role-modeling activities to advocate for aging women; others expressed better ways to empower aging women clients. These participants formulated ideas to provide opportunities to receive funding for creating educational programs for professionals, families, and aging women to teach advocacy skills. Additionally, these ALCA experts suggested that evidence-based practices empowering aging women who deal with microaggressions and verbal or emotional abuse could hold positive results to reduce this ongoing problem toward aging women.

This study found these ALCA experts believed that microaggressions and verbal or emotional abuse recognition is important. These experts’ actions, including advocating or coaching care providers, could be the vision of a call for action toward providing culture change. Educational pursuits can assist with identifying, understanding, and eliminating microaggressions and verbal or emotional abuse toward aging women.
Recommendations

This study explored the meaning that a group of ALCA experts assigned to their perceptions of their aging women clients’ experiences with microaggressions and verbal or emotional abuse. Provided below are recommendations for improved practice and future research.

Recommendations for improved practice. The findings of this study suggest that ALCA experts, care management personnel with aging professionals and leaders, ALCA board of directors, policymakers, researchers, and key stakeholders should develop a shared understanding of microaggressions and verbal or emotional abuse toward aging women. Language by experts and leaders can assist in developing text and context (Schegloff, 1997) when there is a need for shared understanding. The unanticipated findings around the study participants’ definitions of microaggressions and verbal or emotional abuse suggests that ALCA experts and key stakeholders who have leadership roles can impact a positive and important outcome for cultural change regarding how aging women are viewed and treated. Further, stakeholders’ consensus to engage in discussions, exchange information, and create solutions to solve acts of microaggressions and verbal or emotional abuse toward aging women can be developed collaboratively.

Given that there is no single definition of microaggressions used within the aging (gerontology) community and research field, defining microaggressions, as related to other defined verbal or emotional abuse terms in the aging community, will allow for a broader exchange of research as well as open the opportunity to share quality-tested research instruments that address microaggressions used in other disciplines such as
social work, psychology, and sociology. Creating a shared definition of what microaggressions and verbal or emotional abuse are, and what they are not, for professional disciplines and organizations, will provide common language and transparency around the work of microaggressions and verbal or emotional abuse. By agreeing to a definition of microaggressions and verbal or emotional abuse, professional disciplines and organizations can lay the foundation for understanding and action, becoming cultural change leaders for aging women.

Recommendations for policy and legislative initiatives. The findings of this study are in agreement with Pillemer et al. (2015) who stated the need for an elder mistreatment knowledge base, a comprehensive network of elder mistreatment services, and training opportunities, as well as a coordinated policy approach to reducing elder mistreatment, which includes microaggressions and verbal or emotional abuse. Pillemer et al. (2015) further posited that research, service, and policy in the global capacity of a worldwide health issue should impact aging women as individuals as well as impact the professionals and stakeholders who assist in aging women’s care and well-being. ALCA, care management, and aging leadership can encourage the position of providing opportunities to advocate for funding and to build educational programs for professionals, families, and aging women that deliver advocacy skills and evidence-based practices that empower and protect aging women against microaggressions and verbal or emotional abuse. Past frustrations of the these ALCA experts may look at the lack of government funding through Medicare and states’ Medicaid being a formidable barrier toward developing education and training. This educating and training provided to professional care communities would be a key element to reducing or stopping microaggressions and
verbal or emotional abuse toward aging women. There is a tremendous need to advocate and collaborate for funding by Medicare as a preventative initiative. This funding would assist families, professional groups, and health care systems with viable ways to provide cultural change, using training and mentoring programs. Funding for research studies would also help move societal acceptance of microaggressions and verbal or emotional abuse from the sitting on our hands to standing on our feet while we actively learn why microaggressions and verbal and emotional abuse is happening all over in the United States. Legislatively, Medicare could fund programs as well as make policy changes by implementing trauma-informed care protocols addressing microaggressions and verbal or emotional abuse impact toward aging women, and where every citizen needs to recognize the societal impact of not knowing about or acknowledging microaggressions and verbal and emotional abuse. Practitioners, like ALCA experts who physically go across systems of care, have the knowledge base to provide insight, training, and mentorship. ALCA experts could reach other practitioners through a grassroots effort, building a capacity to change practitioners’ knowledge and treatment of aging women who are burdened with microaggressions and verbal or emotional abuse.

Given that women are about two-thirds of the total elder abuse victims (Lachs & Berman, 2011), with many aging women suffering from a life course of inequality and poverty, this study agrees that changes in how aging women are financially supported in their care through their individual Medicare and Medicaid reimbursement policies could prevent and mitigate elder abuse (USDOJ, 2014). And, as given, by using care managers (USDOJ, 2014), such as ALCA experts, Medicare and Medicaid reimbursement then can include the reimbursement for actions to screen, detect, and intervene to prevent elder
abuse, which include microaggressions and verbal or emotional abuse. Further, this study agrees that by creating a comprehensive network of elder mistreatment services, as well as by providing professional training opportunities with best practices through organizations (Pillemer et al., 2015), such as ALCA, aging women suffering from a life course of inequality and poverty (Dannefer, 2003) may benefit. Other researchers (Frytak, Harley, & Finch, 2003; Pavalko & Smith, 1999) posited agreement that a life course of inequality holds influence as a result of factors related to an individual’s socioeconomic status, work, and health outcomes. These experts in the role of champions for aging women can achieve better outcomes through the knowledge of day-to-day challenges with life course inequities in aging women’s lives. The goal is to achieve more favorable outcomes for aging women burdened by microaggressions and verbal or emotional abuse. Consequently, it will produce better opportunities for aging women to be treated in a more-successful, higher quality, more-trained comprehensive network of elder mistreatment services.

**Recommendations for future research.** The research methodology employed in this study could easily be replicated by other researchers to achieve dependability. Dependability is one of the standards of qualitative research, and it is necessary to establish trustworthiness. Additional studies could be conducted with other professional groups within the United States. Also, similar studies could be conducted with organizations within one state or region to understand the cultural differences or other unique variables affecting microaggressions and verbal or emotional abuse use.

A mixed-methods study could examine a larger number of study participants in the United States who could give data about the validity of this study’s themes—
including more exploration of the experiences with microaggressions and verbal or emotional abuse toward aging women. Additional research could lead to the further refinement of the shared experiences found in this study by ALCA experts who are engaged in finding meaning regarding microaggressions and verbal or emotional abuse toward aging women. Understanding these experiences in greater depth could be beneficial to other professional colleagues and their disciplines that have yet to engage in finding meaning in the microaggressions and verbal or emotional abuse toward aging women. By finding common definitions, language, and themes that intersect with other researchers in complimentary fields, like social work, education, and nursing, or using population-centered and at-risk groups studies, such as mental health or at-risk teens, researchers could further collaborate and bridge evidence-based and tested measuring that could be easily adapted to the aging population. For example, Gonzales et al. (2014) explored if persons with mental illness experience microaggressions, and then further in the following year’s study, Gonzales et al. (2015) developed an evidence-based tested instrument that was effective for their study needs. Evidence-based test instruments that can be shared could prove to be an opportunity for collaborative research for researchers.

This study agrees that elder abuse continues to be a public health issue, worldwide, for aging women (Mouton et al., 2004; Teaster & Hall, 2018; Yon et al., 2017), and further research that collected data from aging women and their families directly would provide information that would contribute to the use of evidence-based practices with effective interventions. Research could also assist in helping indicate specific barriers to reporting abuses to help curb elder abuse or give indicators through learned signs or observations of microaggressions and verbal or emotional abuse. This
study supports the Pillemer et al. (2015) belief that research is needed to coordinate policy approaches to reduce elder mistreatment and to expand and coordinate a collection of elder abuse data. Effective intervention studies could divert later-life polyvictimization or abuse trends such as microaggressions and verbal or emotional abuse toward aging women. A further recommendation is to study the source of microaggressions toward aging women.

**Limitations**

An IPA study provides the opportunity to investigate and uncover how individuals make sense of their experiences including professional and clinical observations (Conrad, 1987; Larkin & Thompson, 2012; Smith & Eatough, 2006; Smith & Osborn, 2003). The primary goal of this research was to explore the meaning that ALCA experts assigned to their experience with microaggressions and verbal or emotional abuse toward aging women. The research participants provided detailed descriptions of their perceptions of their aging women clients’ experiences with microaggressions and verbal or emotional abuse. However, this research had limitations.

First, the theory of CAD (cumulative advantage/disadvantage) served as the theoretical framework for understanding the study participants’ meaning of their perceptions of aging women clients’ experiences with microaggressions and verbal or emotional abuse. The application of CAD theory was used to help conceptualize the research findings and not to test CAD theory. Although consistent with the purpose, the application of CAD theory as well as the emergence of the life course of inequality could be viewed as a subjective interpretation of the researcher.
Finally, the researcher is an ALCA expert and owns a care management practice where, for over 20 years at the time of this writing, has questioned her perception of the aging woman’s experience of microaggressions and verbal or emotional abuse. Although this ALCA expert was not a study participant, she was a participant in a pilot interview addressing trauma-informed care for aging individuals experiencing present or past abuse that caused trauma. The experience of the researcher could lead to bias in the study of microaggressions and verbal or emotional abuse toward aging women. The researcher, however, took steps to ensure that bias was mitigated by carefully following the interview protocol, asking clarifying questions, and having the study participants review their transcripts for accuracy. Further, the researcher could have produced unintentional bias into the study by starting with certain definitions of microaggressions and verbal or emotional abuse that formed the basis of the research question.

**Conclusion**

The U.S. Bureau of Labor Statistics (2018) publication “American Time Use Survey – 2017 Results” states that 41.3 million people provide unpaid eldercare to 16% of the civilian population. On any given day, the 26% of citizens engaging in unpaid eldercare spend an average of 2.8 hours providing care.

The demands of being a caregiver or eldercare provider can manifest in mental, emotional, physical, and financial stresses. Even those with a choice can have negative impacts in their primary caregiving role and are more likely to (57%) report negative impacts as a result of providing care and, most likely, will continue to experience these impacts well into the future (NAC & AARP, 2015). Caregiver stress and negative experiences may lead to the adverse treatment of those aging adults who are receiving
care. This adverse treatment is known as elder abuse. Elder abuse can lead to increased psychological distress and geriatric syndromes of aging individuals, which may pose as complex health issues. Dong et al. (2013) found that these health issues are independently associated with premature morbidity and mortality.

WHO (2002) adopted the most recognized definition of elder abuse, which states, “Elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person” (WHO, 2002, p. 3). Elder mistreatment can also come in the form of microaggressions. Microaggressions are defined as subtle behaviors or verbal indignities that communicate negative messages. Microaggressions have been acknowledged as a form of abuse that is linked to psychological distress and trauma (Fleischer, 2017; Gonzales et al., 2015; Owen et al., 2010; Ross-Sheriff, 2012). Burnes et al. (2015) found emotional abuse to be the most prevalent of abuse, followed closely by physical abuse and neglect.

When factoring in gender, elder abuse rates are higher than originally thought. As of 2017, it was estimated that 68 million, or one in six, aging women experience some form of abuse worldwide (Yon et al., 2017). An aging woman is defined as being 65 years and older (Orimo et al., 2006). At any age, women suffer higher rates of interpersonal violence, verbal abuse, and emotional abuse throughout their lifespan than their male counterparts, which is a consistent trend when comparing aging women to aging men (Hamby et al., 2016; Mouton et al., 2004; Yon et al., 2017). A report by Lachs and Berman (2011) revealed that almost two-thirds of the study participants who self-reported being victims of elder abuse were women. Abuse of postmenopausal women did
not diminish as age increased, nor did the serious threat to aging women’s overall health (Hamby et al., 2016; Mouton et al., 2004).

Understanding the lived experiences of ALCA experts who engage in experiences with microaggressions and verbal or emotional abuse toward aging women provides enlightenment and awareness compared to ALCA experts who do not engage in experiences with this phenomenon. Informed ALCA experts may move from simply acknowledging the need for understanding experiences with microaggressions and verbal or emotional abuse, to actively engaging in educating colleagues about this abuse toward aging women within their own organizations.

The purpose of this interpretative phenomenological analysis study was to explore the lived experience of ALCA experts and the meaning they assign to their experiences with microaggressions and verbal or emotional abuse toward aging women. The following research question guided this study: *How do ALCA professionals perceive the occurrence(s) of microaggressions and verbal or emotional abuse toward aging women clients?*

CAD theory served as the theoretical framework for understanding ALCA experts assigning meaning to their experience with microaggressions and verbal or emotional abuse. The theory helped to conceptualize the research findings. When applying the theory of CAD to study participants’ experience with microaggressions and verbal or emotional abuse, Dannefer (2003) addressed that aging women suffering from a life course of inequality by how society is structured. Dannefer’s (2003) insight into diversity and inequality came from his research published in 1987 on life course of inequality and
poverty in old age, which addresses cultural and gender disparities. CAD theory and life course of inequality provided a lens for the interpretation of this study’s findings.

The literature review established a firm foundation for this completed study. The literature presented was an overview of empirical research studies that focused on five conceptual areas: (a) professional perceptions studies on culture, work role, and attitudes toward aging adults; (b) microaggression studies on women as a vulnerable group, with special analysis of aging women; (c) elder abuse studies on the prevalence of abuse and its impact on older women; (d) ageism studies on abusive discriminatory practices toward aging women; and (e) ageist communication studies on vulnerable aging groups. The research focused especially on the review of aging women in relation to public health issues, safety from mistreatment, and social and psychological well-being.

A review of the literature on the uniqueness of ALCA experts was completed to understand the role of the ALCA experts’ work, personal aging anxiety, and attitudes toward aging adults. Following, in a broader review of the literature, careful delineations of microaggression types toward aging women were discussed. The literature provided additional insights into the understanding of microaggression in a term now broadened to include verbal abuse and psychological distress, patronizing speech, financial exploitation, and poverty as applied to older-adult singleness or widowhood stereotyping.

With broader insights, the review of the literature provided more fully the discussions on public health issues and chronic social problems relating to microaggressions of aging women in areas such as the workplace, unemployment and financial instability, healthcare, and the widespread age discrimination through media and advertising. These insights addressed the impact of the outcomes for aging women’s
overall safety, mortality, and well-being. More explicitly, by reviewing the five areas of research specific to abuse in aging women, extrapolated data on this subpopulation from other studies, which were focused on larger populations (e.g., studies on women, studies on elderhood, studies on abusive practices), allowed for an understanding of this current research.

The first phase of the research process involved identifying a small group of ALCA experts who self-identified as having engaged in professional perceptions of the occurrence(s) of microaggressions and verbal or emotional abuse toward aging women, as defined by the researcher. The second phase of the research process included a series of semi-structured interviews with seven participants who were selected based on their potential to contribute to the understanding of the phenomenon and the research problem. Data analysis included transcription and member checking, open line-by-line coding through reading and rereading (first stage), initial noting, developing emergent themes, identification of connections, analysis sequencing, and identification of patterns. During the development of the emergent themes in IPA (codes), data analysis involved inductive and emergent coding, in vivo coding, and a priori coding. After the first level of coding, axial coding was used for the second level of data analysis, followed by selective coding, which produced categories, then categories that yielded the final themes. Besides manually analyzing the study data, an online software program, Quirkos (2020), was also used to further analyzed the study data.

The results of the data analysis yielded five themes. Also, a varied definition of microaggressions and verbal or emotional abuse emerged from the study participants that provided a foundation for how each participant understood the research question. The
results of the analysis found that the following themes emerged: (a) insidious transactions, where microaggressions are negative interactions against aging women; (b) definition interpretation, where microaggressions and verbal or emotional abuse are intertwined; (c) trauma, where higher vulnerabilities in aging women lead to a higher amount of microaggressions and verbal or emotional abuse that traumatize; (d) dignity, where recurring microaggressions and verbal or emotional abuse violate aging women’s human dignity and human rights; and (e) advocacy, where advocacy is an essential tool to use against microaggressions and verbal or emotional abuse toward aging women.

This study found that ALCA experts who engage in understanding more of the professional perceptions of the occurrence(s) of microaggressions and verbal or emotional abuse, and specifically activities that are consistent with the definition of microaggressions and verbal or emotional abuse, were more aware of the importance of self-identifying and self-understanding microaggressions and verbal or emotional abuse toward aging women. These ALCA experts believed that microaggressions and verbal or emotional abuse recognition is important, and their actions of advocating for clients or coaching care providers were consistent with supporting that belief. This belief or action can serve as the vision of a call for action to provide culture change and education in identifying, understanding, and reducing or eliminating microaggressions and verbal or emotional abuse toward aging women.
References


victimization and resilience portfolios: Trends in violence research that can enhance


Appendix A

Approval from Aging Life Care Association (ALCA) to Post for Research Volunteers on ALCA Listserv

REQUEST: Permission to post on ALCA listserv for volunteers

Evanoski, Kim

to jwagner, me, Kim

Dear Julie,

Per our phone conversation and as the acting CEO, I would like to ask your permission to post a notice requesting if Aging Life Care Association (ALCA) professionals would like to volunteer in a research study relating to their professional perceptions of serving aged women in the United States.

If this is acceptable to you, would you please respond back to this email as a way of giving the approval to post the research study request on the ALCA listserve as this is a requirement for study approval.

Thank you very much for your support and consideration.

Kindest regards,

Kim

Kim Evanoski, CMCPA LMSW NYS#004384 CDP CADDCT
Education Doctorate in Executive Leadership (Ed.D.) Candidacy
St John Fisher College

Julie Wagner

to me

Yes, that is fine. Will you just be posting a link to the survey or will they need to respond by email or?

If it seems appropriate once I see it I can also send out by e-flash to all members.

Julie

Julie Wagner

Interim CEO

Aging Life Care Association®
(formerly National Association of Professional Geriatric Care Managers)

3725 W. Ina Road, Suite 130

Tucson, AZ 85741

Click here to read our recent study “How Responsible Parties Value Aging Life Care Professionals’™ Services.”
Thank you very much, Julie, for your prompt response and consent to post through the listserv or email blast.

I would give you the post-draft to review. I would be asking for volunteers to contact me directly through my St. John Fisher College doctoral email. I will be able to provide this post-draft after my committee in December approves my dissertation proposal which includes their consent on the post-draft.

Thank you again for all the support and the opportunity for it to go out in a timely manner through possibly an email blast also.

Kindly,

Kim

Kim Evanowski, CMC MPA LMSW NYS#004384 CDP CADDCT
Education Doctorate in Executive Leadership (Ed.D.) Candidacy
St John Fisher College
Appendix B
Aging Life Care Association Listserv Post

INTRODUCTION: I am a doctoral student enrolled in St. John Fisher College's Doctoral Program in Executive Leadership. I am designing research for a dissertation that will seek to gain an understanding of the phenomenon of microaggressions, verbal or emotional abuse applied to aging women as well as to understand the mistreatment and violence toward aging women in the United States.

BACKGROUND: My goal is to research from the perspective of an Aging Life Care Association (ALCA) professional, how ALCA professionals perceive the occurrence(s) of microaggressions or verbal abuse toward aging women clients under your services.

STUDY DESIGN: The study will be conducting semi-structured interviews to explore how ALCA professionals perceive the occurrence(s) of microaggressions or verbal abuse toward aging women clients under services.

INSTITUTIONAL REVIEW BOARD: This study was reviewed by St. John Fisher College Institutional Review Board for this research. By participating in this study, the participant will add to a new knowledge base that would help better understand perceptions of the occurrence(s) of microaggressions or verbal abuse toward aging women clients.

Kim Evanoski, CMC MPA LMSW NYS#004384
Education Doctorate in Executive Leadership (Ed.D.) Candidacy
St John Fisher College
Phone: xxx-xxx-xxxx
Email: _______@sjfc.edu
Appendix C

St. John Fisher College IRB Approval Letter – Evanoski

August 12, 2019

File No: 4029-062019-03

Kim Evanoski
St. John Fisher College

Dear Ms. Evanoski:

Thank you for submitting your research proposal to the Institutional Review Board. I am pleased to inform you that the Board has approved your Expedited Review project, “Professional Perceptions of Microaggressions and Verbal Abuse toward Aged Women.”

Following federal guidelines, research related records should be maintained in a secure area for three years following the completion of the project at which time they may be destroyed.

Should you have any questions about this process or your responsibilities, please contact me at irb@sjfc.edu.

Sincerely,

Eileen Lynd-Balta

Eileen Lynd-Balta, Ph.D.
Chair, Institutional Review Board
ELB: jdr
Appendix D

Interview Protocol/Guide

The study will use semi-structured interviews using the Interview Guide below to explore how ALCA professionals perceive the occurrence(s) of microaggressions or verbal abuse toward aging women clients under services. All interviews will take place within a secure, password protected “personal room” within the Cisco Webex internet conferencing platform available only through a private secure internet network that is protected using a second password. The use of technology allows the researcher to interview participants in a timely fashion throughout the US without inhibitive costs and time by travel. Participants will be asked to review their transcript for accuracy and any clarifications. Participants will be told they are free to withdraw from the study at any time, and they can omit answers to any questions they feel uncomfortable answering. The study will include one interview for each of eight participants (eight interviews total). Kim Evanoski will give the interviews. The total time of participation will be approximately 60 minutes for each interview and (after transcription and editing) approximately 30 minutes for review of the interview transcript with each participant.

Prequalification Criteria for Participation: (No in any criteria eliminates participant)

| Current Aging Life Care Association Membership: | Yes | No |
| Active qualifying certification in care management: | Yes | No |
| Three years of experience in care management field: | Yes | No |
| Serves aging women clients in caseload: | Yes | No |
| Carry an active care management caseload in the field: | Yes | No |
Interview Guide:

Date of Interview: __________________________ Time of Interview: ______________

Location of Participant Being Interviewed: ______________________________________

Interviewee Pseudonym: ______________________________________________________

Review purpose of the study: The purpose of the study is to research from the perspective of an Aging Life Care Association (ALCA) professional, how ALCA professionals perceive the occurrence(s) of microaggressions or verbal abuse toward aging women clients under services.

Review participant rights: Participation in this study is entirely voluntary. Participants can withdraw the participation in the study at any point by merely informing me (the researcher) that you no longer want to participate. There will be no repercussions for withdrawing from the study.

Demographic Question: State(s) of practice location:

1. How or why did you become involved in the care management profession?

2. Can you describe an occurrence of a microaggression (micro assault, micro insult, micro invalidation) toward an aging woman in your care management work?
   a. Who was involved? How did it affect you or the client?
   (The research participant receives a formal definition of microaggression: defined as verbal indignities communicating negative messages, has been a more recently acknowledged form of abuse linked to psychological distress and trauma significantly affecting aging women)

3. Can you describe an occurrence of verbal abuse toward an aging woman in your care management work?
   a. Who was involved? How did it affect you or the client?
   (The research participant receives a formal definition of verbal abuse: defined as uncontrolled anger, hollering, mocking or name calling, ignoring, threatening, bullying, fear-induced language)

4. In your care management work, what experience do you perceive to be the most traumatic microaggression or verbal abuse toward any aging woman?
   a. What happened? Were there results?

5. Is there anything else you would like to share about your perceptions or experiences concerning our previous discussion of microaggressions and verbal abuse toward aging women?
Close interview: Thank you for agreeing to participate in this study.

Follow-up call/e-mail: After transcribing the interview, I may reach out to you to ensure that I have an accurate understanding of what you have shared today. I can send you the information via e-mail, or we can have a brief phone call, whichever is more convenient for you. If I do not hear back from you at that point, I will assume that I represented your meaning correctly.

Next steps: Over the next two months data will be collected and analyzed from between six to eight participants. The study anticipated completion is by December 2019. Once an approved study for distribution, you will be provided a copy of the study.
Appendix E

E-mail to Participants Selected

Subject Line: Documentation for Research Participation

Good afternoon Ms. ________,

Thank you again for agreeing to participate in my study.

A scheduled WEBEX interview is for _____ day, June 1, 2019, at 3:00 pm.

Please find attached:

Letter of Participation: Please review and keep for your records.

Informational Form: A one-page informational form is being provided to you that summarizes details of the study. Please review and keep for your records.

Informed Consent Form: Please review and if you consent to participate in the study, please sign and return. I will sign and provide a copy at our meeting.

If you have any questions about the documents attached, please do not hesitate to contact me at this email or xxx-xxx-xxxx.

Kindest Regards,

Kim

Kim A. Kozina-Evanoski, CMC MPA LMSW NYS#004384
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Ed.D. Program in Executive Leadership
3690 East Avenue
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Appendix F

Letter (digitally attached to email (see Appendix E) to Chosen Participants

Ms. Jane Doe
123 Any Street
Any City, New York 13206
May 18, 2019

Dear Ms. Doe:

Congratulations on being a research participant selected to participate in this voluntary study. Great appreciation, in advance, for contributing time, knowledge and experiences.

The dissertation committee has approved this proposed research at St. John Fisher College in Rochester, NY for the dissertation in the Ed.D. Program in Executive Leadership. The study will focus on exploring the perceptions of between six to eight Aging Life Care Professionals about the occurrence(s) of microaggressions or verbal abuse toward aging women clients under professional services.

A one-page informational form summarizes details of the study. Participation in this study is entirely voluntary. There is an option of terminating participation at any time without any penalty or repercussions. Additionally, participation will be confidential. During all aspects of the study, the researcher will protect the research participants’ identity by the use of a pseudonym. The organization will also be assigned a pseudonym as an additional measure to protect privacy.
All paper documents and electronic documents collected and analyzed for this study will be kept in a secured and locked file cabinet at the researcher's home address. Only the researcher will have access to the secured file cabinet. All paper documents, electronic documents, and analyzed materials will be kept at the secured location for five years after completion of the study, after which time, all documents will be destroyed by shredding (paper documents) and erasing (electronic documents).

A Webex interview has been scheduled for June 1, 2019, at 3 pm using access by the following information:

Kim Evanoski’s Personal Room  
Join by phone: +1-XXX-XXX-XXXX USA Toll  
Access code: xxx xxx xxx

Agreeing to participate in this study is very appreciated, thank you.  
Sincerely,

Kim A. Kozina-Evanoski, CMC MPA LMSW NYS#004384  
Education Doctorate in Executive Leadership (Ed.D.) Candidacy  
St. John Fisher College, Ralph C. Wilson School of Education  
Ed.D. Program in Executive Leadership  
3690 East Avenue  
Rochester, New York 14618  
Phone: xxx-xxx-xxxx  
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Appendix G

Informational Form

Data Collection and Participant Rights

- The title of the study is “Professional Perceptions of Microaggressions and Verbal Abuse Toward Aging Women.”

- The researcher is Kim A. Kozina-Evanoski, a full-time doctoral candidate in the Ed.D. Program in Executive Leadership at St. John Fisher College in Rochester, New York. The researcher is also the CEO/Owner of Care Manage For All LLC, a woman-owned private care management company in operation for over 8 years with 30 professional contractors serving an 11-county regional area in the Southern Tier, Finger Lakes, and Albany areas of New York State.

- The purpose of the study is to explore the perceptions of between six to eight Aging Life Care Professionals about the occurrence(s) of microaggressions or verbal abuse toward aging women clients under professional services.

- The researcher will conduct one-on-one, WEBEX interviews with six to eight Aging Life Care Professionals. All interviews will take place within a secure, password protected “personal room” within the Cisco Webex internet conferencing platform available only through a private secure internet network that is protected using a second password. The interview will be recorded and stored.

- The two data gathering techniques to be utilized are semi-structured interviews and a research notebook including field notes and reflective memos. All paper documents and electronic documents collected and analyzed for this study will be kept in a secured and locked file cabinet at the researcher's home address.

- The identity of the participants and their organizations will be confidential. Pseudonyms will be used to protect the identity of the participants and their organizations.

- Participation in the study is entirely voluntary. Participants can withdraw the participation in the study at any point by merely informing the researcher that they no longer would like to participate. There will be no repercussions for withdrawing from the study.
Appendix H
St. John Fisher College: Informed Consent Form

Title of study: Professional Perceptions of Microaggressions and Verbal Abuse Toward Aging Women

Name(s) of the researcher(s): Kim A. Kozina-Evanoski

Faculty Supervisor: Kim VanDerLinden, Ph.D.
    Faculty Supervisor for further information: xxx-xxx-xxxx

Purpose of study:
The purpose of the study is to explore the perceptions of between six to eight Aging Life Care Association (ALCA) Professionals about the occurrence(s) of microaggressions or verbal abuse toward aging women clients under professional services. The study will add new information about Aging Life Care Professionals’ perception and knowledge to a vulnerable population they provide service.

Place of study: In the United States at a virtual location determined by the participant.

Length of participation:
- One day for 15-30 minutes - Respond to volunteer participant’s email with an email introduction and participant consent packet
- One day for 60-90 minutes - WebEx interview for Prequalification Criteria for Participation and interview
- One day for 30-60 minutes - as necessary, follow-up (phone call or e-mail)

Risks and benefits:
There are no risks or benefits to participants, though participants may experience typical professional stress related to talking about client cases during the interview.

Participants who feel uncomfortable or who change their minds about participating may stop participating at any time. If participants have any problems during or after the interview, participants should contact a primary care provider.

The benefit of the study is gained knowledge from this research which others use through published works, presentations or as a resource for future scholarly work.
Method for protecting confidentiality/privacy:

All interviews will take place within a secure, password protected “personal room” within the Cisco Webex internet conferencing platform available only through a private secure internet network that is protected using a second password. The interview will be recorded and stored.

Pseudonyms will be used during the completion of all forms, as well as in the interview sessions, and in the typed transcripts to ensure confidentiality and privacy of the participants and their organizations.

Participant information may be shared with appropriate governmental authorities ONLY if the participant or someone else is in danger, or if we are required to do so by law.

Participant rights: As a research participant, the participant has the right to:

1. Have the purpose of the study, and the expected risks and benefits thoroughly explained to the participant before choosing to participate.

2. Withdraw from participation at any time without penalty.

3. Refuse to answer a particular question without penalty.

4. Be informed of the results of the study.

The participant has read the above, received a copy of this form, and has agreed to participate in the study named above.

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<tr>
<th>Print name (Participant)</th>
<th>Signature</th>
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<th>Print name (Investigator)</th>
<th>Signature</th>
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If the participant has any further questions regarding this study, please contact the researcher listed above. If the participant experience emotional or physical discomfort due to participation in this study, please contact a primary care provider for appropriate referrals.

The Institutional Review Board of St. John Fisher College has reviewed this project. For any concerns regarding this study/or if the participant feels rights as a participant (or the rights of another participant) violated or caused undue distress (physical or emotional distress), please contact Xxxx Xxxxxx by phone during regular business hours at (xxx-xxx-xxxx) or ___@sjfc.edu. She will contact a supervisory IRB official to assist the participant.
All digital audio recordings and transcriptions of interviews will be maintained using a private, locked, and password-protected file and password-protected computer stored securely in the private home of the principal researcher.

Electronic files will include assigned identity codes and pseudonyms; they will not include actual names or any information that could personally identify or connect participants to this study.

Other materials, including notes or paper files related to data collection and analysis, will be stored securely in unmarked boxes, locked inside a cabinet in the private home of the principal researcher. Only the researcher has access to electronic or paper records.

This researcher will keep the digitally recorded audio data for five years following the publication of the dissertation. Kept are the signed informed consent documents for five years after publication. All paper records will be cross-cut shredded and professionally delivered for incineration. Electronic records will be cleared, purged, and destroyed from the hard drive and all devices such that restoring data is not possible.

I agree to be audio-recorded/ transcribed  ____ Yes  ____No
(If no, I understand that the researcher will not be able to have you participate in the study.)

I am 18 years of age or older. I have read and understood the above information. I consent to voluntarily participate in the study.

Signature: ___________________________________________________________

Date: __________________________

Signature of Investigator: _____________________________________________

Date: __________________________