Prevalence and Identification of Elder Abuse in India: Current Scenario and Way Forward

Vidushi A\textsuperscript{1}, Swadia A\textsuperscript{2}, Pruthi S, Goel A\textsuperscript{3}

\textsuperscript{1}Senior Registrar, Department of Medical Oncology, Fortis Memorial Research Institute, Gurgaon, India,
\textsuperscript{2}Sri Venkateswara College, Delhi University, Delhi, India- 110021
\textsuperscript{3}Cardiology Fellow, Hartford Hospital, Connecticut, United States

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\textbf{Introduction}

Elder Abuse is not only a violation of fundamental human rights but also responsible for significant problems such as injuries, illness, lost productivity, isolation and mortality.\textsuperscript{(1)} Amongst numerous challenges faced by elders, abuse is not only a standard but also a neglected issue. With the population of older people projected to increase to 1.3 billion by 2040, accounting for 14\% of the total global population, the problems faced by them warrant priority attention. At present the global rates of Elder abuse range from 3.2\%-27.5\%.\textsuperscript{(2)}

The issue of elder abuse is becoming increasingly relevant to India with demographic transition leading to an increase in the share of older people in the national population. The demographic shift has resulted in an increased dependency ratio. Hence elder abuse has become even more topical. The challenge is grave for a developing country as it is estimated that over 80\% of the older world population would be living in the developing world by the year 2050. The socio-cultural transitions such as urbanization, migration and disintegration of the joint family systems that contribute to the problem of elder abuse are occurring at a greater pace in the developing countries. UN Secretary-General Kofi Annan has said, "Mistreatment of older persons may be part of a broader landscape of poverty, structural inequalities and other human rights abuses."

The current report aims to review the currently available literature on the prevalence of elder abuse in India. It attempts to focus community attention on a problem that is either considered taboo or is largely denied in a rapidly transforming society. The paper further attempts to review the tools available to identify elder abuse and understand their applicability in the Indian healthcare system.

\textbf{Definition of Elder Abuse}

The definition of Elder abuse is very contextual since it may happen in a family setting, care unit or among partners. It also depends on the geographical area, relationships between victim and perpetrator, financial and cultural variations. Abuse may be a long-term pattern or only occur in certain stressful circumstances. Hence it is difficult to arrive at a comprehensive detection of Elder Abuse.

World Health Organization defines elder abuse as 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.\textsuperscript{(3)} The International Network for the Prevention of Elder Abuse, further classifies abuse under three broad categories; (a) neglect, including isolation, abandonment and social exclusion; (b) violation of human,
Elder abuse has been shown to lead to poor quality of life among older people causing psychological distress, multiple health problems and increased mortality. The consequences of elder maltreatment are multifold and can be broadly classified into physical and psychological consequences. The physical effects can range from wounds, injuries, malnutrition, sleep disturbances, increased susceptibility to illnesses (including sexually transmitted diseases), exacerbation of preexisting health conditions and increased risks for premature death. The psychological effects of elder abuse include distress, increased risks for depression, fear and anxiety reactions, learned helplessness and Post Traumatic Stress Syndrome.

The magnitude of the problem

It is estimated that 4-6% of older people in high-income countries have experienced some form of maltreatment at home. In a systematic review of 49 population-based studies, it was reported that 6% of older people suffered significant abuse in the last month and 5.6% of couples reported physical violence in their relationship in the previous year, nearly a quarter reported substantial levels of psychological abuse. 5% of family caregivers reported physical abuse towards care recipients with dementia in a year, and a third reported any significant abuse. The estimated prevalence of elder abuse reported in international studies varies widely with the lowest reported prevalence rate in Spain (0.8%), to the highest in Israel, at over 18%, rising to 35% when neglect was included.

Prevalence of Elder Abuse in India

India has a robust joint family system, wherein most people live in joint families, and about 90% of the older persons in India do not have a source of income, social security or a formal pension scheme. The financial and functional dependency of older people puts a strain on the family, leading to more instances of abuse.

Around 75% of Indian elderly live with their sons and 3% with their daughters. It suggests that the common perpetrators of abuse and neglect are sons, who are responsible for the abuse among 41% of male victims and 43% of female victims. Daughters in law also play a significant part in verbal abuse, disrespect and abuse.

A study conducted by Skirbekk and James in 2014 in seven Indian states suggested that education is one of the possible mitigating factors for elder abuse since the educated people up to 8th standard can identify, have the confidence to report, and have a better understanding of policies in place for the protection of the elders. This is supported by the findings of Kaur et al., wherein a significant association was found between psychological abuse and educational status, which inferred that as the level of education increases the perception of psychological abuse also increases.

The average literacy rate is 44%, however, and the literacy rate of elderly females (28%) is half of that of males (59%), adding to the prevalence of elder abuse. Since caregiver and care receiver education level and family income are lower in rural areas, and 71% of the elderly population resides in rural India, more instances of elder abuse, specifically physical and financial abuse are found in rural areas of India. Table 1 gives a list of significant studies on the prevalence of elder abuse in the Indian landscape.

Identification of Elder Abuse

Identification is an integral component of the management of Elder Abuse. Post correct identifying, further abuse can be prevented, and the abuser can be held liable to legal action. However, it generally goes unreported and undetected. In a country like India with a rich legacy of respect for elders since time immemorial, it is even more challenging to make all the stakeholders appreciate the magnitude and presence of elder abuse in our society. Moreover, the complicated relationship and personal bond between the victim of elder abuse and perpetrator (family caregiver, institutional caregiver) makes identification elder abuse the most fundamental and most challenging aspect of the problem of elder abuse.

Healthcare professionals are at an optimal position to identify and report elder abuse. Health care seeking by the elder provides an opportunity for the health system to document the problem of elder abuse. Health care professionals if appropriately trained can identify signs and symptoms of elder abuse in patients presenting to the health facility. Early identification of the problem of elder abuse and even identifying high-risk individuals for elder abuse can help in significantly reducing the problem of elder abuse. Some common identification instruments are given in Table 2.

Methodology

A search on Pubmed database was conducted in January 2018 with keywords "elder AND (abuse OR neglect OR mistreatment)". Filters were then
sequentially applied to identify articles of relevance for inclusion into the review. Articles were screened for appropriateness in terms of the hospital setting, involvement of healthcare professionals and possible suggested interventions. Identified articles were then reviewed, and data were extracted from studies with a focus on the type of intervention proposed by the author to address the situation.

The bucket list of the interventions was then reviewed for economic feasibility, resource availability and cultural applicability in an average Indian hospital setting. The aims were to find the preferred interventions that could be applied in short and long term to address the elder abuse among older individuals presenting to hospitals for related or unrelated problems.

Table 1: Studies on the Prevalence of Elder Abuse in India

| Authors                        | Methodology and Study Setting                                      | Sample Size                                                                 | Conclusions                                                                                   |
|--------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| HelpAge India                  | A quantitative and qualitative cross-sectional study in 8 Urban cities of India | Quantitative- 100 subjects per city, Qualitative- 57 in-depth interviews  | Elder abuse 36%, highest in Bhopal (79%) followed by Chennai (59%) and Kolkata (44%)        |
| Chokkanathan S, Lee AE         | A community-based cross-sectional study in Chennai (Urban)          | 400 community-dwelling older adults aged 65 and above                      | Prevalence of elder abuse 14%                                                              |
| V Skirbekk, KS James          | Community-Based Cross-Sectional Study in 7 Indian States           | A total of 9852 elderly from 9259 households were interviewed.              | 11% of 60+-year-olds have experienced at least one type of elder abuse.                      |
| Mawar S, Koul P, Das S, Gupta S| Community-Based Cross-Sectional Study in Delhi (Urban)             | Two hundred twenty-two elderly persons, aged 60 years or older residing in an urban community of Delhi | The overall prevalence of any type of elder abuse was 24.3%. Psychological abuse was the most common type (22.9%) followed by financial abuse (5.8%), physical abuse (1.4%) |
| Pritish Kumar, Somdatta Patra  | Cross-sectional Study in Delhi (Urban)                             | Elderly residents aged 60 years and above in an urban resettlement colony of east Delhi were screened. | 9.6% of Elders reported experience of abuse. All abused participants faced neglect, four-faced verbal abuse, and two participants reported physical and one financial abuse. |
| Jaspreet Kaur, Jasbir Kaur, N. Sujata | Cross-sectional Study in an urban and rural setting in Ludhiana, Punjab | Two hundred subjects (100 subjects each from rural and urban area respectively) of age 60 years and above was drawn by cluster sampling technique and interviewed. | Perceived physical abuse (25%) was higher among elderly residing in a rural setting and among female elderly who were illiterate, widow/widower and partially dependent on the caregiver. Psychological abuse (71%), financial abuse (37%) and social neglect (74%) were higher among elderly residing in urban settings. The perceived financial abuse was significantly higher among male elderly who were financially independent. |
| Patel V K, Tiwari D S, Shah V R, Patel M G, Raja H H, Patel D S | Random Selection Study                                               | One hundred randomly selected patients in the Out-Patient Department of a tertiary care hospital in Jamnagar. | The prevalence of abuse was 24%. Among those who had experienced abuse, 50% had experienced psychological abuse, 17% had experienced neglect, 8% had experienced exploitation, and 4% had experienced physical abuse. About 54% of patients with severe depression had experienced abuse. |
Table 2: Salient features of different screening tools for elder abuse

| S No. | Name of the tool                                      | Formulated by/Year | Salient Features                                                                 | Respondent | Advantages                     | Disadvantages                                                                                   |
|-------|-------------------------------------------------------|---------------------|----------------------------------------------------------------------------------|------------|-------------------------------|-----------------------------------------------------------------------------------------------|
| 1     | Hwalek-Sengstock Elder Abuse Screening Test (HSEAST)  | Hwalek and Sengstock (1991) | 15 items, 3 domains: violation of personal rights or direct abuse, characters of vulnerability and potentially abusive situation | Older person | Self-report measure          | Small, unrepresentative samples used to validate it, Low internal consistency, A high false-negative rate |
| 2     | The Brief Abuse Screen for the Elderly (BASE)         | Reis and Nahmiash (1998) | 5 items, To assess the likelihood of abuse with caregiver/elder                  | Trained practitioner | Takes 1 minute for completion | Involve both caregiver and care receiver, Trained personnel is required |
| 3     | The Caregiver Abuse Screen (CASE)                    | Reis and Nahmiash (1995) | 8 items, Used for cognitively impaired elderly, To identify potentially abusive caregivers, A score of 4 or more suggestive of higher risk for abuse | Caregiver  | Takes 1-2 minutes for completion | High sensitivity low specificity, Does not address patient |
| 4     | The Indicators of Abuse Screen (IOA)                 | Reis and Nahmiash (1998) | 27 items, The cutoff score of 16 is used to indicate abuse, To identify abuse among health and social services clients | Trained practitioner to assess caregiver and elder | Address patient and caregiver both directly | Requires trained personnel |
| 5     | The Elder Assessment Instrument (EAI)                | Ferguson (1983)      | 41 items, Abuse, neglect, exploitation and abandonment are assessed             | Trained practitioner to identify individuals at high risk of abuse or neglect which should be referred for further assessment | rapid assessment capacity (takes 12-15 minutes), Assess physical, social and medical issues | No scoring system, Weak specificity |
| 6     | Elder Abuse Suspicion Index (EASI)                    | Yaffe et al. (2006)  | Six items                                                                         | Older person | Simple tool suitable for rapid assessment | Administered by physician |
| 7     | Modified Conflicts Tactics Scale                      |                     |                                                                                  |            |                               | Can be cross verified since it involves an interview of both the caregiver and the victim |
| 8     | Vulnerability to abuse screening scale (VASS)        | Schofield et al. (2002) | 12 items, Four factors are assessed: vulnerability, dejection, dependence, coercion | Older women | simple                        | Only for women |
### Table 1: Identification tools for Elder Abuse

| No. | Name of the tool                                      | Formulated by/Year | Salient Features | Respondent | Advantages | Disadvantages |
|-----|-------------------------------------------------------|--------------------|------------------|------------|------------|---------------|
| 9   | Caregiver psychological elder abuse behaviour scale (CPEABS) | Wang (2006)        | 20 items         | 10 minutes for completion |            |               |
| 10  | Elder psychological abuse scale (EPAS)                | Warg (2007)        | 32 items         | Older person | 5-10 minutes for completion Interaction with caregiver |               |

### Discussion

Elder Abuse is a growing global problem, where research and solutions are lacking. It is a complex, multilateral problem that falls under many jurisdictions – healthcare, social system, law enforcement, justice and public policy. Physicians and social work organizations must come together and work on identifying and preventing abuse. In contrast, public policy and the judicial system must work on creating laws protecting older persons.

In the Indian hospital setting, elder abuse might go unnoticed because of the lack of time and the patient’s clinical problems. There are many barriers faced by the patients- lack of awareness about abuse, reluctance to accept outside intervention and unwillingness to accept their problem. In India, the doctor-patient ratio is about 1: 2000, and there are 80 doctors (allopathic and homoeopathic) per lakh people, most hospitals are short-staffed and overcrowded. Hence the interventions and identification tools applied must be time and resource-effective. Out of the 14 Identification tools listed in Table 2, only two are most relevant to the Indian setting.

**HS-EAST**

Hwalek-Sengstock Elder Abuse Screening Test is a short test, containing 15 items that can be included as a routine questionnaire along with history taking of the patient. The questions are based on three aspects; violation of fundamental rights, characteristics of vulnerability and potential abuse situations.

**EASI**

The test contains only 6 ‘yes’ or ‘no’ based items. It is a highly specific and efficient test that not only helps identify abuse, but also its type. It can be administered by any physician/ nurse with basic medical training and can easily be accommodated within the time constraints of the hospital.

### Policy issues and Way forward

India should develop a comprehensive policy addressing the issue of elder abuse. All relevant stakeholders should discuss the pros and cons of starting an elder abuse screening program. It is imperative that appropriate facilities, infrastructure and resources should be put in place to manage and rehabilitate the individuals identified by elder abuse screening. However, more research needs to be carried out to understand better the issue of elder abuse in India, specifically focusing on tools of identification and interventions to prevent and rehabilitate elder abuse victims.

### Conclusion

Elder abuse is a ubiquitous problem facing the country today. A multi-party, multidisciplinary approach to deal with it is required. More research is warranted to document the burden of this problem in the country and research focusing on identification and screening of population at risk is warranted. While the overall study in India gives a comprehensive view of the pervasiveness of Elder Abuse in our society, there is little research and policies for finding solutions.

The available literature suggests that healthcare professionals have a vital role in the management of Elder Abuse. The resources cannot be completely trusted, because ample times the source of information is the abuser or the elderly, who may have certain biases or restrictions in speaking out. Hence a standardized identification and management system is necessary. In the Indian context, EASI and HS-EAST are most relevant.

There are also policies in place to improve the quality of life of older adults such as the IPOP scheme, but many more such programmes are
needed. Elder Abuse Prevention policies must be formed giving due credit to the influence of the socio-cultural context, diversity, relationship between abuser and victim, and financial conditions of families.

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