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# Study of 100 Cases of Elder Mistreatment

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***Abstract***
*Objective: Toscreenforeldermistreatment.*
*Design:Observational study.*
*Setting: Geriatricout-patientdepartmentofGovernmentMedicalCollege,Aurangabad.*
*Participants:100geriatricout-patients.*
*Results- We observe that geriatric abuse is definitely prevalent and on the rise in theIndian scenario too. In this study of 100 cases, two out of three participants lived with spouse or alone, mainly because the children did not want them to stay with them. Neglect(75%), followed by verbal abuse (57%) were the commonest forms of elder mistreatment. Alcoholabuse in the caregiver (15%) was associated with physical abuse. The older adults perceived theirsons to be the primary abuser in 72% cases. Though elder mistreatment is a taboo subject in the traditional Indian society, the patients felt comfortable sharing their experiences with thegeriatrician. An alert and sensitive geriatrician/physician, who is aware of this problem and is patient and discreet, can elicit the history of mistreatment and try to help the sufferer where possible.*
*Conclusions: Elder mistreatment is prevalent in India in all cross-sections of the society. The integration of social services with geriatric outpatient services can be a model to address elder mistreatment.*
***Keywords****Abuse,neglect,geriatric,mis-treatment, elder*

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## I. Introduction

ELDERLY ABUSE (mistreatment) is a multifactorial geriatric syndrome.

- Earlier, in India, old age was never a problem as elders were given the respect, care and love that they deserved.
- Elder abuse was considered to be a 'WESTERN' problem and the concept of old age homes was foreign and taboo.
- However, with changing times, as people become more materialistic, the elderly are often neglected, treated as a burden, financially exploited and physically abused. (1)

Across India, nearly 163 million elders live amidst an environment of rapid urbanization, migration, disintegration of the joint family system and the younger generation becoming more and more materialistic and self-centered. The COVID pandemic, that has added to the isolation and abuse of elders. (2)

Elder mistreatment exists globally, but what we see is the tip of the ice-berg. Inthe United States of America, in spite of established association of elder mistreatment and worsehealth outcomes, only 1.4% of abuse cases reported to Adult Protective Services (APS) come fromphysicians.In a survey of APS workers, of 17 occupational groups, physicians were among the least helpful in reporting abuse.(4)

Why is it a challenge?
1)Abuse can mimic chronic diseases.
2)Elders do not express their angst for fear of aggravating their woes or spoiling the family name. Hence detection and evaluation are difficult. Society presumes that some things are bound to happen as one grows older, one should resign to what happens, be more tolerant and less expecting.

Need for awareness and prevention of Elder Abuse [3]

- Mistreatment is associated with significant increase in mortality (three times) , hospitalization, dementia, depression.
- The identification of elder mistreatment is one of the most difficult clinical challenges in geriatric medicine.
- A mistreated elder has three-fold higher risk of death

## II. Definition Of Elder Mistreatment- (4)

"Intentional actions that cause harm or create serious risk of harm, to a vulnerable elder, by a caregiver or other person who stands in a trust relationship to the elder OR Failure by a caregiver to satisfy the elder's basic needs or protect the elderly from harm."

- Psychological abuse in the form of neglect or verbal abuse, abandonment, financial exploitation, physical, sexual mistreatment of an older person by another person or entity. [4]
- This can occur in any setting (e.g.: home, community, or facility like old age home.). [4]
- Either in a relationship where there is an expectation of trust and/or when an older person is targeted, based on age or disability [4]
- Elders with cognitive impairment or dependence due to physical disabilities are more likely to be mistreated. [4]
- The abuse may be in the form of an act of omission(neglect, not providing nutrition, medicines, safetyetc) or commission (financial /physical / abandonment.[4]

*Violation of a trusting relationship [5]*

- Meant to encompass all forms of abuse in that all forms involve the older person relying on and trusting another party, who through acts of omission or commission, violates that trust, without regard to intent

*Neglect[5]*

- Withholding /not providing medical care, inspite of affording or not having logistic difficulties.
- Failure to provide physical aids such as eyeglasses, hearing aids, false teeth
- Failure to provide safety precautions in the house or while travelling etc.
- Isolating the elder unduly.
- Not speaking/ including in family discussions,decisions etc.

*Psychological, emotional, or verbal abuse [5]*

- Conduct that causes mental anguish.
- Verbal berating, harassment, or intimidation.
- Threats of punishment or deprivation.
- Treating the older person like an infant.
- Isolating the older person from others.

*Financial or material abuse [5]*

- The misuse of the older person's income or resources for the financial or personal gain of a caretaker or advisor.
- Denying the older person, a home.
- Stealing money or possessions or property.
- Coercing the older person into signing contracts, making a will,transferring property.

*Physical abuse[5]*

- Pushing, striking, slapping, force-feeding
- Incorrect positioning. not taking care of bed-ridden or person with disabilities who is dependent for activities of daily living.
- Improper use of restraints (tying, gagging etc) or medications
- Sexual coercion or assault.

*Abandonment [5]*

- The desertion of an older person by an individual who has assumed responsibility for providing care for the older adult or by a person with physical custody of the elder.

## III. Clinical Manifestations Of Potential Mistreatment With Recommended Assessment [(5)]

***History from older adult-***

- Interview the patient without the presence of the caretaker. Watch the attitude and behaviour of the accompanying care-giver.
- Directly enquire regarding physical violence, use of restraint, or neglect. Ascertain precise details about nature, frequency, and severity of events.
- Assess functional status (amount of dependence with activities of daily living [ADLs]).
- See who the designated caregiver is, if disability is present

***History from abuser***- Potential abuser should also be interviewed alone; this interview is best done by professionals with experience in this area; avoid confrontation in the information-gathering phase. Interview other sources if possible.

- Assess recent psychosocial factors (ex. bereavement, financial stresses) and addictions.
- Ascertain caregiver understanding of patient's illness (eg, care needs, prognosis, etc).
- Elicit caregiver's explanations for injuries or physical findings.

***Behavioural observation***

- Withdrawal
- Is caregiver treating the elder as a child, patronizing?
- Does caregiver insist on providing the history?

***General appearance of the elder***

- Hygiene
- Cleanliness and appropriateness of dress
- Skin/mucous membranes - signs of dehydration; multiple skin lesions in various stages of evolution, bruises, decubitus ulcers; Is care of established skin lesions being taken?
- Head and neck- Traumatic alopecia, scalp hematomas,lacerations, abrasions.
- Trunk -Bruises, injury marks- their shape may suggest implement (ex, iron/belt, rope).
- Genitourinary -Rectal bleeding,vaginal bleeding, infestations.
- Extremities- Wrists or ankle lesions suggest use of restraint, like a rope or chain for tying to a bed or chair, or immersion burn (in hot water-stocking/glove distribution).
- Musculoskeletal-examination for occult fracture, pain. Observe gait.

***Neurologic/psychiatric*:**

Are there neurologic deficits? Depressive symptoms, anxiety?

***Mental status***:

- Formal mental status testing (ex,3 object recall, Mini Mental State Examination); cognitive impairment suggests delirium or dementia. The risk of mistreatment is higher. It also affects decision-making.
- Psychiatric symptoms including delusions and hallucinations.

**Social and financial resources**:

- Are other members available to assist the older person's financial resources?
- These resources are crucial in considering interventions that include alternate-living arrangements and home services.

What do the elders want?

*Besides basic needs, safety, medical care, they need to be heard, they need someone to speak to and listened, they need to feel needed and not a burden. They need dignity and to maintain their self -respect. They do not want to be exploited or abused.*

Elders need eight times more medical care than youth [(2)]. The elders may confide better in a familiar clinical setting due to the trust andrespect for their healthcare provider. Can doctors detect elder mistreatment in the clinic? Can clinicsbecomeeffectivepointsofintegrationofmedical andsocialservicesforsenior citizens?

**Role of Doctor**

- Doctors are in the unique position to detect and communicate with and counsel both elders and caregivers regarding possible mistreatment.
- Awareness amongst physicians regarding elder abuse and simple screening tools for detection must be promoted.

## IV. Methods

Background:

The Department of Geriatrics, Government Medical College, Aurangabad, Maharashtra is the firststate-sponsored Post Graduate Geriatrics Department in the state. The department impartsspecialized training and education in the healthcare of older adults. Researchfociincludegeriatricsyndromes-falls,incontinence,dementiaandeldermistreatment.

Our study is an observational, cross-sectional qualitative study at the Geriatrics Out- patient Department at GovernmentMedical College and Hospital, Aurangabad. All participants are 60 years of age and above. The study is approved by the Institutional EthicsCommittee.

Screening:

The Geriatrics OPD has a screening area where resident doctors screen elders for geriatricsyndromes and risk factors for cardiovascular diseases. We screened all patients coming to the OPDin August 2019 with a single screening question- "Are you treated well athome?" Elders answering in the negative were administered the following questionnaire by thegeriatrician- they were also screened for cognitive impairment by the 3 object and 3 name recall test. The patients who had no obvious cognitive impairment were only included in the study.

| Sr.no | Question | Response (Y/N) |
|---|---|---|
| 1 | Doesyourfamilygiveyoufood,shelter,medications? | |
| 2 | Does anyoneathomeverballyabuseyou? | |
| 3 | Does anyoneathometakeawayyourmoneyforcibly? | |
| 4 | Hasanyonemanhandledyouathome? | |

Even if one answer was adverse, the elder was interviewed in detail.

The geriatrician determined mistreatment and its type based on above questionnaire. The elder was empathetically encouraged to tell about the problems being faced and the facts were recorded aftertakinginformedconsent. Theaverage timeofparticipantinterviewwas15 minutes.The geriatrician provided appropriate counselling and information about government schemes totheparticipants. They were then directed for evaluation of whatever physical health problems they had come for. The geriatrician thus screened nearly a thousand patients, 102 of whom screened positive formistreatment. 2 of them declined to get interviewed. 100 older adults participated in the interviewsandwereassessed formistreatment.

## V. Results

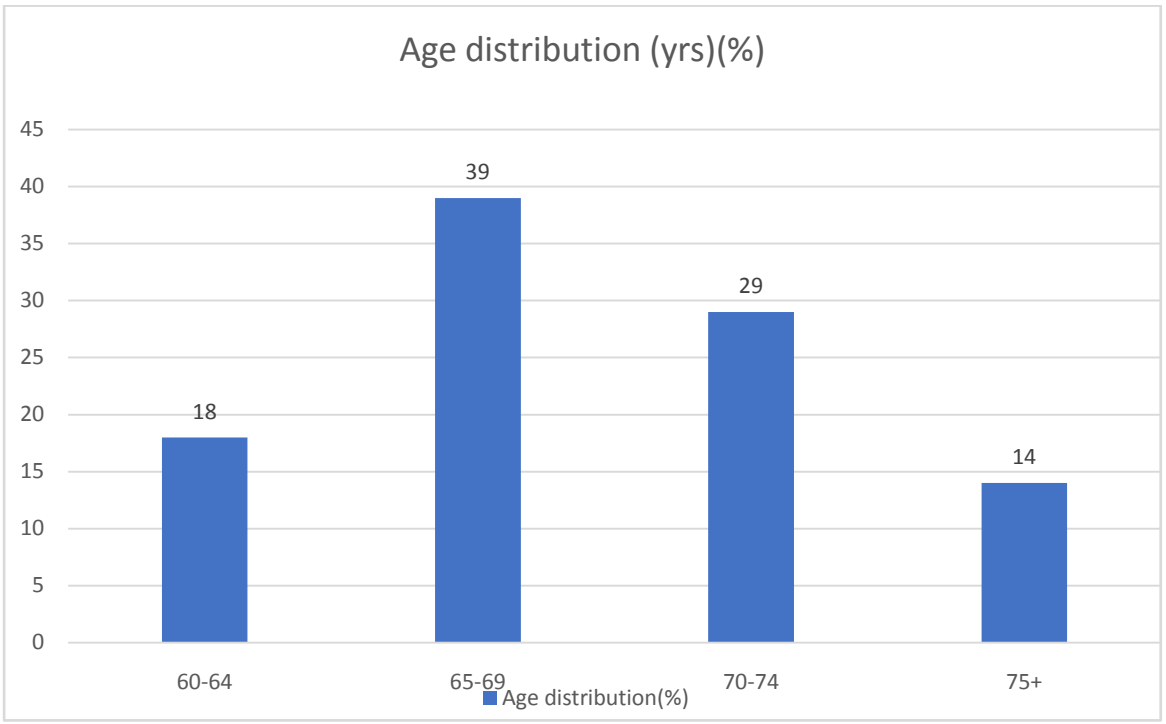
102 older adults reported elder mistreatment out of a thousand adults screened. 100 were included in the study.

Demographiccharacteristics:

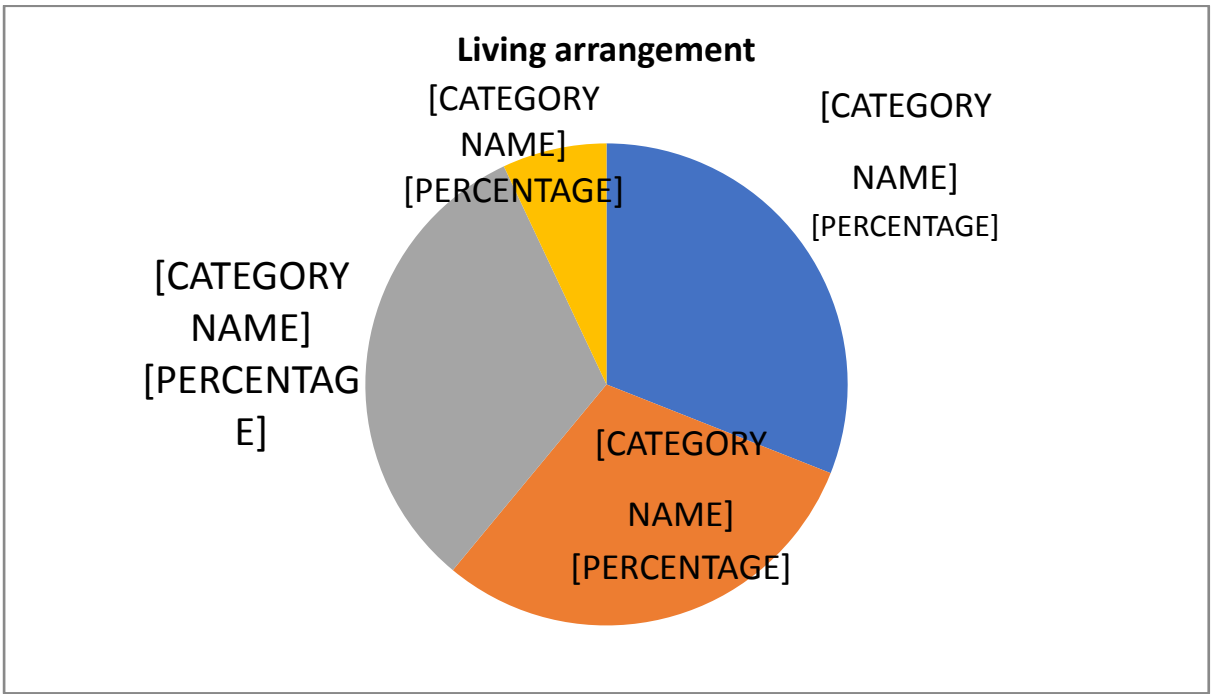
68% of the mistreated elders were aged 65 to 74 years. This life-stage corresponds to a period oftransition for the elderly - from work to retirement and an increase in co-morbidity.70% ofthe mistreated were women. This is similar to findings from previous studies. It alsopoints to the feminization of the elderly population, which in turn increases their vulnerability toabuse.

The living arrangement of the elderly showed that only 32% lived with their children. 31 % of theelderly lived next door to their children, but received no assistance, cooked their own meals and some were mistreated by the children.The 7% who lived with their daughters lived so because their sons refuse to keep them. All theinterviewedelders hadat leastonelivingchild.

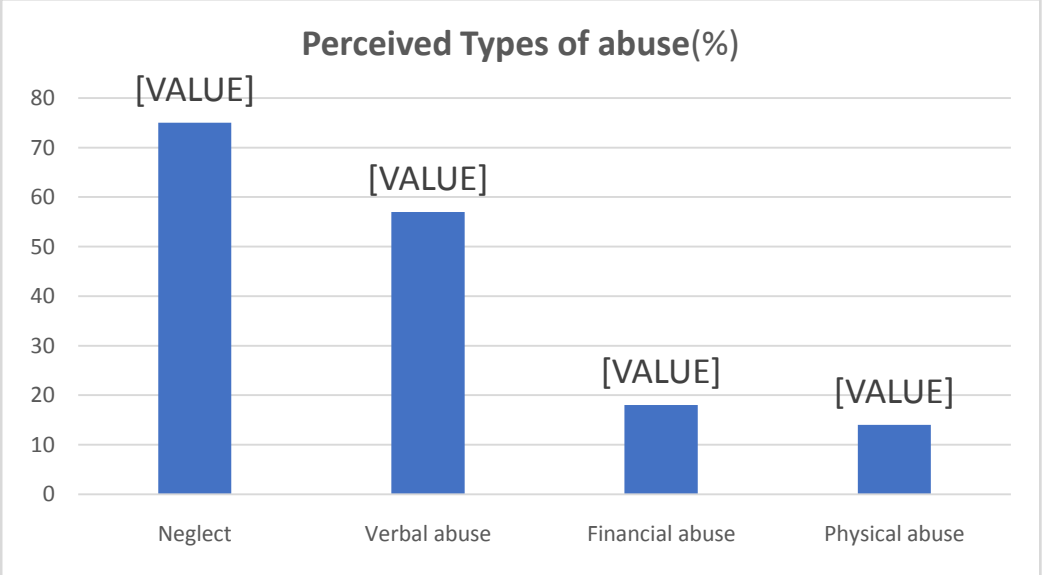
| AGE DISTRIBUTION | % |
|---|---|
| 60-64 | 18 |
| 65-69 | 39 |
| 70-74 | 29 |
| >75 | 14 |



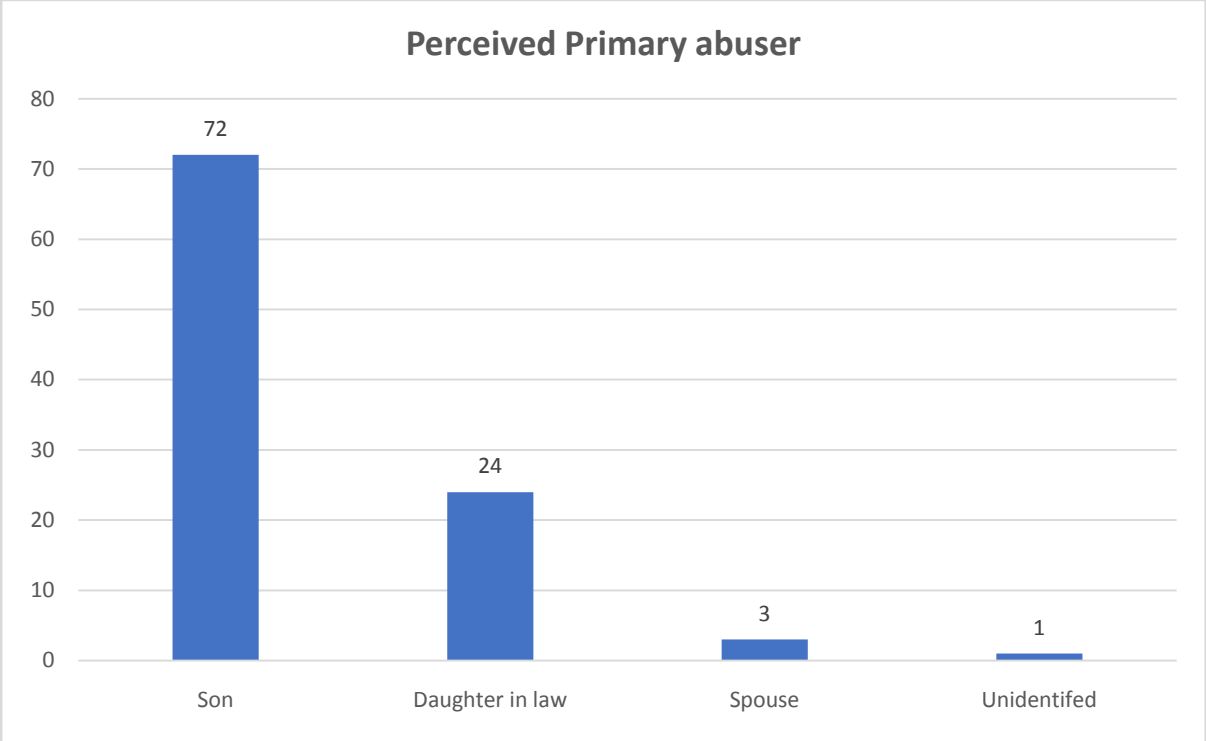

| LIVING ARRANGEMENT | % |
|---|---|
| LIVE WITH CHILDREN | 32 |
| LIVE NEXT TO CHILDREN | 31 |
| LIVE AWAY AND ALONE | 30 |
| LIVE WITH DAUGHTER | 7 |



| PERCIEVED TYPE OF ABUSE | % |
|---|---|
| NEGLECT | 75 |
| VERBAL ABUSE | 57 |
| FINANCIAL ABUSE | 18 |
| PHYSICAL ABUSE | 14 |




| PERCIEVED PRIMARY ABUSER | % |
|---|---|
| SON | 72 |
| DAUGHTER IN LAW | 24 |
| SPOUSE | 3 |
| UNIDENTIFIED | 1 |




Eldermistreatment:
75 % elders identified neglect as the prominent form of mistreatment meted out to them,followed by verbal abuse. 72 % perceived their sons to be responsible for the neglect more oftenthantheir daughterin laws. 24 % daughter inlawswereverballyabusive.

Alcohol use directly contributed to the abuse in 15 per cent cases. 7 per cent of the elderly, allwomen,wereturnedawayfromhomeafter thedeathof theirspouse.

The types of mistreatments are as follows:
Neglect-
Neglect was the commonest form (75%) of mistreatment. From the analysis, the prominent categories ofneglectwere- food, shelterandhealthcare.
Food-

Theolderadultswere fedirregularly, often leftovers, without consideration of their dentition, digestion, nutrition or dignity, sometimeswithaccompanyingphysicalorverbalabuse.

The elderly had very negative perceptions about their age due to the mistreatment, affecting bothphysicalandmental healthandhealthcareseeking.

*Quotes:*

*"Itisour oldage.Sowe havetoeatevenifofferedfoodonslippers."*

*"I eat only once since 12 years as my twice daily meals were creating tension between my daughter-in-law andson."*

*"Mydaughter-in-law justwalkedoutwhenI askedherto accompanymeto thehospital."*

Verbalabuse

Children frequently used expressions like- "You are better off dead", "Go consume poison and die"- makingtheelder feel likeaburden.

Quotesonthethemeofverbal abuseareasfollows-

*"We won't come and see you even if you die."*
*"Mysondoesnotearnbut callsme abeggar."*
*"Weleft.Howwerewesupposedtobear humiliationevery day?"*

Financialmistreatment

Some children handed out sums as meagre as 100 rupees a month to their parents. Widows forcedtowork tofeedthemselvesearnedjustenoughfor foodor barteredworkforfood.
In two instances, where the elders were earning, they felt obligated to give money to their childrenondemandwithoutexpectingany helpfromthechild.
Having property on one's name, perceived to be a sense of security, canalso lead to mistreatment. A couple staged suicide to get the parents to transfer their house and property on theirname beforeturningawaytheelderly couple.

One elderly woman held on to 2 acres of land she had, but she had no means to till it- leaving novalue for thelandin hername.

Quotesonthethemeof financialmistreatment areasfollows-

*"Ikeptmyjewellerywiththejewellerinexchange of 400rupees."*

*"Mysongives only 100rupeeswhenhe comestovisitme.One eye-dropcosts100rupees."*

Elderly couples receiving pension were relatively more self-sufficient than those without it.

***Whatthisstudyadds:***
This study's method can be integrated in clinical setting on a daily basis to screen for eldermistreatment. We strongly suggest integration of medical and social services at geriatricclinicstoaddressthechallengeofeldermistreatment.

## VI. Conclusion

It is estimated that in India there is one government doctor for every 11,528 population. Clinics fail to provide enough intimacy ortime required to elucidate the sensitive topic of mistreatment. Even if a clinician knows, in theabsence of an adult protection service, she is usually at a loss of what to do about the new foundknowledge of her patient's mistreatment.

Our seniors at times themselves argued that their children had no money to take care of two extra members. Security in old age is not perceived as a right, but as a disposable duty. Elderly couples shift out of house in view ofconstantverbalabuse.Financialsupportin the formofpensionsupporthelpselderly takecareof themselves and ensures better treatment from caregivers.

Women have traditionally been vulnerable to domestic violence- at the hands of husbands and parents-in- law- including verbal, emotional and physical violence. With many women outliving their husbands, with possibility of strained relation between daughters-in law and the mother-in-law- female elders becomemoresusceptible tomistreatment when they become dependent.
Neighbors, social workers in the area, do at times help the elderly who are being mistreated. There were at least two instances whereneighbors directly helped the patient reach the hospital in time of acute distress. They often extend support in the form of food.

- Social security net needs expansion. An integration of medical,socialandpension services isneeded.
- Pension schemes need to be user friendly and provided in a time bound manner.
- Spreading awareness about laws against mistreatment, a help- line number and availabilityofsocial security schemes can help.
- Screening has to be carried out gently, with empathy and patience, confidentiality has to be observed.
- Elders should be treated with dignity. This value has to be imbibed from school age.
- Awareness amongst physicians regarding elderabuse and simple screening tools for detection must be promoted. Doctors can counsel elders toreasonably accommodate and the caregivers to have empathy towards the elder.
- A dedicated day for geriatric patients in OPD settings, with information dissemination on available social securityforolder adults as well as laws to prevent mistreatment, maintenance of parents bill-maygoa longway in solvingthis massivechallenge.

**LIMITATIONSOFSTUDY**

1.We could record only the elders' perspective on mistreatment. Caregivers' interviews will helpcreateamore comprehensivepictureof themistreatment.

2.We included only persons who were subjected to abuse and not details of all the 1000 patients who were screened.

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