Original Article

Prevalence of Elder Abuse and its Association with Psychiatric Morbidity in a Rural Setting

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ABSTRACT

Aim: The aim of this study was to evaluate the prevalence of elder abuse in a rural setting. In addition, the study aimed to evaluate the association of elder abuse with psychiatric morbidity and demographic factors. **Methodology:** A total of 125 elderly (age ≥55 years) were evaluated for psychiatric diagnosis as per the International Classification of Diseases, 10th revision (ICD-10) criteria by the qualified psychiatrist and were evaluated on Vulnerability to Abuse Screening Scale for elder abuse. **Results:** More than half (58.4%) of the participants had one psychiatric disorder, with depression being the most common. Elder abuse was seen in more than one-third (41.6%) of the study participants. Those with psychiatric morbidity had significantly higher prevalence of abuse. None of the demographic factors was associated with abuse. **Conclusion:** Elder abuse is highly prevalent in rural setting, especially among those with psychiatric morbidity. **Implications:** Considering the high prevalence of elder abuse, there is an urgent need to address the problem. Public awareness, education, and sensitization of people toward the abuse are need of the day.

KEYWORDS: *Abuse, depression, elderly*

INTRODUCTION

Elder abuse is not a new phenomenon and it has been reported since ancient times. However, it saw a resurgence in later half of the 20th Century, with the emergence of phrases like "granny battering" and "granny bashing."[1-4] It was first described in scientific literature in 1975.[2] Although many scientific or other societies tried to define the concept of abuse in elderly or mistreatment, there is a lack of consensus on the definition of elder abuse. One of the most accepted definition was developed by Action on Elder Abuse in the United Kingdom. This definition was later adopted by the International Network for the Prevention of Elder Abuse and according to this "*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.*" The abuse can be seen in the form of physical abuse, psychological or emotional abuse, sexual abuse, financial abuse, and neglect. The elder abuse can be intentional or unintentional.[5,6]

Many studies have evaluated the prevalence of elder abuse across different countries. Studies from the United States of America (USA) suggest that about 10% of the elderly experience abuse;[7] however, the figures for patients with dementia from the USA has been reported to be as high as 47.3%.[8] Data from European countries suggest the prevalence of elder abuse to be 61.1%[8] and that from countries such as Peru suggests a prevalence figure of 79.7%.[9]

In terms of factors, associated with experience of elder abuse, available data suggest that elder abuse is more commonly experienced by females, those living in shared living situations, older subjects, and those with cognitive decline.[10-14] Elder abuse has also been shown to be associated with self-neglect, social isolation, and financial problems.[15-19] Apart from these factors, depression, loneliness, poor quality of life, poor physical health, living in rented housing, unemployment, and low socioeconomic profile are considered to be contributing

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factors.[16,20,21] Abuse in elderly is most frequently perpetrated by family members, which could be due to the high rate of caregiver burnout, stress, substance use, financial problems, mental health problems, and family problems affecting the caregivers.[22-25]

According to the WHO, the prevalence of elder abuse varies widely from 1% to 35%[9,26] and is influenced by many factors such as settings, definitions, and methodological issues. Data from India suggest the prevalence of elder abuse to varies from 14% to 40%, with higher prevalence in cities.[27,28] However, there is lack of data in terms of elder abuse in rural population. The present study aimed to evaluate the prevalence of elder abuse in a rural setting. In addition, the study aimed to evaluate the association of elder abuse with psychiatric morbidity and demographic factors.

METHODOLOGY

This cross-sectional study was carried out at the rural health clinic of village Kheri situated in the Panchkula district of Haryana, which falls in the catchment area of Community Clinic of Department of Community Medicine of Postgraduate Institute of Medical Education and Research, Chandigarh. The village has 288 families and the population is 1605. Out of this, 823 were male while the females count 782 here. The illiteracy rate for the village is reported to be 31%. Only 539 people of the village are involved in paid occupation, of which 78 are entirely dependent on agriculture.

For this study, elderly (age ≥55 years) people were identified by a female health worker and were explained about the study. Those who agreed to participate were brought to the rural health clinic along with their family members who were well versed with the patient's mental and physical health status. At the rural health clinic, they were interviewed in detail by the qualified psychiatrist well versed with the local language, dialect, traditions, and customs. The patients were recruited after obtaining written informed consent and approval was obtained from the Institute Ethics Committee. Patients, who were very sick, uncooperative, and had significant cognitive decline, had psychotic symptoms against family members and those who did not provide written informed consent were excluded from the study. The study sample comprised 125 patients.

Using a semi-structured interview, based on the available information from the patient, family members, and mental status examination, psychiatric diagnosis was made as per the International Classification of Diseases, 10th revision (ICD-10) criteria by the qualified psychiatrist, and if required, the patients were started on treatment. In addition, these patients were evaluated on Vulnerability to Abuse Screening Scale (VASS) by providing privacy.

Vulnerability to Abuse Screening Scale

This questionnaire has 12 items, with "yes" and "no" responses. It provides information on various forms of family abuse such as emotional, psychological, and verbal abuse.[29,30] The items of the scales are further categorized into four factors, that is, vulnerability, dependence, dejection, and coercion. The vulnerability and coercion factors are reported to have high face validity for abuse and moderate-to-good construct validity. The dejection factor resembles a general measure of depression, whereas the dependence factor represents an indirect measure of vulnerability to abuse. Cronbach's alpha coefficients of various factors or domains of VASS vary from 0.31 to 0.74. For this study, VASS was translated into Hindi by following the methodology laid down by the World Health Organization.[31]

RESULTS

The mean age of the study population was 65.4 years (standard deviation [SD] = 6.4), and they had received formal education for a mean duration of 1.3 (SD = 2.9) years. About two-third of the study participants were female (n = 78; 62.4%) and married (n = 80; 64.0%) at the time of assessment. The majority of the people were not on paid employment (n = 111; 88.8%), were from lower socioeconomic status (n = 108; 86.4%), and more than three-fourth of the participants were living in a joint or extended families (n = 97; 77.6%) set up.

On semi-structured interview, 73 patients were diagnosed with a primary psychiatric diagnosis as per the ICD-10 criteria, with depressive disorder being the most common diagnosis, followed by somatoform disorder and anxiety spectrum disorders [Table 1]. Very few patients had more than one psychiatric disorder. More than half of the participants also had concomitant comorbid physical illnesses [Table 1].

As is evident from Table 2, 41.6% of the elderly had a score of 6 or more on VASS, which is considered as a cutoff of the presence of abuse. The presence of elder abuse in various domains was considered to be present if the participant reported "yes" to at least one of the items. Accordingly, more than two-third of the elderly reported coercion and dejection, 60% reported experiencing dependence, and about half reported vulnerability to abuse.

Based on the presence or absence of elder abuse, the study sample was divided into two groups, i.e., those with and those without abuse. As shown in Table 3, none of the demographic factors differed significantly

Table 1: Sociodemographic and clinic profile	
Variables	**Study group mean (SD)/frequency (%) (*n*=125)**
Age (years)	65.4 (6.4)
Age groups	
55-59	14 (11.2)
≥60	111 (88.8)
Education in number of years (mean and SD)	1.3 (2.9)
Gender	
Male/female	47 (37.6)/78 (62.4)
Marital status	
Currently single/married	45 (36.0)/80 (64.0)
Occupation	
Currently on paid employment/currently not on paid employment	14 (11.2)/111 (88.8)
Type of family	
Nuclear/nonnuclear	28 (22.4)/97 (77.6)
SES status as modified Kuppuswamy socioeconomic scale	
Lower/middle/upper	108 (86.4)/13 (10.4)/4 (3.2)
Clinical profile	
Physical illness present[a]	67 (54.6)
Primary psychiatry illness - present	73 (58.4)
ICD-10 diagnostic category	73 (58.4)
Psychosis NOS	1 (1.4)
Mild depressive episode - with or without somatic symptoms	24 (32.9)
Moderate depressive episode - with or without somatic symptoms	19 (26.0)
Severe depressive episode - with or without psychotic symptoms	6 (8.2)
Anxiety NOS	6 (8.2)
OCD	1 (1.4)
Somatoform disorder	9 (12.6)
Somatization disorder	4 (5.6)
Insomnia	3 (4.2)
Presence of more than one psychiatric disorder - present[b]	2 (1.6)
Duration of psychiatric illness (months)	12.9 (11.1)
Comorbid substance use disorder - present	
Alcohol use/abuse	7 (5.6)
Tobacco use/abuse	27 (21.6)
Presence of psychotic symptoms	7 (9.6)
Medication given	73 (100)

[a]Cerebrovascular accident-10; hypertension-36, coronary artery disease-8, diabetes mellitus-18, Hypothyroidism-1, diabetes mellitus + hypothyroidism-4, rheumatoid arthritis-8, benign prostate hypertrophy-3, chronic liver disease-2, cataract-2, chronic obstructive pulmonary disease-7, other-1, [b]One patient had dementia presented with depression, and the another one had patient depressive disorder along with co-morbid OCD. OCD: Obsessive-compulsive disorder, ICD: International Classification of Diseases, SES: Socioeconomic status, NOS: Not Otherwise Specified, SD: Standard deviation

between those with and without abuse. Among the clinical variables, those with abuse had significantly lower frequency of tobacco use/abuse and higher prevalence of psychotic symptoms.

Further, when those with and without psychiatry morbidity were compared, as is evident from Tables 4 and 5, those with psychiatric morbidity had higher scores in all the domains and also had higher prevalence of abuse in the domains of vulnerability, dejection, and coercion.

When those with and without psychiatry morbidity were compared, those with psychiatric morbidity were

significantly younger, were more often females, and were not using substances [Table 6].

DISCUSSION

Elder abuse is understood as a socially and culturally constructed phenomenon.[20] Improving the understanding of this phenomenon can help in not only understanding the extent of the problem but also will help in understanding the risk factors. This understanding can help in increasing the awareness among the public, sensitizing the clinicians in recognizing the problem in the vulnerable people, and taking appropriate measures to stop abuse and prevent further abuse. The present

Table 2: Components and prevalence of elder abuse

Items	Frequency (%)
Vulnerability	62 (49.6)
Are you afraid of anyone in your family?	37 (29.6)
Has anyone close to you tried to hurt you or harm you recently?	29 (23.2)
Has anyone close to you called you names or put you down or made you feel bad recently?	57 (45.6)
Dependence	75 (60.0)
Do you have enough privacy at home?	13 (10.4)
Do you trust most of the people in your family?	42 (33.6)
Can you take your own medication and get around by yourself?	47 (37.6)
Dejection	85 (68.0)
Are you sad or lonely often?	77 (61.6)
Do you feel that nobody wants you around?	68 (54.4)
Do you feel uncomfortable with anyone in your family?	54 (43.2)
Coercion	86 (68.8)
Does someone in your family make you stay in bed or tell you're sick when you know you're not?	24 (19.2)
Has anyone forced you to do things you didn't want to do?	44 (35.2)
Has anyone taken things that belong to you without your OK?	77 (61.6)
Scoring	
≤5	73 (58.4)
>6	52 (41.6)

study was a step in this direction. According to the findings of the present study, 41.6% of the elderly participants reported experiencing abuse. In terms of abuse as per the various domains of VASS, more than two-third of the elderly reported experiencing coercion and dejection, 60% reported experiencing dependence, and about half reported vulnerability to abuse. When one attempts to compare the findings of the present study with the existing literature, it is evident that prevalence of abuse is similar to the previous studies from India, which have reported it to be 40%[27,28] but is significantly higher than that reported in other studies, which have estimated the prevalence of elder abuse to be 14%.[27] The findings of the present study are also comparable to that reported in European and other countries[32-36] but are significantly higher than that reported in the from USA.[8,37]

The high prevalence indicates that there is an urgent need to recognize this problem and provide support to the vulnerable elderly. The Government of India has Law in the form of "Maintenance and Welfare of Parents and Senior Citizens Act, 2007," which has provisions for maintenance and welfare of elderly. According to this law, it is a legal obligation for children and other heirs to provide maintenance to senior citizens and

Table 3: Comparison of sociodemographic and clinical profile of those with and without elder abuse

Variables	Abuse present (*n*=52)	Abuse absent (*n*=73)	χ^2 (*P*)
Age (years)	65.7 (5.5)	65.3 (7.1)	0.278 (0.782)
Age groups			
55-59	4 (7.7)	10 (13.7)	1.1 (0.29)
≥60	48 (92.3)	63 (86.3)	
Education in number of years (mean and SD)	1.8 (3.5)	0.9 (2.5)	1642.5 (0.083)
Gender			
Male	17 (32.7)	30 (41.1)	0.914 (0.339)
Female	35 (67.3)	43 (58.9)	
Marital status - currently single	22 (42.3)	23 (31.5)	1.538 (0.215)
Occupation			
Currently on paid employment	7 (13.5)	7 (9.6)	0.458 (0.499)
Currently not on paid employment	45 (86.5)	66 (90.4)	
Type of family			
Nuclear	14 (26.9)	14 (19.2)	1.048 (0.306)
Nonnuclear	38 (73.1)	59 (80.8)	
Socioeconomic status			
Lower	46 (88.5)	62 (84.9)	1.034 (0.223)
Middle	6 (11.5)	7 (9.6)	
Upper	0	4 (5.5)	
Clinical profile			
Physical illness present	40 (76.9)	27 (36.9)	0.101 (0.751)
Comorbid substance use disorder			
Alcohol use/abuse	4 (7.7)	3 (4.1)	0.005 (0.945)
Tobacco use/abuse	24 (46.2)	3 (4.1)	13.2 (<0.001***)
Presence of psychotic symptoms - present	6 (11.5)	1 (1.4)	5.94 (0.001**)

SD: Standard deviation; ***P<0.001, **P<0.01

parents by providing monthly allowance. This act is thought to provide protection to the elderly from abuse, but till now, this has not been implemented by all the states in the country. Further, although some states have implemented the same, there are minimal efforts in the form of awareness campaigns to make elderly aware of existence of the law and their rights. Police is also not much aware of the law and hence fail to protect the elderly. Accordingly, there is a need to develop awareness campaigns to spread the message that the elderly can seek protection using the "Maintenance and Welfare of Parents and Senior Citizens Act."

In terms of factors associated with abuse, the present study suggests that elder abuse was more common among those who had psychiatric morbidity. Previous studies from other parts of the world have also reported similar results.[38-40] However, previous studies had mainly evaluated the relationship of abuse with dementia.[41] In contrast, the present study has evaluated the association with any psychiatric morbidity. This finding suggests that elderly with psychiatric disorders are a vulnerable group to experience abuse. However, it is important to note that the present study was cross-sectional in nature and cannot provide information about cause and effect relationship between psychiatric morbidity and elder abuse. It can be hypothesized that it is quite possible that experience of abuse may lead to the development of psychiatric morbidity. However, it is also possible that elderly participants who develop psychiatric morbidity, may be neglected, because of lack of or poor contribution to the household. Future studies with longitudinal study design can possibly provide

answer to the cause and effect relationship between elder abuse and psychiatric morbidity. However, considering the high prevalence of elder abuse among those with psychiatric disorders, it can be said that psychiatrists managing elderly patients should routinely inquire about the elder abuse and increase the awareness of the elderly about their rights.

The present study has certain limitations. This was a cross-sectional study. The study did not attempt to evaluate the perpetuators of elder abuse nor did the study evaluate the awareness of elderly about the existing law. Although the present study shows that elder abuse is more common among those who have psychiatric morbidity, no cause-effect relationship can be concluded. The study sample was recruited by purposive sampling, was relatively small, and was limited to rural setting. The study also did not evaluate other factors such as social support, self-esteem, living situation in terms of privacy, and sexual abuse faced by the elderly. However, the present study has certain strengths in the form of psychiatric diagnosis being made by a qualified psychiatrist rather than based on screening questionnaire and evaluation of abuse by a clinician by providing privacy to the patient.

CONCLUSION

The present study suggests that elder abuse is common in the Indian setting, especially among those with mental illnesses. Considering the high prevalence of elder abuse, there is an urgent need to address the problem. Public awareness, education, and sensitization of people toward the abuse are the need of the hour. There is also a need to improve the awareness of the clinicians dealing with geriatric patients. All such clinicians should screen the elderly for abuse and must make them aware about their rights. There is also a need to develop legal aid cells to provide legal aid to the elderly facing abuse in the hands of their children, other heirs, and significant others.

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Conflicts of interest
There are no conflicts of interest.

Table 4: Comparison of abuse experienced by those with and without psychiatric morbidity

	With psychiatric morbidity	Without psychiatric morbidity	*t*-test (*P*)
Vulnerability	1.25 (1.23)	0.6 (0.9)	1361.00 (0.004**)
Dependence	0.9 (0.8)	0.7 (0.8)	1639.00 (0.163)
Dejection	1.9 (1.2)	1.2 (1.3)	1284.5 (0.001**)
Coercion	1.4 (0.9)	0.9 (1.1)	1364.0 (0.005**)
Total VASS score	5.5 (3.3)	3.4 (3.1)	3.46 (0.001***)

VASS: Vulnerability to Abuse Screening Scale; **$P<0.01$; ***$P<0.001$

Table 5: Comparison of the presence or absence of abuse experienced by those with and without psychiatric morbidity

	With psychiatric morbidity (*n*=73), *n* (%)	Without psychiatric morbidity (*n*=52), *n* (%)	χ^2 (*P*)
Vulnerability - yes	43 (58.9)	19 (36.5)	6.077 (0.014*)
Dependence - yes	48 (65.8)	27 (51.9)	2.420 (0.12)
Dejection - yes	59 (80.8)	26 (50.0)	13.258 (<0.001***)
Coercion - yes	58 (79.5)	28 (53.8)	9.276 (0.002**)
VASS score >6	39 (53.4)	13 (25)	10.1 (0.001***)

VASS: Vulnerability to Abuse Screening Scale; *$P<0.05$; **$P<0.01$; ***$P<0.001$

Table 6: Comparison of sociodemographic and clinic profile with psychiatric illness and those without psychiatric illness

Variables	Psychiatric morbidity present mean (SD) (*n*=73), *n* (%)	Psychiatric morbidity absent mean (SD) (*n*=52), *n* (%)	χ^2 (*P*)
Age (years)	64.0 (4.6)	67.5 (7.9)	3.029 (0.003**)
Education in number of years (mean and SD)	1.3 (2.6)	1.2 (3.4)	1674.0 (0.129#)
Gender			
Male	20 (27.4)	27 (51.9)	7.786 (0.005**)
Female	53 (72.6)	25 (48.1)	
Marital status - currently single	29 (39.7)	16 (30.8)	1.057 (0.304)
Occupation			
Currently on paid employment	6 (8.2)	8 (15.4)	1.57 (0.211)
Currently not on paid employment	67 (91.8)	44 (84.6)	
Type of family			
Nuclear	20 (27.4)	8 (15.4)	2.52 (0.112)
Nonnuclear	53 (72.6)	44 (84.6)	
SES status as modified Kuppuswamy socioeconomic scale			
Lower	61 (83.6)	46 (88.5)	0.55 (0.759)
Middle	8 10.9)	5 (9.6)	
Upper	3 (4.1)	1 (1.9)	
Clinical profile			
Presence of physical illness	38 (52.1)	29 (55.8)	0.17 (0.681)
Co-morbid substance use disorder - present	5 (6.8)	29 (55.8)	36.7 (<0.001***)
Alcohol use/abuse	3 (4.1)	4 (7.7)	0.737 (0.391)
Tobacco use/abuse	2 (2.73)	25 (48.1)	36.86 (<0.001***)
Presence of psychotic symptoms - present	6 (8.2)	1 (1.9)	2.277 (0.131)

SD: Standard deviation, SES: Socioeconomic status; **P<0.01; ***P<0.001; #Mann-Whitney U value

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