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OF SCIENCES AND LITERATURE

The Pattern of Elderly Abuse in the District of Rawalpindi and Islamabad, Pakistan

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DEDICATED TO MY FAMILY

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DR. NAVEED AHMED KHAN

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LIST OF ABBREVIATIONS

S.No.	Abbreviation	Detail
1.	AMA	American Medical Association
2.	EASI	Elder Abuse Suspicion Index
3.	MDTs	Multidisciplinary Teams
4.	NCEA	National Center on Elder Abuse
5.	NEAIS	National Elder Abuse Incidence Study
6.	SWE	Social Work Evaluation

Chapter 1

ABSTRACT

BACKGROUND:

Elderly people are often abused in many ways, with serious and lasting consequences. Elder abuse remains one of the most hidden forms of family conflict, and its frequency is anticipated to be rising in many countries that are rapidly experiencing population aging.

OBJECTIVE:

- To determine the frequency of types of elder abuse in people living in old age homes

SETTING:

The old age homes in District Rawalpindi and Islamabad are

• Shelter Old Age Home Rawalpindi.
• Nijaat Old People Home, Rawalpindi.
• Edhi Homes, Islamabad.
• M.G.Q Memorial Trust, Rawalpindi.

STUDY DESIGN:

- Cross-sectional study

DURATION OF STUDY:

From: 1st Feb,24 to 31st July,24

METHODOLOGY:

After approval from the ethical committee, persons living in old age homes in Rawalpindi and Islamabad, Pakistan who fulfilled the inclusion criteria were enrolled and informed consent was taken from them. History regarding the type of elder abuse (financial, psychological, physical, sexual, and neglect abuse) was taken from the persons as per operational definition. I collected all the information on Performa by myself.

RESULTS:

In our study, out of 93 cases, 47.31%(n=44) were between 60-75 years of age whereas 52.69%(n=49) were between 76-90 years of age, mean±sd was calculated as 75.20±6.08 years, 44.09%(n=41) were male and 55.91%(n=52) were females. Frequency of elder abuse shows that 29.03%(n=27) had financial abuse, 21.51%(n=20) had psychological abuse, 6.45%(n=6) had physical abuse and 43.01%(n=40) were neglected.

CONCLUSION:

- We conclude that neglect is a common elderly abuse in our population followed by financial and psychosocial abuse, however, our results are primary and need verification through other local trials.

KEYWORDS:

- ***Elderly abuse, neglect, financial, and psychosocial abuse***

INTRODUCTION

Elder abuse represents a profound and disturbing issue within our society, characterized by harmful actions or the absence of necessary actions that negatively impact older individuals. According to the World Health Organization, elder abuse is defined as “a single, or repeated act, or lack of appropriate action intentionally or unintentionally, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.[1]” This definition underscores the complexity and severity of the issue, highlighting that elder abuse can manifest both through direct acts and through neglect.

Despite the significant impact of elder abuse, there is a surprising lack of comprehensive evidence and research on this subject. Elder abuse is one of the most concealed and prevalent forms of family violence, often remaining hidden due to its occurrence within the private sphere of family relationships. Social changes, including urbanization, cultural assimilation, and the erosion of traditional values and familial norms, have contributed to increasing challenges in family dynamics, leading to an uptick in domestic elder abuse. While elder abuse is not a new phenomenon Elder

abuse is not a new issue, it has recently been raised as a main public health and a widespread, growing social problem worldwide.2

The study of elder abuse began in the 1970s, marking the inception of formal research into this troubling issue. Since then, the field has evolved, reflecting growing concern and interest. This increased attention has led to a range of questions about how elder abuse is defined, measured, and theorized. There is no universally accepted definition or standardized approach to measuring elder abuse, which complicates

efforts to gather reliable data. A review from 2009 highlights how variations in definitions and measurement tools can significantly influence reported prevalence rates of elder abuse. Recent research has categorized elder abuse into five distinct types: psychological, physical, sexual, financial, and neglect, as outlined by the World Health Organization in The Toronto Declaration. Abuse perpetrated against an older person is often not limited to only one form; for example, physical violence is often accompanied by psychological abuse and financial abuse may be accompanied by neglect or physical abuse.3

Empirical studies consistently indicate that women are more frequently victims of elder abuse than men. For example, a study conducted in the United Kingdom found that 3.8% of women and 1.1% of men were victims of mistreatment. Even when neglect was excluded from the analysis, the rate of abuse remained significantly higher among women (2.3%) compared to men (0.6%) 4. These statistics underscore a troubling gender disparity in the prevalence of elder abuse.

Further illustrating the complexity of this issue, different studies report varying prevalence rates for the types of abuse. In one study, financial abuse was observed in 90% of cases, psychological abuse in 85%, physical abuse in 60%, and neglect in 80%, with no instances of sexual abuse reported 5. In contrast, another study found much lower rates: financial abuse at 2%, psychological abuse at 2.2%, physical abuse at 0.5%, and neglect at 1.1% 6. This variability highlights the need for consistent research methodologies and definitions to better understand the prevalence and patterns of elder abuse.

In Pakistan, there is a notable lack of detailed information about elder abuse and its patterns. The existing literature on this issue is sparse, which impedes efforts to address and prevent elder abuse effectively. Given the variability in global data, the

objective of this study is to investigate and identify the specific patterns of elder abuse in Pakistan. This research aims to shed light on why elder abuse may be severe enough to compel elderly individuals to leave their homes and seek refuge in old age homes, despite the traditionally strong joint family system and familial support structures in place. Understanding these patterns is crucial for developing targeted interventions and support systems to protect older adults from abuse and improve their quality of life.

Chapter 2

REVIEW OF LITERATURE

HISTORICAL BACKGROUND OF ELDER ABUSE:

The abuse, neglect, or mistreatment of the elderly has unfortunately accompanied human existence since the ancient era and has spanned the globe. Classical Greek literature and mythology chronicle accounts of children killing their parents, called parricide, to consolidate power.[7] An extreme form of self-abuse and neglect is known in the medical lexicon as Diogenes Syndrome, whose namesake was a fourth-century BCE philosopher who shunned common comforts and lived much of his life in a tub.[8] The Greek culture also found euthanasia acceptable for the ill and incurable older population. Shakespeare wrote in King Lear about the king's maltreatment by his sons.[9] Tales of vampirism from Europe often have centered on an elderly man accused of aberrant behavior, whose pallid appearance may have been the result of an anemia of chronic disease. Some tribal cultures in Africa will isolate and abandon elder members by accusing them of witchcraft and blaming them in times of scarce resources.[10] Some cultures have promoted the ritual suicide of tribal elders during famine or drought so that precious food and water could be allocated to the more productive younger people.[7] Colonial American history reminds us that victims of witch hunts who were stoned or burned were often postmenopausal women.[11] Like other forms of family violence, elder abuse had historically been deemed a private affair and exempt from outside inquiry.

Despite its historic prevalence, elder abuse was not formally recognized by the medical community until 1975. Two British journals published reports on ‘‘Granny battering’’ 1 month apart to finally shed some light on this longstanding problem.[12] Since then, reports have surfaced worldwide, and increasingly more research is being done on the topic.[10]

In the United States, Congressional hearings first occurred in the late 1970s and early 1980s and heralded the gradual expansion of resources devoted to elder abuse. A 1987 amendment to the Older Americans Act defined certain terms. The Elder Abuse Task Force was created in 1990 by the Department of Health and Human Services, which enlarged the scope of the federal government's contribution to solving the problem. Following this, the United States Administration on Aging created the National

Resource Center on Elder Abuse, which has evolved into today's agency called the National Center on Elder Abuse (NCEA). The Joint Commission on Accreditation of Health Care Organizations then began to specifically include elder abuse as a form of domestic violence to raise awareness in its directive for the recognition and treatment of all forms of domestic violence.[13] Elder abuse is joining the ranks of the other forms of domestic violence as they slowly make their way out from the veil of secrecy, embarrassment, and shame, which had formerly hidden these maladies from scrutiny.

As a tangible benefit from this political awareness, President Clinton's first legislative signing was the Family Medical Leave Act in 1993. Among other changes, this act provided families with an easier means to care for their elder relatives. The Clinton administration also expanded Medicare benefits for senior citizens and saw the NCEA receive a one million dollar grant to expand its services and further its research. Hopefully, future administrations will be as progressive.

Despite heightened awareness of elder abuse and improvements in elder care, medical providers should anticipate treating more cases of elder abuse, neglect, and mistreatment in the coming years simply because the population is aging. The aged bring a myriad of special challenges to their health care in the emergency department, one of which is elder abuse. Overall advances in medical care are keeping Americans alive for more years than ever before. Many will enter institutions with varying levels of supervision and care before their deaths, which will introduce them to the possibility of an institutional abuser.

The population statistics and projected life expectancies are indeed astounding. The average American child born in 1990 will live to be more than 75 years old. Compare this to the average lifespan of 47 years for a child who had been born in 1900.[14] Reaching the milestone of age 65 in the year 1990 meant to that fortunate senior citizen that he or she could expect to live an additional 17 years, thereby exceeding the average lifespan by over 7 years.[14] The most rapidly growing segment of the elderly population is referred to as the ''old-old,'' that is, age over 75. The Census Bureau has subdivided this group to identify the ''oldest-old'' of age over 85. The number of this group's living members increased by 38% from 1980 to 1990. Additionally, the number of American centenarians doubled in this decade.[7,14] Senior citizens comprise an ever-increasing proportion of all Americans. In 1980, there were over 25 million Americans at

age 65 or older.[14] By the year 2000, this number increased to 35 million. Predictions estimate that by the year 2020, more than 52 million Americans will be 65 or over.[15] The elder boom is not just an American phenomenon. Currently, 20% of the population of the United Kingdom is over age 60, and by the year 2050 this proportion will increase to 40%.[16]

The marked increase in the elderly population will necessarily increase total interactions with the health care system, particularly the emergency department. Studies have shown that elders use emergency departments more frequently than the general population.17-18 These statistics should come as no surprise to practicing emergency physicians, who readily recognize the stressors that this special population

places on ED resources. The elderly are more frequently admitted to the hospital, more likely to require an intensive care unit, and more likely to require a comprehensive level of emergency department service.[17] Therefore, one may conclude that the elderly are more in need of emergency medical resources than younger patients. Indeed, the elderly may access emergency services on a more justified and efficient basis than the young. The emergency medical community must recognize this calling and prepare itself to see and treat elders with all of their medical problems and nonmedical issues. These may increasingly include abuse and neglect

Elder abuse and neglect is the latest discovery in the field of familial violence. Nevertheless, its importance as one of the major sociological issues of the 1990s will become quickly and uniquely apparent, as did the social problems of child abuse and spouse abuse in the preceding two decades. The two major developments that will exacerbate the already complex phenomenon of elder abuse and neglect are firstly the implications of the changing demography and secondly, the policy implications of community care, Caring for People: Community Care in the Next Decade and Beyond. Clearly, the demographic changes from 1991 through 2025 will demand greater resources within the community setting. Office of Population, Censuses, and Surveys projections suggest an increase from 6. 9 million to 8.5 million within the 65-79-year age range and an increase from 2.2 million to 2. 9 million for the over-80-year-old range. It is also important to consider that this population includes increasing numbers of elderly people from differing ethnic backgrounds. Although we do not have any British research to suggest that abuse or neglect is prevalent among differing ethnic

groups it may be important to consider the American findings. The American research suggests that elder abuse and neglect do not respect ethnic origin or socioeconomic class. British research may replicate these findings. These demographic changes combined with the practical implications of community care changes: Community care means providing the services and support that people who are affected by problems of aging, mental definitions and theories of illness, mental handicaps, or physical or sensory disability need to be able to live as independently as possible in their own homes, or homely settings in the community. would suggest that increased levels of elder abuse and neglect may be expected. However, the concept of elder abuse and neglect as a social problem continues to remain elusive despite more than 15 years of anecdotal articles written by various healthcare professionals. Commentators have suggested that the 1960s was the period during which child abuse was discovered and the 1970s spouse abuse (the former by the medical profession and the latter by the feminist movement). The concept of elder abuse and neglect as a separate form of familial mistreatment has not yet gained acceptance as a social problem in Britain. However, it has been claimed in America that the 1980s would be the decade when elder abuse and neglect would be discovered. To a large extent, this has been experienced both in America and Canada though the discovery of elder abuse and neglect in Britain remains in a formative stage. Ironically the first article to be traced in English language literature of recent origin (there are numerous anthropological references to the ill-treatment of elders often to the point of matricide and patricide was British, namely Baker's 1975 article 'Granny battering'. Baker's article, in retrospect, although seen as the formative work on elder abuse and neglect, was a false lead along the path to understanding the phenomenon. The term 'granny' clearly stereotypes elder abuse and neglect as a single-sex problem and the inference is that only 'grannies' are abused and neglected. At this point, the question of abuse and neglect to 'grandad' was not considered an issue. Beyond the gender issue, there is the stereotyping of a 'granny' as an elderly white-haired lady sitting in a rocking chair reading nursery rhymes to her grandchildren. This stereotype had the word 'battering' added to it: To strike with repeated blows to bruise or shatter, to subject to crushing or persistent attack, or to beat out of shape. The word battering was already in common usage within the spouse abuse movement with the term 'wife battering' and Historical

background 3 This may account for its use at that time. This terminology suggesting only severe physical abuse confused rather than clarified what was conceived as elder abuse and neglect. Beyond this retrospective criticism, Baker makes the point that there is evidence of abuse and ill-treatment and more importantly that: While sometimes covert it can also occur in situations where it is motivated by good intentions and with the approval of both the professions and the community at large. This is an issue that has both professional and political repercussions; the elderly are marginalized and facilities for them have been historically under-resourced. These are issues that will be returned to. Following this seminal article some two years later came, 'Do your elderly patients live in fear of being battered'. The thrust of Burston's article suggests that the lack of both medical and nursing specialization in elderly care allied with ageist attitudes toward the elderly is to blame for the phenomenon not being recognized as a social problem. This comment is as true 15 years later as it was in 1977. Burston also had the foresight to suggest that the responsibility for recognizing elder abuse and neglect lies squarely with the primary health care team. Within these two articles, differing terminology continued to emerge in the main text including ill-treatment and rejection, and Burston acknowledges this discrepancy by suggesting: that Granny battering is an emotive phrase, but perhaps it makes people stop and think. From an international perspective, these two articles helped to prompt Americans to consider the issue of elder abuse and neglect. However, it was not only the medical profession that became involved, the academic fraternity started to consider the issue. Within a year the Americans had established a research background to the phenomenon. Within a further year, the topic was on the political agenda with United States Congress House Select Committee hearings. Meanwhile, the second phase of British articles began to emerge, with Edwards claiming that granny battering is a problem that doctors are failing to detect. Traynor and Hasnip, however, in a perceptive article claimed the Development of terminology Granny battering Granny bashing Granny abuse Old age abuse. They also suggest that 'granny battering' is an emotive phrase serving to obscure rather than clarify the reality, and the terms 'old age abuse' or 'elder abuse' are preferable. The first call for a major research initiative into both the prevalence and nature of the phenomenon is also made. This particular article was unique because it did not follow the claims made by other authors that cases of elder

abuse and neglect were increasing. Eastman at last began to examine the conceptual issues surrounding elder abuse and neglect. Social workers were asked about their views of old age abuse and a definitional discussion began to emerge. Table 1.1 lists the development of terminology. The Americans by 1984 had published 27 research papers and elder abuse and neglect was also clearly on the political agenda. In an attempt to establish the same political concern in Britain Andrew F. Bennett MP asked the Secretary of State for Social Services in 1982: Whether he had any plans to institute research into the incidence of non-accidental injury of elderly people by their relatives? ... what information he has as to how many elderly people are at risk of being physically abused by their caregiving relatives? ... what information is available to him as to the causes of the abuse of elderly people by their relatives? A prevalence figure only emerged a decade later in Britain Pn and only the work of Homer and Gilleard has considered Historical background 5 the causation of elder abuse and neglect. The reply from Geoffrey Finsberg claimed: Little information is available at present, but independent studies suggest that there is a correlation between a high level of dependency in the elderly person and abuse by a supporter. This apparent British apathy at a political level explains the immense difference in the development of elder abuse and neglect as a legitimate social problem compared with the trend in America. When the American House Select Committee on Aging inquiry indicated that elder abuse and neglect were occurring nationwide and incidence reports increasing, the impact was public and professional consciousness-raising. Andrew Bennett's attempt to raise the same profile of elder abuse and neglect in Britain as a social problem failed. The momentum after 1984 was slow to build, Eastman's book Old Age Abuse was a noticeable exception but in general anecdotal reports appeared only irregularly in British journals. The Americans were quick to build on the earlier research and enacted 'Mandatory reporting laws' in much the same way that child abuse laws had developed. From 1984 onwards British articles continued to draw attention to the phenomenon although the articles were predominantly aimed at practitioners. The research agenda was non-existent and few agencies were prepared to produce or enact policies and procedures. Within the health care setting the Department of Health produced a performance indicator that asked: What arrangements are obtained when abuse of an elderly patient is identified or suspected? Research suggests that few District Health

Authorities addressed this 'indicator' even though this checklist was designed to evaluate services in conjunction with the numerical performance indicators. This omission would be unthinkable if the performance indicator had been related to child abuse. The momentum appeared to increase when in 1988 the British Geriatrics Society held a major conference aimed at establishing elder abuse and neglect as a social problem. At the conference, it became clear that doctors, nurses, therapists, and social workers were not prepared to see the phenomenon of 6 Historical background: definitions and theories elder abuse and neglect remain in the dark. Advice to prevent elder abuse and neglect carne in a document jointly published in 1990 by a consortium of Age Concern The British Association of Social Workers The British Geriatrics Society The Carers National Association Help the Aged The Police Federation of England and Wales The first research in Britain to assess the prevalence of abuse of elderly people by their carers and also the characteristics of both abused and abuser was completed by Horner in 1990. Horner's research analyzed a population of 71 patient carer pairs and a further 51 carers and 43 of their patients. Interviews were carried out and risk factors were identified in the abused group and compared with a non-abused group. Although definitions were based on Pillemer and Finkelhor's prevalence study limited comparisons can be made as this population was not a random sample. Nevertheless, it is useful to consider any comparable findings. Physical abuse was defined as being pushed, grabbed, slapped, or hit with a weapon. Verbal abuse was defined as chronic verbal aggression, repeated insults, being sworn at, and threats at least 10 times in the preceding year. Neglect constitutes deprivation of some assistance that the elderly person needs for some important activities of daily living such as getting meals and drinks, washing, and going to the toilet. Twenty-three carers (45%) admitted to some form of abuse: 14 (27%) admitted to one type, seven (14%) to two types, and two (3%) to all three types of abuse. Homer's conclusion questions the stereotyped picture of the typically abused as a frail white-haired woman over 75 years of age being abused by a well-meaning daughter driven to breakdown by stress. Different types of abuse seem to arise for different reasons. The characteristics of the abuser in physical abuse situations seemed more important than those of the abused, with alcohol consumption being greater in abusive carers. Verbal abuse Historical background 7 seemed to have been a long-standing problem before disability. The important considerations made by

Homer include: • It is difficult to correlate abuse with physical signs (bruising). • Social isolation and lack of services did not appear to be a risk factor. • There is no correlation between abuse and dementia or mental impairment. • The presence or absence of disruptive behaviors seems a potential risk factor. • Past abusive relationships may be a risk factor. The findings from Homer's research are most important because this is the first British study that considers causation. There is an urgency to replicate the research with a random stratified sample to compare the risk factors in Britain with the risk factors found by Pillemer. In May 1991 the Department of Health commissioned a report on the current state of knowledge on elder abuse and neglect from the Age Concern Institute of Gerontology This report supplies an up-to-date picture of developments so far in Britain, with an analysis of American and Canadian research. McCreadie's conclusion suggests that there is a noticeable absence of British research, definitions remain unresolved, and we do not have a prevalence figure in Britain. To consider the developments in the elder abuse/neglect debate thus far in Britain it is useful to use Blumer's model of social problem construction. The American Context Emergence The emergence of the problem evolved through the research findings in 1979. This was agreed after the United States House Select Committee on Aging published the report, Elder Abuse: The Hidden Problem This legitimation was reinforced by the media, with a Harris poll of November 1981 finding 79% of the public believed elder abuse and neglect to be a serious problem, and 72% who believed it to be a major responsibility assumed by government Mobilization of action This emerged with continued research into elder abuse and neglect, considering both the quantitative dimensions (how big is the problem) and the qualitative dimensions (what causes elder abuse and neglect and how do service practitioners intervene). The Adult Protective Services and Aging Agencies also began to involve themselves in the debate. Formulation of an official plan This arrived with changes in the law and continued research into the social problem of elder abuse and neglect Implementation of the plan As of 1988 all fifty states have legislation addressing elder abuse and neglect. Forty-three states were operating mandatory statewide reporting systems, while the remaining states administered reporting systems which are not mandatory or statewide in scope The British context Emergence Although the first reports came from Britain research evidence is sparse; as of 1992 only Homer and Gilleard's research and the

prevalence study of Ogg and Bennett exist. All the other work is anecdotal, clearly important, but difficult to use to legitimate the problem. Legitimation Numerous attempts have been made to legitimate the phenomenon, including the British Geriatrics Society Conference and limited media coverage. Mobilization of action Action on a macro scale, including interventions of a political and policy nature, remains elusive. However, the Department of Health did commission the 1991 exploratory study, but no policy changes have occurred since its publication. At a micro level, many agencies have published guidelines for practitioners to follow but central coordination is absent In early 1991 a group of interested practitioners began to meet informally to frame a response to elder abuse and neglect. This organization is called 'Action on Elder Abuse' and is supported by Age Concern England. Formulation of an official plan No official plan exists; health and social service officials continue to develop policies on an ad hoc basis. At this point, there is no evaluation of the efficacy of the policies in existence. Implementation of the plan Outcome is awaited on this. This state of affairs is summed up by Blumer: Social problems are not the result of an intrinsic malfunctioning of society but are the result of a process of definition in which a given condition is picked out and defined as a social problem. A social problem does not exist for a society unless it is recognized by that society to exist. The task of this and subsequent texts is to legitimate the social problem of elder abuse and neglect. The main controversy which has caused research and conceptual difficulties remains the definition of elder abuse and neglect. The definition of elder abuse and neglect has probably caused more contention than any other area of concern, and the debate continues. Terminology remains in a state of flux with the latest contribution by Fulmer and O'Malley [31] arguing that 'Inadequate Care' is the term that encompasses the problem holistically. This latest contribution has developed from numerous previous definitions starting in 1979 Abuse: the wilful infliction of physical pain, injury, or debilitating mental anguish; unreasonable confinement; or deprivation by a caretaker of services which are necessary to maintain mental and physical health. This definition, as with nearly all the definitions, is flawed with inconsistencies. What of the carer who inflicts pain, but not with any wilful intention (perhaps because of a lack of caring skills)? What behaviors constitute debilitating mental anguish, and more to the point from whose viewpoint, that of the abused abuser, or service practitioner? Does unreasonable confinement suggest there is such

a thing as reasonable confinement? Finally, who decides what services are necessary to maintain mental and physical health? This type of criticism, although used constructively, can be used to dismantle most definitions to date. Table 1.3 lists some early definitions. This lack of definitional uniformity has meant that researchers have been unable to compare and contrast results. Practitioners are also unsure how to intervene and what therapeutic Definitions of elder abuse and neglect Early definitions of elder abuse and neglect Block and Sinnott Physical abuse: malnutrition, injuries, e.g. bruises, sprains, dislocations, abrasions or lacerations. Psychological abuse: verbal assault, threat fear, isolation. Material abuse: theft, misuse of money or property. Medical abuse: withholding medication or aids required. Lau and Kosberg Physical abuse: direct beatings, withholding personal care, food, medical care, lack of supervision. Psychological abuse: verbal assaults, threats, provoking fear, isolation. Material abuse: monetary or material theft or misuse. Violation of rights: being forced out of one's dwelling or forced into another setting. Eastman The abuse either physical, emotional, or psychological of the elderly by a caregiving relative on whom that elderly person is dependent. outcomes are required and necessary. Finally, any changes in the law that may be required are not possible because of the lack of consistent data. The development of more precise definitions would be a major step forward in the debate to produce a solid analytical knowledge base. However, it will serve no useful purpose to become entangled in the difficulties that have plagued the American experience. De finitions are necessary and it may be that some useful mileage can be gained from the work of Aber and Zigler in the child abuse arena. Aber and Zigler suggest that at least three differing sets of definitions are necessary to pursue three differing aims. These are set out in Table 1.4. Case-management definitions are considered within this chapter (see Chapter 5 for legal definitions and Chapter 9 for research definitions). The major criticism of the early definitions relates to their specific design for research and legal purposes; Valentine and Cash make the point when they suggest that by recognizing the necessity of different sets of definitions to pursue different goals, the debate between the legal and social work orientations begins to be resolved .... legal definitions are essential for the protection of the individual Legal, case management, and research definitions (Aber and Zigler Legal definitions: to guide decision making that would specify what acts or conditions justify initial state intervention into private

family life. Case-management definitions: to guide clinical decision-making that would specify eligibility for services and establish a baseline against which services are evaluated and clinical decisions about families are made. to guide scientific research that would provide the basis for studying lawful causal relationships. social work definitions ... for the identification and intervention... by service practitioners. The latest definitions considered useful to frame the identification and intervention for practitioners are: the concept of elder mistreatment, Johnson and the concept of inadequate care, and Fulmer and O'Malley's Elder mistreatment Johnson's definition of elder mistreatment falls into four sequential stages. Stage 1: Intrinsic definition A state of self- or other-inflicted suffering unnecessary to the maintenance of the quality of life of the older person. Johnson argues that at this level the definition needs to be rather abstract and there are distinct advantages in using such a wide overall intrinsic definition. It is so wide that any form or degree of mistreatment may fall within the parameters. Other advantages are the ability to differentiate mistreatment from behaviors that 'may' be considered culturally acceptable. This is important and research may find that different cultures may wish to have different views on what is or is not considered mistreatment. Any form of abuse may fall within this wide definition including neglect, self-neglect, and institutional abuse. If definitions are too restrictive then certain Definitions of elder abuse and neglect 13 forms of abuse may be excluded as not falling within the parameters of the definition. This is an important point to consider in the formative stage of the development of elder abuse both as a concept and a social problem. Stage 2: Extrinsic definition Identified as one or more behavioral manifestations, categorized as physical, psychological, sociological, or legal circumstances. This extrinsic definition names the categories of abuse; this helps to identify the behavioral manifestations that may be under scrutiny. This is important from the case manager's perspective because it may suggest which service professional is best suited as a primary interventionist, for example, medical, psychiatric, legal, social, or other. Stage 3: Extrinsic definition Measured by determining the intensity and density of the behavioral manifestations. This definition has the potential to consider the mistreatment from the perspective of the abused person as well as the interventionist. If this is the case behaviors Four domains of increasing potential danger DENSITY Number of different forms of abuse Singular Medium-danger domain INTENSITY Frequency and severity Low-danger domain High

~----------r----------~Low High-danger domain Medium-danger domain Multiple 14 Historical background: definitions and theories degree. For example, the mistreatment may be low density (only one form of abuse) but of high intensity (frequently happens and is severe in form). One can imagine a schema of mistreatment intensity/density. This type of schema suggests four domains of increasing potential danger. This type of schema can predict the potential degree of danger that an individual may be facing. Practitioners may then be in a position to decide the urgency or otherwise of intervention strategies. Stage 4: Causal definition The causal definition considers whether the abuse/neglect is active or passive. There are four domains: Active abuse Active neglect Passive abuse Passive neglect. The causality will strongly influence the therapeutic intervention and interfaces with the continuum from Aggressive Passive interventions +----------~interventions This model shadows the competing philosophies model examined. This model also considers the degree of danger the elderly find themselves facing and the speed at which the interventionist wishes to act. The rationale put forward by Johnson for this particular approach is to move away from the 'tautological trap of using the word abuse to define abuse'. Johnson further claims that suffering is a matter of 'degree' rather than 'kind' and that to move forward in any attempt to reach definitional 'common ground' we must: ... look at degree rather than kind and the problem rather than the parties. Inadequate care Fulmer and O'Malley's definition of inadequate care derives from their argument that: Definitions of elder abuse and neglect 15 Neglect Abuse Inadequate care Used by kind permission of Fulmer, T.T. and O'Malley, T.A. Inadequate Care of the Elderly: A Health Care Perspective on Abuse and Neglect. Springer Publishing Company Inc., New York 10012 (1987) it is easier to reach a consensus on what constitutes adequate and inadequate care than it is to agree upon what is acceptable and unacceptable behavior within families or among professionals. The other dimension relates to the labeling of abuse; it is easier to define a case as inadequate than to label a case as elder abuse/neglect. Fulmer and O'Malley also claim that most definitions are too restrictive (as did Johnson previously) and have evolved from a research perspective rather than a patient care perspective. By opening out the definition, all cases of abuse and neglect can be considered to fall under the global definition of inadequate care with abuse being sub-defined as: ... actions of a caretaker that create unmet needs for the elderly

person. and neglect is defined as: ... the failure of an individual responsible for care-taking to respond adequately to established needs for care. Within both definitions 'needs' may consist of food, shelter, clothing, supportive relationships, freedom from harassment or threats of violence, and the requirements of activities of daily, the qualitative dimension of unmet need can be considered alongside the quantity of need. Both Johnson's and Fulmer's and O'Malley's definitions see the perception of the abused person as crucial: ... although society can develop general descriptions of the behaviors it considers unacceptable, only the elderly person can decide if those definitions apply in his or her case. In a sense, the elderly person can render a definition of abuse or neglect meaningless. The early British reports on elder abuse and neglect conceptualized the phenomenon as the result of the stressed-carer hypothesis. Carers, predominantly female, who had agreed (sometimes reluctantly) to care for an elderly person had been driven to abuse because of the continued pressure and stress of caring. This picture was reinforced by Eastman's study of social service staff attitudes to elder abuse and neglect. The actual cause of abuse was considered mainly to be stress-related, with 80% considering stress to be the overriding factor. The scenario of the stressed carer was difficult to dispute because the research was not available to offer any other conceptual frameworks. However, it quickly became apparent that not all carers abused or neglected the elderly they cared for, although many of these carers would admit to varying degrees of stress. One survey of 3000 carers [38] found 88% of women carers said that: they suffered from stress through being a carer Table 1.6 Causation of elder abuse/neglect. Factors in order of importance. From Eastman 1. Stress 2. Psychological problems 3. Lack of community resources (Refusal to accept) 4. Alcohol problems 5. Lack of community resources (Inadequate resources) Revenge 6. Theories of elder abuse and neglect 17 Risk factors for elder abuse/neglect Intraindividual dynamic (Psychopathology of the abuser). Intergenerational transmission of violence (Cycle of violence theory). Dependency and exchange relationships between abuser and abused. External stress. Social isolation. as well as working, while 44% of men said that they suffered stress for the same reason. When Pillemer and Finkelhor's prevalence figure suggested that 3.2 cases in 100 suffered abuse the pertinent question to ask was: What is unique about this particular 3.2% both from the perspective of abused and abuser? The answer came

from American research, albeit substan tiated in the work of Homer in Britain. A theoretical review of the literature on elder abuse and neglect suggests five areas that consistently emerge as risk factors To test whether these hypothetical risk factors hold a study of physically abused elders was conducted as part of the Three-Models Project The research compared 42 abused elders with a matched non-abused group of 42 elders. Intraindividual dynamics The first risk factor tested was the hypothesis that abusive behavior is linked to some form of pathology on the part of the abuser. Two questions were asked relating to mental or emotional problems on the part of their carer. The abused elderly reported substantially higher levels of pathology on the part of the carer: 79% compared with only 24% in the non-abused group. Questions about psychiatric hospitalization were also asked; again the relatives of the abused elderly had reported levels of 35.7% compared to 7.1% in the non-abused group. Alcohol abuse was also considered, with the caseworkers of both the abused and non-abused being asked: To the best of your knowledge is (relative) an alcoholic? 18 Historical background: definitions and theories The abusers were again substantially more likely to be alcohol dependent (45.2% compared to 7.1 %). These findings suggest that mental status (illness past or present) and alcohol abuse need to be considered as high-risk factors for elder abuse and neglect. Similar findings by Homer and Gilleard would substantiate these findings. intergenerational transmission of violence The concept of intergenerational transmission of violence was considered by asking the respondents: How did you usually tend to punish (child) when he or she was a child/teenager? Two codes were used for replies, either: • physical punishment mentioned, or • physical punishment not mentioned. Only one respondent mentioned using physical punishment. This question was followed by: How frequently have you used physical punishment in the year you used it most, ranging from never to 20 times? No significant differences were found in this variable between the abused and non-abused groups. Pillemer suggests that this data is limited and does not support the hypothesis that abusers were victims of abuse by their parents. Pillemer further suggests that methodologically the survey format may not be the ideal way to gain information on punishment and abuse of children. The traditional rhyme, although anonymous, in the introduction of Schlesinger and Schlesinger's text needs more research to justify its inclusion in many elder abuse texts: When I was a lady, I lived

with my granny, and many a hiding me granny guide me. Now I am a man, and I live with my granny, and I do to my granny what she did to me. Dependency has traditionally been seen as a potentate of stress, with the view that: Theories of elder abuse and neglect 19 Increased dependency = Stress = Abuse/neglect However, the alternative hypothesis suggesting that abuse and neglect may be caused by an imbalance in the power relationship with the abuser dependent on the abused is gaining ground Elders that were abused were not considered more functionally disabled and ill than the control group, and surprisingly in certain areas were less impaired. The abused group was not more dependent on their care than the non-abused group in activities of daily living (ADL). In support of the imbalance of power relationship theory, the abusers were more likely to be dependent on their victims than the non-abused. Stress External stress did not seem to be a significant risk factor, other than to say that three particular stressors emerged in the abused group: someone moving in with the abuser someone leaving the household someone getting arrested. However, the abuser was responsible for the event because the shared living became unbearable. Therefore if these three questions are not considered, stress items between groups would not differ. Social isolation With the final risk factor of social isolation the abused group scored fewer contacts (family members and friends) than the non-abused group (36% and 17% respectively). The abused group considered their relationships to be less satisfactory (39% and 20% respectively). These results do not suggest that isolation causes elder abuse and neglect and Pillemer claims that abusers may break down social support structures because of their behavior towards visitors. In essence, this particular piece of research suggests that the concept of elder abuse as 'Caregiver Abuse' may need to be substituted for the concept of elder abuse and neglect as another facet of 'Domestic Abuse'. A move away from the 20 Historical background: definitions and theories characteristics of the abused towards the characteristics of the abuser may also be necessary to begin to conceptualize the nature of elder abuse as a social problem.

TERMS, DEFINITIONS, AND TYPES OF ABUSE

There exists considerable variability among authors about what constitutes elder abuse. Different disciplines, representing the medical, legal, and social work arenas all seem to place their particular perspectives on terminology.

Even providers within each arm cannot agree. No generally accepted meanings for the terms abuse, mistreatment, or maltreatment exist.[18] Some authorities include neglect in these terms while others do not. [19-20] The somewhat gentler expression ‘‘inadequate care’’ has been used as an umbrella phrase by some authors.[21] Although there exist many variations among individual authors, it is worthwhile to review the published definitions by three key groups in the past 20 years likely to have the greatest impact. In 1985, the US Congress passed the Elder Abuse Prevention, Identification, and Treatment Act, which clarified terminology.[22] Another reasonable collection of terms was defined in 1992 by the American Medical Association in this organization’s guidelines.[23] These sets were seemingly used by a later project, the National Elder Abuse Incidence Study (NEAIS) to produce an update.[24] The NEAIS was sanctioned by the NCEA in 1996 to study the problem of domestic elder abuse. The US
Department of Health and Human Services Administration on Aging authorized a group of national experts to research and conduct surveys on potential definitions to use before creating and selecting their final terms for publication. This should become the standard to which all those who provide care to the elderly should be held.

The term neglect can be even more confusing than abuse. Some panelists regard neglect as a lesser form of elder maltreatment and suggest that neglect should comprise those situations whereby intent to cause harm is absent.[25] However, an act of neglect may be just as willful and just as harmful as a more overt act of abuse. Indeed, such an action, or inaction, may be even more sinister and disturbing, because cases of neglect necessarily involve a person with whom the victim has an established relationship, either personal or professional. Many authorities do not even mention or describe self-neglect in their works. Self-neglect is perhaps the most deeply psychologically challenging concept of all and calls significant ethical considerations into question.

All this lingo can cause bewilderment in the medical community. Emergency providers should familiarize themselves with these terms so that they can recognize cases of elder maltreatment and alert the necessary law enforcement or government agencies. This is the ultimate benefit that can be conferred to the elder that has been victimized by abusive or neglectful circumstances.

The most easily recognizable form is physical abuse. This involves the deliberate infliction of force upon a victim with resulting pain, injury, suffering, or impairment. Examples include slapping, pinching, striking with objects, kicking, biting, shaking, shoving, burning, rough handling, and force-feeding.[26-27] The abuser's hand is the most common instrument of damage used to cause harm. Other more subtle behaviors that would constitute physical abuse include unindicated or inappropriate use

of physical or chemical restraints or the administration of or overmedication with a drug such as a sedative or a tranquilizer. Sexual abuse is sometimes included as a form of physical abuse. Obvious examples include rape, fondling, or unwanted touching. Other less direct violations may be just as unbecoming: coerced nudity, indecent exposure, and lewd talk. Although the subject of the sexual assault of an elderly person is loathsome, emergency physicians must not dismiss this as a possibility. There is not much data on the topic, but one study reported that only 1% of elder abuse victims suffered a sexual assault.[28] Most of these victims sustained the mistreatment while living in an institutional setting, not at home. Furthermore, prohibiting or restricting consensual sexual activity involving a competent elder may be considered abusive. Senior citizens have as much right to continue to explore human sexuality as any other adults do, as long as they can make such decisions.

Physical neglect in general involves bodily harm brought about by the failure of a provider to supply the means for an elder's well-being. Examples include inadequate hydration, nourishment, physical activity, or therapy.

Failing to provide or maintain in working order basic appliances that assist daily living like glasses, hearing aids, dentures, and canes or walkers constitute neglectful conduct. Inadequate home safety measures to prevent injury such as handrails or side rails also qualify. Neglect may be active or passive, depending upon the presence or absence of intent.[29] From a legal perspective, intent is often difficult to prove. From a purely medical perspective, the intent is probably immaterial to the medical evaluation and decision-making.

The practicing clinician in the emergency department should not attempt to evaluate this issue too deeply, if at all. He or she must identify and treat any injury discovered and consider the possibility of abuse or neglect. The next step should be to ensure the safe
disposition of the patient. Regardless of whether or not a significantly adverse occurrence to an elder was the result of an intentional act of omission or commission, that it occurred at all should heighten the suspicion of the clinician that the elder should not return immediately to the environment from which he or she came unless additional help or supervision can be arranged.

The matter of self-neglect may present a particular quandary in the emergency department. This situation involves value judgments on the part of the physician and provokes ethical dilemmas. For example, a patient may present to the emergency department with foot ulcers skin lesions, or dental infections resulting from poor hygiene and inadequate basic care but may choose to shun the level of personal care that most other people would choose for themselves. As long as patients have decisional capacity, they cannot be forced into another social situation against their will. The clinician should naturally educate these patients as to the importance of such basic care with regard to its therapeutic and preventative benefits, but should recognize that it is outside the scope of medical practice to impose his or her personal values upon the patient. If, however, such a patient demonstrates signs of reduced decisional capacity, it may be justified and ethical and obligatory for an emergency physician to ensure that the patient is indeed removed from the living situation contributing to the problem, perhaps against the patient's will. Signs of concern would include hypoxia, perhaps a high fever, disorientation, active psychosis, and other significant abnormal findings on a mental status examination.

Psychologic or emotional abuse wreaks mental anguish using threat, humiliation, fear, or other cruel conduct. It may be inflicted via verbal or nonverbal communication cues. Examples include harassment, scolding, and stalking. Threatening an elderly person with physical punishment or deprivation of basic needs is a particularly heinous
form of this type of abuse. Psychologic neglect deprives an elder of healthy mental well-being.

Examples include prolonged periods of solitude and failure to provide adequate companionship. A caregiver might be providing an elder with adequate essential needs such as food, water, and shelter, but neglect to provide this person with adequate social stimulation. This can lead to feelings of isolation and low self-esteem. Many of the elderly suffer from clinical depression already;[30] psychologic abuse and neglect can advance such mental health problems.

The financial exploitation of an elder includes direct criminal behaviors such as theft of money or property and coercion to sign any unwanted agreement. Many professional scam artists target the elderly as a particularly vulnerable segment of the population upon whom to prey. More commonly, however, an elder who falls victim to material abuse is exploited by a family member or caregiver. These victims may possess considerable assets, or may live on the fixed income of a government subsidy. Even small monthly sums can entice an exploiter to take advantage of an elderly person.[31]

Elder abuse may also be classified by its setting. Domestic abuse or maltreatment occurs in the home of the victim.[24] The abuser has an established personal relationship with the elder, such as a spouse, child, relative, friend, or in-home caregiver. Conversely, institutional mistreatment transpires outside a private residence, such as in a nursing home, hospital, assisted living center, or group home. The perpetrators have a professional or contractual duty to provide care and can be nurses, aides, or techs. Additionally, a complex form of institutional financial abuse occurs when executives and administrators of such facilities take advantage of elderly patients' monetary resources or file false claims with an insurance company or Medicare. These white-collar criminals defraud companies out of thousands of dollars and deprive elderly victims of needed services.

Types of Elder Abuse

Elder abuse can be categorized into several types, each with its characteristics and implications. Understanding these types is crucial for recognizing abuse and providing appropriate support and intervention.

1. Physical Abuse: Physical abuse involves the deliberate infliction of force on an elderly person, resulting in pain, injury, suffering, or impairment. Examples of physical abuse include:

- Slapping or pinching

- Striking with objects
- Kicking or biting
- Shaking or shoving
- Burning or rough handling
- Force-feeding

Physical abuse can also include the inappropriate use of physical or chemical restraints. For instance, the use of sedatives or tranquilizers without medical justification can be considered a form of physical abuse. These actions not only cause harm but can also undermine the dignity and autonomy of the elderly person.

2. Sexual Abuse: Sexual abuse involves any non-consensual sexual activity. This can include:

- Rape or sexual assault
- Fondling or unwanted touching
- Coerced nudity or indecent exposure
- Lewd talk or behavior

While sexual abuse is a serious and often underreported issue, healthcare providers need to consider it as a potential factor, especially in institutional settings. Studies indicate that sexual abuse among the elderly is less common but still a significant concern.

3. Neglect: Neglect is a form of abuse characterized by the failure to provide adequate care or meet the basic needs of an elderly person. It can be classified into:

- **Physical Neglect:** Involves failure to provide necessary hydration, nourishment, physical activity, or medical care. This can also include neglecting to maintain essential appliances such as glasses, hearing aids, or mobility aids.
- **Active vs. Passive Neglect:** Active neglect involves a deliberate choice to withhold care, while passive neglect may result from a lack of awareness or understanding of the needs.

Neglect can be more challenging to identify than other forms of abuse, as it may not always involve overt actions. It often requires careful assessment to determine whether it results from intentional neglect or a lack of resources or knowledge.

4. Self-neglect: Self-neglect involves an elderly person failing to meet their own basic needs, leading to harm. This form of neglect raises complex ethical issues and involves:

- Poor hygiene and grooming
- Unattended medical conditions
- Unsafe living conditions

Self-neglect is particularly challenging because it involves value judgments about personal care and autonomy. Healthcare providers must navigate these situations with sensitivity and respect for the individual's autonomy, while also ensuring that any immediate health and safety needs are addressed.

5. Psychological or Emotional Abuse: Psychological abuse involves inflicting mental anguish through threats, humiliation, or other forms of cruel conduct. Examples include:

- Verbal harassment or scolding
- Emotional manipulation or threats
- Isolation or failure to provide companionship

This form of abuse can severely impact an elderly person's mental health, leading to conditions such as depression or anxiety. Psychological abuse is often intertwined with other forms of abuse and can exacerbate the overall impact on the individual's well-being.

6. Financial Exploitation: Financial exploitation involves the misuse or theft of an elderly person's financial resources. This can include:

- Theft of money or property
- Coercion to sign unwanted agreements
- Mismanagement of financial resources by caregivers or family members

Elderly individuals are often targeted by scammers or unscrupulous individuals seeking to exploit their assets. Financial exploitation can have long-term consequences for the victim's financial security and overall quality of life.

Settings of Elder Abuse

Elder abuse can occur in various settings, each with its dynamics and implications.

1. Domestic Abuse: Domestic abuse occurs within the victim's home, where the abuser has a personal relationship with the elderly person. This relationship might include:

- Spouse or partner
- Adult children
- Other relatives or friends
- In-home caregivers

In domestic abuse situations, the abuser often has established access to the victim and may exploit this relationship to perpetrate abuse. Addressing domestic elder abuse requires careful consideration of the family dynamics and the potential for ongoing risk.

2. Institutional Abuse: Institutional abuse takes place in settings such as:

- Nursing homes
- Assisted living facilities
- Hospitals
- Group homes

In institutional settings, the abuser is typically a professional caregiver, such as a nurse, aide, or facility staff member. Institutional abuse can also include complex forms of financial exploitation by facility administrators or executives.

3. Financial Exploitation in Institutions: In institutional settings, financial exploitation may involve:

- Misuse of patient funds
- False claims for reimbursement from insurance or Medicare
- Fraudulent financial practices

Such exploitation can deprive elderly residents of necessary services and contribute to the overall decline in their quality of care.

Legal and Ethical Considerations

1. Legal Framework: Legal responses to elder abuse vary by jurisdiction but generally include:

- Criminal statutes addressing physical, sexual, and financial abuse
- Civil laws protecting elderly individuals from exploitation and neglect
- Reporting requirements for suspected abuse

Legal frameworks aim to protect victims, hold perpetrators accountable, and provide mechanisms for intervention and support.

2. Ethical Challenges: Ethical considerations in addressing elder abuse involve:

- Balancing the need for intervention with respect for the elderly person's autonomy
- Navigating complex family dynamics and caregiver relationships
- Ensuring that interventions do not inadvertently cause additional harm or distress

Healthcare providers and social workers must carefully navigate these ethical challenges while prioritizing the safety and well-being of the elderly individual.

Role of Healthcare Providers

1. Recognition and Reporting: Healthcare providers play a critical role in identifying and reporting elder abuse. They should:

- Be familiar with the signs and symptoms of various forms of abuse
- Report suspected abuse to appropriate authorities or agencies
- Provide support and resources to victims

2. Assessment and Intervention: Healthcare providers must assess the physical and psychological impact of abuse and provide appropriate interventions. This includes:

- Immediate medical care for injuries or health issues
- Referrals to social services, legal aid, or counseling
- Coordination with law enforcement and protective services

3. Ethical Decision-Making: Providers must balance the need for intervention with respect for the individual's autonomy. This may involve:

- Engaging in discussions with the elderly person about their care and safety
- Ensuring that any decisions made prioritize the individual's well-being
- Navigating situations involving self-neglect or reduced decisional capacity with sensitivity and respect

Elder abuse is a complex and pervasive issue that affects individuals across various settings and circumstances. Understanding the different types of abuse, the variability in definitions, and the legal and ethical considerations is crucial for effectively addressing and preventing elder abuse. Healthcare providers, legal professionals, and social workers must work together to recognize, report, and intervene in cases of abuse, ensuring that elderly individuals receive the protection and support they need.

Ongoing research, collaboration, and education are essential to improving our understanding of elder abuse and developing more effective strategies for intervention

and prevention. By continuing to refine definitions, enhance professional training, and advocate for policy changes, we can work toward a future where elder abuse is significantly reduced, and all elderly individuals can live with dignity and respect.

EPIDEMIOLOGY:

Yongjie Yon, in a 2018[32] study, reveals that fourteen academic databases and other online platforms were systematically searched for studies on elder abuse. This thorough review process involved not just automated searches but also the consultation of 26 experts in the field, aiming to identify further studies that might have been overlooked by the databases. These experts provided valuable insights, ensuring a comprehensive collection of relevant research. After gathering these studies, each was meticulously screened for inclusion criteria by two independent reviewers. This process was crucial in maintaining objectivity and ensuring that the studies selected for the meta-analysis were of high quality and relevance.

The data extracted from these studies were subjected to rigorous meta-analysis, a statistical technique that combines results from multiple studies to identify patterns and derive overall conclusions. The researchers made a deliberate choice to separate self-reported data from older residents and staff reports, recognizing the potential biases and different perspectives that could influence the findings. This approach allowed for a more nuanced understanding of elder abuse within institutional settings.

The review revealed that from an initial pool of 55 studies identified for potential inclusion, only nine met the strict criteria set by the reviewers. This significant reduction highlights the challenges in finding high-quality, reliable studies on elder abuse, a topic that is often underreported and understudied. Despite this, the findings from the staff reports were alarming: 64.2% of staff admitted to engaging in some form of elder abuse within the past year. This statistic alone underscores the gravity of the problem and the urgent need for interventions.

However, the review also pointed out a significant gap in the research: there were insufficient studies to calculate an overall prevalence estimate based on self-reported data from older residents. This lack of data from the victims themselves is concerning, as it suggests that the true extent of elder abuse may be underrepresented in the literature. Among the different types of abuse reported by older residents, psychological

abuse was the most prevalent, with 33.4% reporting experiences of such mistreatment. Physical abuse followed at 14.1%, financial abuse at 13.8%, neglect at 11.6%, and sexual abuse, though less common, was reported by 1.9% of the respondents.[32]

Due to the inconsistencies in the working definitions of elder abuse, differences in sampling and survey methods, and underreporting of cases, obtaining accurate information on the incidence of elder abuse and neglect is difficult. Although it is difficult to estimate the incidence of elder abuse and neglect, a 2010 US study found an incidence of 7.6-10% among study participants.[33] Elder abuse occurs among members of all racial, socioeconomic, and religious backgrounds. The NCEA found the following racial and ethnic distribution among older persons who had been abused:[34]

- White, non-Hispanic – 66.4%
- Black – 18.7%
- Hispanic – 10%
- Other – 4.9%

Women are believed to be the most common victims of abuse, perhaps because they report abuse at higher rates or because the severity of injury in women typically is greater than in men. Numerous studies, however, have found no differences based on sex. Other studies suggest that 3-10% of elders are abused or neglected. Elder abuse is a complex and multifaceted issue that encompasses various forms of harm directed at older adults. The World Health Organization (WHO) 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." This broad definition includes several types of abuse, each with its unique characteristics and impacts.

Certain characteristics of the elderly person, such as age, gender, health status, and cognitive functioning, can increase the risk of abuse. For instance, older adults who suffer from dementia or other cognitive impairments are more vulnerable to abuse due to their diminished ability to recognize and report mistreatment. Physical frailty and dependence on others for daily care also make elderly individuals more susceptible to abuse.

The nature of the relationship between the elderly and their caregiver is a significant determinant of abuse. Caregivers who experience high levels of stress, substance

abuse, or have a history of violence are more likely to abuse those in their care. Dependency can be mutual; an elder may depend on the caregiver for physical needs, while the caregiver may rely on the elder for financial support or housing, creating a situation ripe for exploitation or mistreatment.

Social isolation is a critical risk factor for elder abuse. Older adults who are isolated from family, friends, or community services are less likely to have their needs met and more likely to suffer abuse undetected. Communities that lack support systems for the elderly and their caregivers may contribute to situations where abuse occurs due to the stress and demands of caregiving without adequate respite or assistance.

Societal Factors: Broader societal attitudes toward aging and older adults can also influence the prevalence of elder abuse. Societies that devalue older adults or view them as burdens are more likely to tolerate or ignore abuse. Additionally, inadequate legal frameworks, insufficient funding for elder care services, and lack of public awareness campaigns contribute to the perpetuation of elder abuse.

Elder abuse is a global issue that affects millions of older adults worldwide, transcending cultural, socioeconomic, and geographical boundaries. The prevalence of elder abuse varies significantly across regions, influenced by cultural norms, economic conditions, and the effectiveness of legal and social support systems.

In many developing countries, the problem of elder abuse is exacerbated by poverty, lack of resources, and inadequate healthcare systems. Traditional family structures, which once provided care for older adults, are breaking down due to urbanization, migration, and economic pressures. As a result, many older adults are left vulnerable to neglect and exploitation, with little recourse to justice or support.

In contrast, in developed countries, while there may be more robust legal and social services to protect older adults, elder abuse persists, often hidden within institutional settings or behind closed doors in private homes. The aging population in these countries poses additional challenges, with increasing numbers of older adults requiring care and a corresponding rise in the demand for caregiving services. This has led to concerns about the quality of care and the potential for abuse in understaffed and underfunded facilities.

International organizations like the WHO and the United Nations have recognized the need for a coordinated global response to elder abuse. They advocate for increased

research, improved data collection, and the development of policies and programs that address the root causes of elder abuse. This includes promoting public awareness, strengthening legal frameworks, and ensuring that older adults have access to the resources and support they need to live safely and with dignity.

The impact of elder abuse extends far beyond the immediate harm inflicted on the victim. The consequences can be devastating, affecting the physical, emotional, and social well-being of the elderly individual, as well as having broader implications for families, communities, and society as a whole.

The physical effects of abuse can range from minor injuries, such as cuts and bruises, to more severe conditions, including fractures, internal injuries, and even death. Elderly individuals who experience physical abuse are also at a higher risk of developing chronic health conditions, as the trauma can exacerbate existing medical issues or lead to new health problems. Additionally, neglect can result in malnutrition, dehydration, and untreated medical conditions, further compromising the health of the elderly.

The emotional and psychological toll of elder abuse can be profound. Victims may experience depression, anxiety, post-traumatic stress disorder (PTSD), and feelings of hopelessness. The loss of trust in caregivers and others can lead to social withdrawal and isolation, exacerbating the sense of loneliness and abandonment. In severe cases, the psychological impact of abuse can lead to suicidal thoughts or behaviors.

Elder abuse can strain relationships within families and communities. Family members may feel guilt, shame, or anger upon discovering that a loved one has been abused. This can lead to conflicts and divisions within families, particularly if the abuser is a family member. Communities may also suffer as elder abuse undermines social cohesion and trust. The knowledge that abuse is occurring within a community can create an environment of fear and mistrust, further isolating victims and preventing others from coming forward.

The financial impact of elder abuse is significant, both for the individual and society. Victims of financial abuse may lose substantial amounts of money, property, or assets, leaving them unable to afford basic needs such as housing, healthcare, or food. This can lead to increased reliance on social services and public assistance programs, placing a financial burden on society. Additionally, the costs associated with

investigating, prosecuting, and addressing the consequences of elder abuse add to the economic toll.

Raising awareness about elder abuse is a crucial first step in prevention. Public education campaigns can help to change societal attitudes toward aging and older adults, promote respect and dignity for elders, and encourage reporting of suspected abuse. These campaigns should target not only the general public but also specific groups such as healthcare providers, law enforcement, and social service professionals who are in a position to identify and respond to abuse.

Caregiving can be a demanding and stressful role, especially for those who are untrained or unsupported. Providing caregivers with the resources, training, and respite they need can help to reduce the risk of abuse. Support programs might include access to respite care, counseling services, and support groups where caregivers can share experiences and receive advice. Additionally, educating caregivers about the signs of stress and burnout, and how to manage these effectively, is vital for preventing situations where abuse might occur.

Legal frameworks that protect older adults from abuse must be robust and enforced consistently. This includes laws that mandate the reporting of suspected abuse, provide protection orders for victims, and prosecute offenders. Governments should also ensure that older adults have access to legal assistance and are aware of their rights. In cases where elder abuse is suspected, authorities must act swiftly to investigate and intervene, providing protection for the victim and holding the perpetrator accountable.

Given the high prevalence of elder abuse in institutional settings, improving the quality of care in these environments is critical. This includes ensuring that care facilities are adequately staffed, that staff are properly trained, and that there is regular oversight and monitoring to detect and prevent abuse. Facilities should also have clear policies and procedures for reporting and responding to abuse, and these should be communicated to both staff and residents.

Community-based programs can play a vital role in preventing elder abuse by providing older adults with social connections, access to resources, and opportunities to remain active and engaged in their communities. Programs such as senior centers, adult day care, and volunteer visitor programs can help to reduce social isolation, a significant

risk factor for abuse. These programs also provide a network of support that can identify and intervene in cases of abuse.

Healthcare providers are often the first to identify signs of elder abuse, making their role in prevention and intervention critical. Training healthcare professionals to recognize the signs of abuse, ask the right questions, and take appropriate action is essential. Early detection of abuse can lead to timely intervention, which can prevent further harm and potentially save lives. Healthcare providers should also be aware of the legal requirements for reporting abuse and the resources available to support victims.

Healthcare providers play a pivotal role in identifying and responding to elder abuse. As trusted professionals who interact regularly with older adults, they are in a unique position to detect signs of abuse that may not be evident to others. However, recognizing and addressing elder abuse requires specific skills, knowledge, and a proactive approach.

Routine screening for elder abuse should be part of every healthcare provider's practice. This involves asking older adults about their living conditions, relationships with caregivers, and any experiences of mistreatment. Screening tools and questionnaires can assist in identifying potential abuse, especially in cases where the elder may be reluctant to disclose information.

Healthcare providers must be trained to recognize the physical and psychological signs of abuse. Physical signs might include unexplained bruises, burns, fractures, or malnutrition. Psychological signs could involve sudden changes in mood, withdrawal from social activities, or signs of anxiety and depression. Providers should also be alert to signs of neglect, such as poor hygiene, untreated medical conditions, or unsafe living conditions.

When abuse is suspected, healthcare providers have a legal and ethical obligation to report it to the appropriate authorities. This might include adult protective services, law enforcement, or other relevant agencies. Providers should be familiar with the reporting procedures in their jurisdiction and ensure that reports are made promptly and accurately. In addition to reporting, healthcare providers should offer support to the victim, which may include referrals to counseling services, legal assistance, or safe housing.

Addressing elder abuse often requires a multidisciplinary approach. Healthcare providers should collaborate with social workers, legal professionals, law enforcement, and community organizations to ensure a coordinated response to abuse. This collaboration can help to ensure that the elder receives comprehensive care and that all aspects of the abuse are addressed.

Elder abuse is a pervasive and deeply troubling issue that affects millions of older adults worldwide. The study by Yongjie Yon and colleagues highlights the high prevalence of abuse in institutional settings, emphasizing the urgent need for global action to address this issue. However, elder abuse occurs in many forms and across various settings, affecting individuals of all backgrounds.

Preventing elder abuse requires a concerted effort from individuals, communities, healthcare providers, and governments. By raising awareness, providing support to caregivers, strengthening legal protections, improving institutional care, and ensuring early detection and intervention, we can make significant strides in protecting older adults from harm.

As the global population continues to age, the issue of elder abuse will only become more pressing. We must take action now to ensure that older adults can live with dignity, free from fear, and in environments that support their health and well-being.

ELDER ABUSE IN PAKISTAN

It is reported officially through the Pakistan Demographic and Household Survey 2001 that the actual population of the aged people in the year 2,000 was over eight million and the dependency ratio of these aged people in the working population was nearly eleven percent. The projected burden is alarming and will be about 20% by 2015 (Pakistan Demographic & Household Survey, 2001). The highest indicated growth in size of 75 years and above, especially the women. In light of existing health services and long-term care facilities, these changes may have influential supply-demand implications.

ELDER ABUSE CLINICAL PRESENTATION

Elder abuse is a critical issue in the realm of geriatric care, requiring vigilant attention from healthcare providers. As our population ages, the incidence of elder

abuse has become a growing concern, prompting medical professionals to adopt proactive measures in identifying and addressing this issue. The American Medical Association (AMA) has long recognized the importance of routine screening for elder abuse, recommending that doctors routinely inquire about abuse in geriatric patients, even in the absence of overt signs[35]. This recommendation stems from the understanding that elder abuse often remains hidden due to the vulnerable nature of the elderly population and the complexities surrounding their care.

Despite the AMA's recommendation, the field still faces significant challenges, particularly in the area of screening and detection. Currently, there is a notable lack of randomized trials that specifically assess the efficacy of elder abuse screening in asymptomatic populations. This gap in research underscores the need for further studies to validate the effectiveness of such screenings and to develop standardized assessment instruments. The absence of consensus on what constitutes an appropriate screening tool for elder abuse detection has impeded the advancement of the field. As a result, healthcare providers are often left without reliable tools to guide their evaluations, leading to inconsistencies in detection and reporting.

The evolution of elder abuse assessment instruments has been hindered by several factors, including the lack of primary research in elder mistreatment. Many existing tools have not been rigorously tested across diverse clinical settings, populations, or healthcare providers. This limitation poses a challenge in ensuring that these instruments are both sensitive and specific enough to detect elder abuse accurately. The need for validated tools is particularly urgent given the wide range of settings in which elder abuse can occur, from private homes to long-term care facilities. Without reliable assessment instruments, healthcare providers may struggle to identify abuse, particularly in its more subtle forms.

Substantial evidence has been gathered regarding the risk factors associated with elder abuse. Understanding these risk factors is crucial for healthcare providers, as it allows them to maintain a heightened awareness and take appropriate preventative measures. Some of the most significant risk factors include:

One of the most critical risk factors for elder abuse is a shared living situation with the abuser. This proximity increases the opportunity for contact, which can lead to various forms of abuse, including physical, emotional, and financial exploitation. The dynamics

of shared living arrangements can be complex, often involving dependence on the caregiver, which may contribute to the likelihood of abuse. In many cases, the caregiver may experience stress or frustration, leading to abusive behaviors.

Dementia is another significant risk factor for elder abuse. Individuals with dementia are particularly vulnerable due to their cognitive impairments, which can make it difficult for them to recognize or report abuse. Additionally, dementia patients may exhibit challenging behaviors, such as aggression or wandering, that can increase caregiver stress and potentially lead to abusive responses. The cognitive decline associated with dementia also makes it easier for abusers to manipulate or deceive the elderly individual.

Social isolation is a pervasive issue among the elderly and a substantial risk factor for abuse. Isolated individuals may lack the support networks necessary to protect them from abuse or to seek help if they are being mistreated. Isolation can occur due to various factors, such as the loss of a spouse, physical disabilities, or living in remote areas. Abusers may exploit this isolation to exert control over the elderly person, knowing that few external contacts might intervene.

Pathologic Characteristics of Perpetrators: The characteristics of the abuser also play a crucial role in the risk of elder abuse. Perpetrators who suffer from mental illness or substance abuse, particularly alcohol misuse, are more likely to engage in abusive behaviors. These individuals may be less capable of managing the stresses of caregiving or may have impaired judgment, leading to abusive actions. The presence of such pathologies in a caregiver should raise immediate concerns and prompt further investigation.

Given the serious implications of elder abuse, healthcare providers must remain vigilant in their interactions with elderly patients. Awareness of the risk factors mentioned above is essential, but providers should also maintain a high index of suspicion, even in the absence of clear indicators. Elder abuse can manifest in many forms, from physical harm to emotional manipulation and financial exploitation. Therefore, healthcare providers must adopt a comprehensive approach when evaluating patients for potential abuse.

When conducting evaluations, healthcare providers should adhere to some general recommendations to improve the accuracy of their assessments:

Questions should be direct and simple, avoiding any language that could be perceived as judgmental or threatening. This approach helps to build trust and encourages the patient to disclose any concerns or experiences of abuse.

It is often beneficial to interview the patient and the caregiver both together and separately. Disparities in their accounts can offer valuable clues to the diagnosis of abuse. For example, if a caregiver provides a different explanation for an injury than the patient, this inconsistency may warrant further investigation.

Thorough and accurate documentation of the interview and physical findings is crucial. This documentation can serve as evidence in criminal trials or guardianship hearings, making it essential that all records are complete, thorough, and legible. Direct statements made by the patient should be quoted verbatim to ensure that their voice is accurately represented.

The forensic documentation of elder abuse presents its own set of challenges. A

A systematic review of published work on forensic markers of elder abuse highlights a significant gap in primary data. Much of the existing research on clinical findings related to elder abuse is anecdotal, deriving from case reports or small case series rather than large, controlled studies. This lack of robust evidence makes it difficult to establish definitive forensic markers that could reliably indicate abuse.

In the clinical setting, healthcare providers are encouraged to consider elder abuse in the differential diagnosis of every elderly person entering the emergency department (ED). A thorough physical examination is vital, including the disrobing of the patient to evaluate for any unexpected injuries. This examination should include an assessment of the patient's back to check for injuries or decubitus ulcers, which are often indicative of neglect.

Although the evidence base is limited, several clinical findings and observations can raise strong suspicions of elder abuse. These include:

The presence of multiple injuries in different stages of healing may suggest ongoing abuse. It indicates that the patient has sustained repeated trauma over time, which is often a red flag for abuse.

Injuries that cannot be explained by the patient or are inconsistent with the history provided are another cause for concern. For example, if a patient presents with a

fracture and the explanation given does not align with the nature of the injury, further investigation is warranted.

A significant delay between the time an injury was sustained and when treatment was sought can be indicative of abuse. Abusers may prevent the elderly person from receiving medical care promptly, either to avoid detection or due to neglect.

Contradictory explanations given by the patient and caregiver should prompt further scrutiny. Discrepancies in the accounts of how an injury occurred may signal that the The caregiver is attempting to cover up abusive behavior.

Laboratory findings that indicate dosage or over dosage of medications can be a sign of abuse, particularly if the caregiver is responsible for administering the medications. This could suggest neglect or intentional harm.

Bruises, welts, lacerations, rope marks, and burns are all physical signs that should raise suspicion of abuse. These injuries may be located in areas of the body that are not typically prone to accidental injury, further suggesting that they were inflicted intentionally.

Venereal disease or genital infections in elderly patients are serious indicators of possible sexual abuse. Given the vulnerability of this population, such findings should prompt immediate investigation.

Dehydration, malnutrition, decubitus ulcers, and poor hygiene are all signs that the elderly person may be suffering from neglect. These conditions are often the result of inadequate care and can have severe consequences if not addressed promptly.

Signs of withdrawal, depression, agitation, or infantile behavior can also be indicative of abuse. These changes in behavior may reflect the psychological impact of ongoing mistreatment.

During the physical examination, it is crucial to document the size, shape, and location of all injuries meticulously. The use of body maps or charts can be particularly helpful in cases involving extensive injuries, as they provide a visual representation that can be referenced later. In situations where the abuse is suspected or confirmed, photographing the injuries is essential for forensic documentation. These photographs can serve as critical evidence in legal proceedings, providing a clear and objective record of the patient's condition.

Healthcare providers play a pivotal role in the detection, intervention, and prevention of

elder abuse. Their position at the forefront of patient care allows them to identify signs of abuse that might otherwise go unnoticed. However, this role also comes with significant ethical responsibilities. Providers must balance the need to protect their patients with respect for patient autonomy and confidentiality. In cases where elder abuse is suspected, the provider must navigate the complexities of mandatory reporting laws, which vary by jurisdiction.

The ethical dilemmas faced by healthcare providers in these situations are multifaceted. On the one hand, the provider must protect the patient from harm, which may involve reporting suspected abuse to the appropriate authorities. On the other hand, the provider must consider the patient's wishes, particularly if the patient is competent and expresses a desire not to involve law enforcement or social services. These situations require careful consideration and, often, consultation with legal and ethical experts to ensure that the provider's actions align with both ethical principles and legal obligations.

Elder abuse is a pervasive and complex issue that requires a multidisciplinary approach to address effectively. Healthcare providers are at the frontline of detecting and responding to elder abuse, making their role critical in the protection of vulnerable elderly individuals. By maintaining a high index of suspicion, utilizing appropriate screening tools, and ensuring thorough documentation, providers can make a significant impact in preventing and addressing elder abuse. Continued research and the development of validated assessment instruments are essential to improving the detection and management of elder abuse, ultimately leading to better outcomes for this vulnerable population.

AGING, POVERTY, AND SOCIAL SAFETY NETS IN PAKISTAN

Pakistan is a country where 74% of people earn less than US$ 2 a day.[36] Life expectancy at birth is still 63 years for males and 65 for females (Human Development Report, 2004). The social sector expenditures in Pakistan are dismal because the expenditures at % the age of GDP are 0.5 on social protection, 0.1% on social insurance, and 0.2 on social assistance (Social Protection Strategy, 2006). The inflation rate, according to independent observers stands at 8% (The News International, 26 Sep 2006). Under these dismal economic conditions, little is left for social welfare, particularly for the welfare of the aged who are the poorest in the country with little or no economic resources.

The process of aging is expected to become faster and this shall consequently enhance the old-age dependency ratio to a great extent. Social security schemes and pensions are offered to the currently serving and retired and retired private sector workforce but they only manage to cover a rather small part of the aged population in the private sector.

Pakistan has some sporadic welfare nets as well. There is an old-age pension system for about 0.85 million employees on retirement out of a total aged people of over seven million. There is the Employees Social Security Institution, providing insurance against death, disability. As a result of this situation, the social problems of begging, crimes, illiteracy, ill health, etc. haunt most Pakistanis.

Pakistan is confronted with the politics of poverty and the poverty of politics. As a result, there is a gloomy situation for social protection of the masses particularly the aged poor. According to some authentic reports, there is an indication that at least one out of every four Pakistanis is invariably poor and that one in every two Pakistanis may be vulnerable to becoming poor in the immediate future. Another recently conducted

assessment of vulnerability by the World Bank reported that 56.2 % of the total population in Pakistan faces a more than 50% chance of falling into poverty in the upcoming few years…Pakistan has no overreaching social protection strategy. The existing programs for the provision of social protection have also clearly been shown to be highly inadequate in terms of coverage of poor and vulnerable households as well as in terms of the types and levels of support provided by them (World Bank and Gallop, 2006).

Recent trends show a rise in poverty in Pakistan posing a new wave of challenges, which are very likely to negatively influence the elderly population of the country currently living with little or no economic and social support. According to recent estimates, it is indicated that 33% of the population is living on or below the poverty line. Not only will the older people's quality of life be affected with the advancement in age and the increase of poverty in Pakistan but it will also cause a decrease in the economically active portion of the total population, thus highlighting the need for provision of adequate and proper safety nets. Researches indicate that the dependency ratio is expected to steadily increase in Pakistan with a value of 6.7 in the year 2000, then increasing to 7.9 by the year 2025, and a staggering 12.1 by 2050 (UNO, 2002).

A vastly large number of the total workforce in Pakistan is employed in a loose and informal economy, and so a high majority of the senior population completely lacks any cover pension or other type of social security scheme.[37] The elderly, and especially the female elderly, are highly prone to being exposed to harsh conditions with the increase in poverty. Such a situation is going to prevail in Pakistan, as the female life expectancy has surpassed the male's life expectancy in recent years.[38] A small portion of the old-age population is covered by some form of social security schemes available in the public as well as private sectors, but an overwhelmingly large portion of the senior population working or retired from the informal sector of the economy remains unprotected as they do not fall under any such social security schemes. This challenge of catering to the needs and coping with the demands of a rapidly increasing elderly population requires substantial improvements in the support base and systems of social security in Pakistan.

Estimates indicate that the needs of mere 20 percent of the total elderly population are catered by the Pay and Pension Scheme.

Whereas, necessary coverage to a population of 7.34 million elderly citizens (as reported in 1998) is expected to cost approximately 88 billion rupees, provided that 1000 rupees are given as monthly benefits to each individual.

FACTORS AND RECOGNITION

There is no stereotypical victim of elder abuse and neglect. Individuals from all races, cultures, and socioeconomic groups have been victims, and the abuse can occur anywhere (eg, in a personal home, a nursing home, or a hospital). Elderly women and the "old old" (>85 years old) are more likely to be victimized, though it is not clear if this higher risk stems from a decreased ability to defend oneself or the inability to escape from the situation. Most abusers (89%) are family members, as detailed below:[39]

- Decreased physical health, (eg, requiring more assistance with activities of daily living)
- Dementia or cognitive impairment
- Female
- History of violence
- Increased age
- Shared living arrangements

- Social isolation
- Victim or caregiver with mental health or substance abuse issues

Poor health and cognitive impairment probably increase the risk of maltreatment by reducing the elderly person's ability to report the abuse or defend himself or herself from it. Individuals who live alone are less likely to be abused, but elderly people who are socially isolated are at increased risk because they tend to have smaller support systems and the abuse is less likely to be noticed.

A history of violence, mental illness, or alcohol/drug abuse increases the risk of abuse.[40] A good patient history, including an in-depth social history, can identify most of these risk factors. Unfortunately, these areas usually are not addressed in the Emergency Department.

Healthcare providers must be able to recognize the signs of elder abuse and neglect. Some red flags are highlighted as below:

<u>Signs of neglect</u>

- Lack of medical aids (eg, medication, walker, cane, glasses)
- Lack of adequate food, basic hygiene, heat, water, or appropriate clothing
- Untreated medical issues (eg, pressure sores, Foley catheters, colostomy)
- Confinement to a bed without assistance for long periods
- Signs of financial abuse
- Excessive financial gifts or reimbursements for care provided or companionship
- Lack of amenities the patient should be able to afford (eg, heat, water, food)
- Signs of psychological or emotional abuse
- Unexplained changes in behavior (eg, depression, withdrawal, altered mental status)
- Isolation from family members and friends
- A caregiver who appears to be controlling, demeaning, overly concerned about spending money, or is verbally or physically aggressive toward the patient

- Signs of physical or sexual abuse
- Inadequately explained injuries (eg, fractures, sores, lacerations, welts, burns)
- Delay in seeking medical attention after an injury
- Unexplained sexually transmitted diseases
- General signs of abuse and neglect
- Incongruity between accounts given by the patient and caregiver
- Vague or improbable explanations for injuries
- Presentation of a mentally impaired patient without a care provider
- Laboratory or radiology findings that are not consistent with the history provided

Several screening tools have been designed to facilitate the detection of elder abuse.

One that is easy to complete in the Emergency Department is the Elder Abuse Suspicion Index (EASI), which consists of the following 6 questions:[41]

Elder Abuse Suspicion Index (EASI)

Questions 1 through 5 are answered by the patient. Question 6 is answered by the physician

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?
2. has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care or from being with people you wanted to be with?
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?
4. Has anyone tried to force you to sign papers or to use your money against your will?
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?
6. Doctor: Elder abuse may be associated with findings such as poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises,

inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?

The patient can answer “yes,” “no,” or “unsure.” A response of “yes” on one or more of questions 2 through 6 should prompt concern for abuse or neglect.

Validation of the EASI occurred in family practice offices and ambulatory care settings, demonstrating a sensitivity and specificity of 0.47 and 0.75, respectively. The EASI requires less than 2 minutes to obtain.

It was validated against a recognized, detailed elder abuse Social Work Evaluation (SWE).[41] An answer of “yes” to one or more of Questions 2 through 6 should prompt concern about abuse or neglect. A screening tool created by the American Medical Association (AMA) consists of the 9 questions presented as following:[42]

American Medical Association screening questions for abuse

1. Has anyone ever touched you without your consent?
2. Has anyone ever made you do things you didn’t want to do?
3. Has anyone taken anything that was yours without asking?
4. Has anyone ever hurt you?
5. Has anyone ever scolded or threatened you?
6. Have you ever signed any documents you didn’t understand?
7. Are you afraid of anyone at home?
8. Are you alone a lot?
9. Has anyone ever failed to help you take care of yourself when you needed help?

An answer of “yes” to any one of these questions should raise concern and prompt a more thorough evaluation.

The education of medical care providers and mandatory reporters is often promoted as a way of improving the recognition of elder abuse.[43] Educational interventions have been shown to increase knowledge, increase the use of assessment tools, and decrease reports of abusive actions by staff.[44-45] However, only Iowa requires that all mandatory reporters complete 2 hours of training within 6 months after initial

employment and every 5 years thereafter. Sadly though, there has been no change in the investigation and substantiation rates since the law was enacted.[46]

Education alone cannot increase the recognition of elder abuse unless medical care providers have the time and resources to screen patients for this often occult problem. All medical providers should be educated on the screening for elder abuse. In the United States, the Joint Commission that accredits most hospitals already requires that Emergency Departments screen all patients to ensure that they are not victims of abuse or neglect.[47] Typically, this is thought to be a domestic violence screen but it is also meant to identify elder abuse. Electronic medical records can also be designed to prompt for elder abuse.[48-49]

Medical practitioners must conduct a thorough history and physical examination, which could be instrumental in determining a patient's risk factors and identifying signs of abuse. At least a portion of the history should be conducted in private, without family members or care providers present, so that the EASI or AMA screening questions can be asked. A thorough physical examination should then be conducted. This examination includes completely disrobing the patient to visualize any signs of abuse. Bruises or lacerations in various stages of healing, burns, or injuries that are not consistent with the mechanism reported should alert the provider to potential abuse. Decubitus ulcers, sores, dehydration, and poor hygiene should prompt concern for neglect or self-neglect. Again, one does not have to confirm that abuse occurred to make a report; you only need to have a legitimate concern, which will prompt a more thorough evaluation of the patient and his or her living situation.

The provider should ensure that their note is factual, and does not make any accusations. The document should accurately reflect the concerns of the provider and any physical examination or emotional findings that would make them suspect that abuse could be occurring. It is especially important to consider the diagnosis for patients who have frequent Emergency Department visits for dehydration or who show unexplained weight loss or a decline in physical and cognitive function.

PREVENTION OF ELDER ABUSE

The most pressing need in the field of elder abuse is for interventions that have the potential to prevent mistreatment. Selecting and evaluating prevention options poses a considerable challenge, however, because reliable evaluation data do not exist

on any of the options.[50] Indeed, it is unfortunate that the greatest gap in knowledge about elder abuse lies in the area of prevention, given the pressing nature of the problem.

Only approximately 10 intervention studies have been conducted with even minimally acceptable methods, and the results of most of these efforts have been negative or equivocal.[51] No international comparative studies of prevention programs have been conducted. Further, no information exists on the cost-effectiveness of programs; indeed, there is virtually no descriptive data on any kind of the costs incurred by any elder abuse interventions.

Despite the lack of effective data from rigorous controlled designs, the seriousness and scope of the problem of elder abuse require countries and communities to take action to prevent it. We have, therefore, identified five interventions as "promising" based on the evidence from multiple case studies or program descriptions that report the beneficial effects of the program. We do so with the caveat that program initiators must proceed with caution, given the absence of randomized, controlled intervention studies in elder abuse. However, it is believed that guidance from the descriptive literature can be useful in identifying programs that merit further testing.

Caregiver Interventions

Caregiver interventions were among the first models used to prevent elder abuse. These interventions provide services to relieve the burden of caregiving, such as housekeeping and meal preparation, respite care, education, support groups, and daycare, and are promoted as abuse-prevention strategies. There is suggestive evidence that these interventions when directed specifically to abusive caregivers, may help prevent revictimization.[52] Further, there is some indication that the potential for the onset of abuse may be reduced by caregiver support interventions.[53] Caregiver interventions therefore are a promising approach to prevention.

Money Management Programs

Extensive case study reports suggest that individuals vulnerable to financial exploitation can be helped through money management programs.[54] Such programs feature daily money management assistance, including help with paying bills, making bank deposits, negotiating with creditors, and paying home care personnel. These

programs are targeted to groups at high risk for financial exploitation and in particular individuals with some degree of cognitive impairment and who are socially isolated. This intervention is also promising, as the preventive potential is high, and with well-trained and accredited money managers, the risks of adverse outcomes are low.

Helplines

The most widely used intervention across countries is telephone "helplines," which allow individuals to seek advice and assistance regarding elder abuse. There is considerable case study evidence suggesting that helplines facilitate early intervention that can prevent or forestall mistreatment. Such helplines are typically staffed by trained volunteers or professionals. Because many elders experience shame about the abusive situation, helplines have the advantage of allowing callers to remain anonymous if they choose. In some countries, existing helplines have been expanded to support elder abuse victims. In other countries, hotlines have been established specifically for elder abuse victims, such as the "Helpline for Abused Older People" in Milan, Italy, which counsels abuse victims (Van Bavel, Janssens, Schakenraad, & Thurlings, 2010). The most extensive helpline system is a national network of helpline centers created by ALMA France that provides both immediate counseling and longer-term follow-up.[55] Helplines should be considered a promising intervention, given the positive case reports and lack of evidence of any adverse outcomes.

Emergency Shelter

The provision of emergency shelter is a hallmark of intervention for battered women, providing a safe haven to both escape abuse and to plan for the next stage of life.[56] Shelters, however, are underutilized by older women, who are often unaware of them. Additionally, battered women's shelters typically are not designed to accommodate older women with physical health problems or dementia, and they do not offer services to abused men. Therefore, specialized shelter programs for elder abuse victims have been developed. These programs offer temporary relocation for victims, providing not only a safe environment but also a medically appropriate one. As such, they may prevent permanent relocation to a nursing home, providing security while allowing a plan for safety at home to be put in place. Descriptive studies of shelter programs suggest positive results,[57] indicating that this is a promising program option.

Multidisciplinary Teams

In all countries, effective elder abuse prevention requires the coordination of available services. The responses required for elder mistreatment cut across many systems, including criminal justice, health care, mental health care, victim services, civil legal services, adult protective services, financial services, long-term care, and proxy decision-making. Case study and quasi-experimental evidence show that multidisciplinary teams (MDTs) are likely to be an effective response to coordinating care and reducing fragmentation, leveraging resources, increasing professional knowledge, and improving outcomes.[58] These teams can also drive collaboration between the elder justice field and other allied fields involved with older adults. As one of the field's most promising practices, MDTs should be implemented and tested internationally. However, it should be noted that MDTs are at present more appropriate in higher-income nations, given that services must first be available in order to be coordinated. In lower-income countries, a higher priority is likely to be establishment of basic elder abuse services, with later attention to coordination.

SUMMARY

In summary, given both a scarcity of resources in many countries and the lack of a solid evidence base, efforts to create comprehensive prevention approaches to elder abuse are still in their infancy. Substantial differences exist among nations; there are clearly much more expansive elder abuse service systems in high-income countries. Although there is a paucity of evaluation data, there is consensus in the field internationally regarding the need to expand the range of services for elder mistreatment. However, there are several prevention options that are supported by preliminary evidence of their effectiveness and no reports of adverse outcomes. Programs with the greatest promise based on clinical, quasi-experimental, or single case study evidence are (a) MDT approaches (particularly in countries where the service system is sufficiently developed to require coordination); (b) helplines for potential victims; (c) financial management for elders at risk of financial exploitation; (d) caregiver support interventions; and (e) emergency shelter for victims.

Although the literature on elder abuse interventions is not sufficiently developed to offer extensive guidance to countries and localities, this review suggests an important role for practitioners in promoting prevention and treatment approaches. It is vitally necessary that practitioners follow developments in the field, making them able to

adopt evidence-based approaches as they are tested and disseminated. Practitioners can also play a critically important role as collaborators in applied research projects, providing locations for intervention studies and access to participants. Further, a key role for service providers engaged in the issue of elder abuse is to serve as advocates for service development in their regions and in their countries. In areas where such concerted advocacy has occurred, improvements in elder abuse intervention have often followed.

Elder abuse is a growing international problem with different manifestations in different countries and cultures. Substantial variation in legal and legislative approaches to the problem also exists between different countries. Similarly, resources available to prevent and intervene in elder abuse, and the degree to which they are coordinated, vary considerably throughout the world. Promising prevention and intervention strategies are being developed primarily in higher-income countries (e.g., MDTs) that may have applicability to other societies, but these should be tested in the context of available resources and the local manifestations of elder abuse. In some countries, awareness campaigns may first take precedent over intervention and prevention efforts given a limited public understanding of the problem. Irrespective of the local strategies employed, cases of elder abuse will only increase given the aging of the population worldwide, making it a public health problem of global importance.

The most urgent need at present is for a widely expanded research base that uses high-quality methods. There is a paucity of information about the nature and extent of elder abuse in low-income countries, and most studies have taken place in high-income nations. Culturally specific forms of elder abuse and cultural attitudes toward prevention and treatment (including potential barriers) remain virtually unexplored. Further, the applicability of transferring service models from high-income to low-income countries requires serious study, as resource-intensive options such as adult protective services may not be feasible in nations where the aging services sector is underdeveloped. Although multicounty studies have taken place in Europe, they should be expanded to low-income countries as well. Improved scientific knowledge about elder abuse is the key to developing effective prevention and treatment strategies and should be promoted worldwide.

Chapter 3

Data & Methodology

OBJECTIVE

- To determine the frequency of types of elder abuse in people living in old age homes

OPERATIONAL DEFINITIONS

Elder abuse:

- It was an intentional act by a caregiver or another person that causes or creates a risk of harm to an older adult. It was assessed by using the Emotional Abuse Suspicion Index (EASI). The EASI is comprised of only six questions and is rapid to administer. The first five are asked by the researcher/doctor and answered by the patient in a YES/NO format. The sixth question is answered by the doctor/researcher, based on his or her observations of the patient. All six questions should be required in the order in which they appear in the EASI. A response of YES on one or more of questions 2-6 should raise concern about mistreatment/elder abuse.

ELDER ABUSE SUSPICION INDEX

Questions 1-5 are asked of the patient and may be answered “Yes,” “No” or “Did not answer.”

Question 6 is answered by the physician and may be answered “Yes,” “No” or “not sure.”

Within the past 12 months:

1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	Yes	No	Did not answer
2) Has anyone prevented you from getting food, clothes, medication,	Yes	No	Did not answer

glasses, hearing aides or medical care, or from being with people you wanted to be with?			
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	Yes	No	Did not answer
4) Has anyone tried to force you to sign papers or use your money against your will?	Yes	No	Did not answer
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	Yes	No	Did not answer
6) Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	Yes	No	Not sure

Types of elder abuse:

- These are physical, psychological, financial, sexual, and neglect abuse and measured on the EASI. 10 or more occurrences of any of these types in the last 12 months were said to have elder abuse.
  - **Physical abuse**:
    It was the use of physical force that may result in bodily injury, physical pain, or impairment.
  - **Psychological abuse**:
    It was the infliction of emotional pain or distress, e.g., verbal assault, insults, threats, intimidation, or refusal to communicate.
  - **Financial abuse**:
    It **was** the illegal or improper use of an elder's fund, property, or assets.
  - **Sexual abuse:**
    It was non-consensual sexual contact of any kind with an elderly person.
  - **Neglect:**

    It was refusal, or failure, to fulfill any part of a person's obligations or duties to an elderly person.

MATERIALS & METHODS

SETTING:

- The Old age homes in District Rawalpindi and Islamabad.

STUDY DESIGN:

- Cross-sectional study

DURATION OF STUDY:

From: 1st Feb,24 to 31st July,24

SAMPLE SIZE:

By using WHO sample size calculator

P = 60% [5]

Confidence level = 95%

Absolute precision required = 10%

Sample size = 93

SAMPLING TECHNIQUE:

- Nonprobability consecutive sampling

SELECTION CRITERIA

Inclusion Criteria:

- Persons (both genders) 60-90 years of age living in old age homes

Exclusion criteria:

- The elder persons involved in the past in illegal activities like cases of theft, murder, and smuggling for which they have been accused and received punishment under the Constitution of Pakistan from the courts.

DATA COLLECTION PROCEDURE:

After taking approval from the ethical committee, persons living in old age homes in District Rawalpindi and Islamabad, Pakistan who fulfilled the inclusion criteria were enrolled and informed consent was taken from them. History regarding the type or elder abuse (financial, psychological, physical, sexual, and neglect abuse) was taken from the persons as per operational definition by me. All the information was collected on Performa by myself.

DATA ANALYSIS:

All the data was entered and analyzed on SPSS Version 21. Mean ± Standard Deviation was calculated for age. Frequency and percentages were calculated for gender, marital status, education, income resources, family structure, and type of elder abuse. Effect modifiers like age, marital status, education, income resources, family structure, and gender were stratified, and a post-stratification chi-square test was applied. A p-value ≤ 0.05 was considered significant.

Chapter 4

Contents & Results

A total of 93 cases fulfilling the selection criteria were enrolled to determine the frequency of types of elder abuse in people living in old age homes.

Age distribution shows that 47.31%(n=44) were between 6-75 years of age whereas 52.69%(n=49) were between 76-90 years of age, mean±sd was calculated as 75.20±6.08 years. (Table No. 1)

Gender distribution shows that 44.09%(n=41) were male and 55.91%(n=52) were females. (Table No. 2)

Marital status of the cases shows that 44.08%(n=41) were married, 27.96%(n=26) were divorced and 27.96%(n=26) had dead spouse. (Table No. 3)

Educational status shows that 16.13%(n=15) were uneducated, 20.43%(n=19) had primary, 45.16%(n=42) were middle, 13.98%(n=13) were matriculate, 4.30%(n=4) were intermediate. (Table No. 4)

Income resources of the cases shows that 36.56%(n=34) were dependent on children, 15.05%(n=14) were dependent on others, 33.34%(n=31) were self-employed and 15.05%(n=14) were pensioners. (Table No. 5)

Family structure shows that 54.84%(n=51) had joint family structure, 39.78%(n=37) had extended structure, and 5.38%(n=5) were living alone. (Table No. 6)

Frequency of elder abuse shows that 29.03%(n=27) had financial abuse, 21.51%(n=20) had psychological abuse, 6.45%(n=6) had physical abuse and 43.01%(n=40) were neglected. (Table No. 7)

Effect modifiers like age, marital status, education, income resources, family structure, and gender were stratified, and a post-stratification chi-square test was applied.

A p-value ≤ 0.05 was considered significant. (Table No. 8-13)

TABLE No. 1

AGE DISTRIBUTION

(n=93)

Age(in years)	No. of patients	%
60-75	44	47.31
76-90	49	52.69
Total	**93**	**100**
Mean±SD	**75.20±6.08**	

TABLE No. 2

GENDER DISTRIBUTION

(n=93)

Gender	No. of patients	%
Male	41	44.09
Female	52	55.91
Total	**93**	**100**

TABLE No. 3

MARITAL STATUS OF THE CASES

(n=93)

Marital status	No. of patients	%
Married	41	44.08
Divorced	26	27.96
Dead spouse	26	27.96
Total	**93**	**100**

TABLE No. 4

EDUCATIONAL STATUS OF THE CASES

(n=93)

Educational status	No. of patients	%
Uneducated	15	16.13
Primary	19	20.43
Middle	42	45.16
Matriculate	13	13.98
Intermediate	4	4.30
Graduation or above	0	0
Total	**93**	**100**

TABLE No. 5

INCOME RESOURCES

(n=93)

Income resources	No. of patients	%
Dependent on children	34	36.56
Dependent on others	14	15.05
Self-employed	31	33.34
Pension	14	15.05
Total	**93**	**100**

TABLE No. 6

FAMILY STRUCTURE OF THE PATIENTS

(n=93)

Family structure	No. of patients	%
Joint	51	54.84
Extended	37	39.78
Nuclear	0	0
Living alone	5	5.38
Total	**93**	**100**

TABLE No. 7

FREQUENCY OF ELDER ABUSE

(n=93)

Type of abuse	No. of patients	%
Financial abuse	27	29.03
Psychological abuse	20	21.51
Physical abuse	6	6.45
Sexual abuse	0	0
Neglect	40	43.01
Total	**93**	**100**

TABLE No. 8

STRATIFICATION FOR FREQUENCY OF ELDER ABUSE WITH REGARDS TO AGE (n=93)

Type of abuse		Age distribution(in years)		P value
		60-75	76-90	
Financial abuse (n=27)	Yes	14	13	0.57
	No	30	36	
Psychosocial abuse (n=20)	Yes	12	8	0.19
	No	32	41	
Physical abuse (n=6)	Yes	4	2	0.33
	No	40	47	
Neglect (n=40)	Yes	14	26	0.04
	No	30	23	

TABLE No. 9

STRATIFICATION FOR FREQUENCY OF ELDER ABUSE WITH REGARDS TO GENDER

(n=93)

Type of abuse		Gender distribution		P value
		Male	Female	
Financial abuse (n=27)	Yes	10	17	0.38
	No	31	35	
Psychosocial abuse (n=20)	Yes	10	10	0.55
	No	31	42	
Physical abuse (n=6)	Yes	1	5	0.16
	No	40	47	
Neglect (n=40)	Yes	20	20	0.32
	No	21	32	

TABLE No. 10

STRATIFICATION FOR FREQUENCY OF ELDER ABUSE WITH REGARDS TO MARITAL STATUS

(n=93)

Type of abuse		Marital status			P value
		Married	Divorced	Dead spouse	
Financial abuse (n=27)	Yes	11	9	7	0.76
	No	30	17	19	
Psychosocial abuse (n=20)	Yes	10	5	5	0.83
	No	31	21	21	
Physical abuse (n=6)	Yes	3	1	2	0.81
	No	38	25	24	
Neglect (n=40)	Yes	17	11	12	0.93
	No	24	15	14	

TABLE No. 11

STRATIFICATION FOR FREQUENCY OF ELDER ABUSE WITH REGARDS TO EDUCATIONAL STATUS

(n=93)

Type of abuse		Educational status					P value
		Uneducated	Primary	Middle	Matric	Intermediate	
Financial abuse (n=27)	Yes	4	3	11	7	2	0.16
	No	11	16	31	6	2	
Psychosocial abuse (n=20)	Yes	3	7	9	1	0	0.26
	No	12	12	33	12	4	
Physical abuse (n=6)	Yes	1	1	3	1	0	0.98
	No	14	18	39	12	4	
Neglect (n=40)	Yes	7	8	19	4	2	0.90
	No	8	11	23	9	2	

TABLE No. 12

STRATIFICATION FOR FREQUENCY OF ELDER ABUSE WITH REGARDS TO INCOME RESOURCES

(n=93)

Type of abuse		Income resources				P value
		Dependent on children	Dependent on others	Self-employed	Pension	
Financial abuse (n=27)	Yes	8	5	10	4	0.38
	No	26	9	21	10	
Psychosocial abuse (n=20)	Yes	5	3	6	6	0.48
	No	29	11	25	8	
Physical abuse (n=6)	Yes	0	4	2	0	0.14
	No	34	10	29	14	
Neglect (n=40)	Yes	21	2	13	4	0.52
	No	13	12	18	10	

TABLE No. 13

STRATIFICATION FOR FREQUENCY OF ELDER ABUSE WITH REGARDS TO FAMILY STRUCTURE

(n=93)

Type of abuse		Family structure			P value
		Joint	Extended	Living alone	
Financial abuse (n=27)	Yes	11	15	1	0.13
	No	40	22	4	
Psychosocial abuse (n=20)	Yes	15	3	2	0.03
	No	36	34	3	
Physical abuse (n=6)	Yes	3	3	0	0.76
	No	48	34	5	
Neglect (n=40)	Yes	22	16	2	0.99
	No	29	21	3	

Chapter 5

DISCUSSION

Elderly people are often abused in many ways, with serious and lasting consequences. Elder abuse remains one of the most hidden forms of family conflict, and its frequency is anticipated to be rising in many countries that are rapidly experiencing population aging.

To the best of my knowledge, there is scarce information regarding the elderly abuse and its pattern in Pakistan. As there is variability in literature, so the goal of this study is to identify the exact pattern of elder abuse which is so severe that the older persons left their homes and loved ones and take refuge in old homes despite the strong joint family system and family based support of the elders.

In our study, out of 93 cases, 47.31%(n=44) were between 6-75 years of age whereas 52.69%(n=49) were between 76-90 years of age, mean$\pm$sd was calculated as 75.20$\pm$6.08 years, 44.09%(n=41) were male and 55.91%(n=52) were females. Frequency of elder abuse shows that 29.03%(n=27) had financial abuse, 21.51%(n=20) had psychological abuse, 6.45%(n=6) had physical abuse and 43.01%(n=40) were neglected.

We compared our data with previous studies where the elder abuse indicate that women are more often victims than men, it is in agreement with our data, for instance, the United Kingdom (UK) study on mistreatment reported that 3.8% of women and 1.1% of men were victims. When neglect was excluded, the prevalence of abuse continued to be significantly higher for women (2.3%) than men (0.6%).[4]

Another study reveals that financial, psychological, physical, sexual abuse and neglect were observed in 90%, 85%, 60%, 0% and 80% among older persons respectively.[5] In another study, financial, psychological, physical and neglect were found in 2%, 2.2%, 0.5% and 1.1% among older persons respectively.[6] Our data is not in line with this study by calculating 29.03%(n=27) financial abuse, 21.51%(n=20) psychological abuse, 6.45%(n=6) physical abuse and 43.01%(n=40) were neglected. It may be due to regional differences.

In a meta-analysis of 50 studies from throughout the world, the overall prevalence of abuse of elderly women was estimated to be 14.1%, and estimates were obtained for the prevalence of psychological abuse (11.8%), neglect (4.1%), financial

abuse (3.8%), sexual abuse (2.2%), and physical abuse (1.9%).[59] In a study in the city of Pune, India, abuse was reported among 47.0% of elderly women.[60] In the Prevalence Study of Abuse and Violence against Older Women (AVOW) study, 28.1% of old women underwent abuse; as such, those results are dramatically different from those of the present study. In the AVOW study, psychological abuse and physical violence were the most and least common forms of abuse, respectively.[61]

Khalili et al[62] had similar results where many elderly women (80.0%) stated that they had experienced abuse, but financial abuse was the most common type of abuse in his study. In studies conducted by Alizadeh-Khoei et al[63] and Hosseini et al[64], abuse was only reported among 14.7 and 17.4% of the elderly, and physical abuse was the most common type in both studies.

CASE STUDY 1

Background:

Mr. Imtiaz Hassan is an 70-year-old retired civil engineer living in Rawalpindi. He had a successful career, having worked for the state government for over 35 years before retiring with a pension of Fifty Thousand rupees per month. Mr. Imtiaz is a widower; his wife passed away ten years ago, leaving him to live alone in their family home. He has four children—three daughters and one son, all are married and settled in Pakistan.

Family Dynamics:

Mr. Imtiaz's son, Mr. Ahmed, is a 35-year-old businessman who has faced several financial setbacks in recent years. His business ventures have not been successful, leading to significant financial stress. Mr. Ahmed has a wife and two children, and the financial strain has caused tension within his household. Despite these challenges, Mr. Ahmed has always maintained a close relationship with his father, often visiting him and helping with day-to-day activities.

The Abuse:

Over the past year, Mr. Ahmed started experiencing severe financial difficulties, leading him to borrow money from his father. Initially, Mr. Imtiaz Hassan was more than willing

to help, giving his son substantial sums to cover debts and business expenses. However, Mr. Ahmed's financial problems persisted, and he began to ask for more money more frequently and also convinced his father to sign over a portion of his monthly pension directly into his account, promising to return the money once his business recovered .His father trusting his son, agreed without much hesitation. Over time, his son began manipulating his father into signing additional checks and even convinced him to take out a loan against his home, assuring him that it was a temporary measure to tide the family over. His son used these funds for his own expenses and to cover debts unrelated to his father's support. His Fathers savings began to decrease, and he noticed that his bank accounts were being depleted faster than expected. When he questioned his son, He reassured him that everything was under control and that he would repay the money soon. However, his father began receiving calls from the bank about missed loan payments, which was alarming. Upon investigating he discovered that his son had taken out multiple loans in his name without his knowledge, forging his signature in some cases. The total amount of debt was substantial, and he was now at risk of losing his home, the very place he had lived in for over 40 years at last bank forfeiture his home and he became homeless and then shifted to shelter home

Consequences:

Mr. Imtiaz Hassan was devastated by the betrayal. He felt trapped, both financially and emotionally. He loved his son and wanted to help him, but he was now facing homelessness in his old age. His physical health also began to decline due to the stress and anxiety caused by the situation. His daughters were also in their homes but were not able to help their father.

Mr. Imtiaz Hassan was reluctant to take legal action against his son, fearing the impact it might have on their relationship and the shame it could bring to the family..

Lessons Learned:

Mr. Imtiaz Hassan case highlights the vulnerability of the elderly to financial abuse, especially when it involves close family members. It underscores the importance of maintaining control over one’s finances and seeking professional advice before making significant financial decisions. The case also illustrates the need for open

communication within families and the importance of recognizing the signs of financial abuse early to prevent further damage.

Case study 2

Background:

Mrs. Salma is a 65-year-old retired school teacher living in a quiet residential area in G-10 Islamabad. She lost her husband 5 years ago and has since lived alone in her modest but well-kept home. Mrs. Salma has two children: a daughter, Mrs. Tanvir, who was in Lahore with her family, and a son, Mr. Abdullah, who lives in Islamabad also and visits her regularly. Mrs. Salma has always been an independent and strong-willed woman, managing her finances, home, and daily activities on her own.

Family Dynamics:

Mr. Abdullah, Mrs. Salma's 40-year-old son, is a businessman who has struggled with his career. Despite being financially stable, Mr. Abdullah has a controlling and domineering personality. He often feels that his mother's decisions are irrational and outdated. Over the years, he has increasingly taken it upon himself to "manage" her affairs, often without her consent. Although his mother deeply loves her son, she finds his behavior overbearing and dismissive.

The Abuse:

The psychological abuse began subtly. His son started by frequently visiting his mother, ostensibly to "check on her." During these visits, he would criticize her decisions, such as how she spent her money or how she managed her household. He would often tell her that she was too old to make sound decisions and that she should let him take control of her finances and daily life. He would also belittle her when she forgot things or made mistakes, often calling her "senile" or "incapable."

As time went on, his behavior became more controlling. He began to isolate her mother from her friends and neighbors by insisting that they were a bad influence or that they

we’re taking advantage of her. He discouraged her from going out to social events, telling her it was unsafe for someone of her age to be out alone. He even took away her phone for "safekeeping," claiming she might lose it or gets scammed by strangers.

He also began making decisions about the house without consulting his mother. He changed the locks, rearranged her furniture, and even sold some of her belongings, claiming they were "unnecessary" or "too old." When her mother protested, he would dismiss her concerns, telling her she was too old-fashioned to understand modern needs. The emotional manipulation intensified when he began using guilt to control his mother. He would remind her constantly of how much he was sacrificing to take care of her, making her feel indebted to him. He would say things like, "I’m doing all this for your own good, and you don’t even appreciate it," or "If it weren’t for me, you’d be helpless." These remarks made her mother feel guilty and dependent on her son, despite her growing discomfort with his behavior.

Consequences:

Mrs. Salma’s mental and emotional health began to deteriorate due to the constant psychological pressure. She became anxious, depressed, and increasingly withdrawn. She started doubting her own judgment and became afraid to make any decisions without her son’s approval. The vibrant, independent woman she once was had turned into someone fearful and unsure of herself.

The isolation took a severe toll on her well-being. Mrs. Salma stopped meeting her friends, ceased attending social gatherings, and spent most of her days alone at home. Her physical health also began to decline, as she lost interest in eating and caring for herself. She became increasingly reliant on her son, which only fueled his control over her. One day his son sends her mother to the old age home and occupied hers mother house.

Lessons Learned:

Mrs. Salma's case highlights the insidious nature of psychological elder abuse, which can erode a person's self-esteem and independence over time. It demonstrates the importance of recognizing the signs of psychological abuse, such as isolation, manipulation, and emotional blackmail. The case also underscores the need for family members to stay vigilant and supportive, ensuring that elderly relatives retain their autonomy and dignity. With proper support and intervention, victims of psychological elder abuse can regain their confidence and restore their sense of self.

CASE STUDY 3

Background:

Mr. Khan is a 70-year-old retired government employee living in a small town in Rawalpindi. He spent his entire career working as a clerk in the state electricity office and receives a monthly pension of Rs. 20,000. Mr. Khan is a widower; his wife passed away ten years ago. He has only one son who is married. Mr. Sohail, who is 30 years old and lives with him in the family home,

Family Dynamics:

Mr. Sohail has struggled with unemployment and has a history of substance abuse, particularly alcohol. He has not been able to hold a steady job and has become increasingly dependent on his father for financial support. Although his father initially supported his son, he became concerned as his son drinking habits worsened, leading to erratic and aggressive behavior.

Mr. Khan tried to help his son by encouraging him to seek employment and by paying for rehabilitation programs, but his son either refused the help or relapsed shortly after. Over time, the relationship between father and son became strained, and he becoming more demanding and volatile.

The Abuse:

The physical abuse began gradually, often triggered by Mr. Sohail's demands for money to support his drinking habits. When Mr. Khan refused to give him money, he would become angry and lash out. Initially, the abuse was limited to shouting and verbal threats, but it soon escalated to physical violence.

On several occasions, Mr. Sohail pushed and slapped his father, especially when he was drunk. Mr. Khan would try to defend himself or leave the house to avoid confrontation, but Mr. Sohail would often block his way or follow him, continuing the assault. The abuse became more frequent, with Mr. Sohail sometimes throwing objects at his father or kicking him during heated arguments.

One night, the situation took a particularly dangerous turn. Son in a drunken rage, demanded a large sum of money from his father. When his father refused, his son grabbed him by the collar, threw him to the ground, and began kicking him repeatedly. The Father was unable to defend himself, suffered several bruises and a broken rib as a result of the attack. He was too afraid and ashamed to tell anyone about the incident and did not seek medical attention, fearing that it would make the situation worse.

Despite the severity of the abuse, Mr. Khan continued to live in fear, hoping that his son would change but his all efforts to change his son's behavior ended in smoke.

Consequences:

The physical abuse took a significant toll on Mr. Khan's health. He began experiencing chronic pain due to the injuries inflicted by his son, and his pre-existing conditions, such as high blood pressure and arthritis, worsened due to the stress. Mr. Khan also became emotionally withdrawn, suffering from anxiety and depression as a result of the constant fear of his son's outbursts. The situation reached a breaking point when Mr. Khan's left his home to take refuge in an old age home.

Lessons Learned:

Mr. Khan's case illustrates the devastating impact of physical elder abuse, particularly when it comes from a close family member. It highlights the importance of recognizing the signs of abuse and the need for timely intervention to prevent further harm. The

case also underscores the challenges faced by elderly individuals in reporting abuse, often due to feelings of shame, fear, or love for their abusers.

This case also emphasizes the importance of legal and social services in protecting vulnerable elders and holding abusers accountable for their actions.

CASE STUDY 4

Background:

Mrs. Mahmoud is an 67-year-old widow living in a rural village in Rawalpindi. She has lived in the same house for over 50 years, which she once shared with her husband, who passed away a decade ago. Mrs. Mahmoud has two children: her daughter who is married and lives Karachi, and a son, Mr. Pervaiz, who moved to a nearby city Jhelum for work. Although her children visit occasionally, She primarily lives alone, with her neighbors and a distant relative helping her with daily chores.

Family Dynamics:

Mrs. Mahmoud's family is loving and supportive, but they are not always present due to geographical distances and their own family responsibilities. She has been relatively healthy for her age, though she has mobility issues and relies on a walking stick.

Despite her physical limitations, She has maintained her independence and enjoys spending time in her garden or chatting with her neighbors.

In recent months, a distant male relative, Mr. Rizwan, who is in his late 40s, began visiting her more frequently. Mr. Rizwan is unemployed and has a reputation in the town for being involved in petty crimes and alcohol abuse. She was initially uncomfortable with his visits but did not want to be rude, as he was a family member.

The Abuse:

The sexual abuse started subtly. Mr. Rizwan would linger around the house, making inappropriate comments about Mrs. Mahmoud's appearance or touching her in ways that made her uncomfortable, such as hugging her too tightly or brushing against her

under the pretense of helping her with something. She felt increasingly uneasy but didn't know how to address it, especially since Mr. Rizwan was a relative.

One evening, after having too much to drink, Mr. Rizwan forced himself on Mrs. Mahmoud while pretending to help her into bed. Mrs. Mahmoud was unable to fight back and was too terrified to scream for help. The assault left her physically hurt and emotionally devastated. She felt a deep sense of shame and fear, not knowing whom to tell or what to do. The abuse didn't stop there. Mr. Rizwan continued to visit, and each time, he would find ways to isolate her, threatening her not to tell anyone. He assured her that no one would believe her because of her age and his status as a younger male relative.

Consequences:

The repeated assaults took a severe toll on Mrs. Mahmoud's physical and mental health. She became withdrawn, avoided leaving her home, and refused to see her neighbors or other visitors. Her appetite decreased, and she started losing weight. The trauma also led to sleep disturbances and experiencing nightmares and insomnia.

The emotional burden of the abuse weighed heavily on her, leading to deep depression. She started questioning her self-worth and even contemplated suicide as a means of escape. Her children, who were unaware of the abuse, noticed her declining health during their visits but attributed it to aging. She was too ashamed and scared to tell them what was happening, fearing they might blame her or that the community would shun her if the truth came out. One day she quietly moved to shelter old age home to prevent herself from this abuse.

Lessons Learned:

Mrs. Mahmoud's case is a heartbreaking example of sexual elder abuse, particularly in a context where cultural and familial ties can complicate the ability to speak out. It underscores the vulnerability of elderly individuals, especially those who live alone or have limited physical capabilities. The case highlights the importance of awareness and education about elder abuse, both within families and communities, to prevent such tragedies.

The involvement of her family was crucial in addressing the abuse and ensuring her safety. This case demonstrates the need for open communication within families, encouraging elders to speak up about their experiences without fear of judgment or blame. It also shows the importance of legal and social interventions in holding abusers accountable and providing survivors with the necessary support to heal and rebuild their lives.

CASE STUDY 5

Background:

Mr. Ghulam is an 70-year-old retired government servant living in I-10 Islamabad. He lost his wife five years ago and has since lived with his only son, Mr. Imran, and daughter-in-law, Mrs. Nadia, in their family home. Mr. Ghulam has two grandchildren, both of whom are in their early teens. Mr. Ghulam has several chronic health conditions, including diabetes, arthritis, and hypertension, which require regular medication and monitoring. Despite his age and health issues, Mr. Ghulam had always been a lively, independent individual who enjoyed reading, gardening, and spending time with his grandchildren.

Family Dynamics:

Mr. Imran is a busy corporate executive, often working long hours and traveling for business. Mrs. Nadia, a homemaker, is responsible for managing the household and taking care of the children. Over the years, the relationship between Mr. Ghulam and his son's family became strained. Mr. Imran and Mrs. Nadia began to view Mr. Ghulam as a burden, particularly as his health started to decline, requiring more care and attention.

Initially, Mrs. Nadia would assist Mr. Ghulam with his medications and ensure he had meals on time. However, as time went on, she grew increasingly resentful of the responsibilities, feeling overwhelmed with managing the household and caring for her father-in-law. Mr. Imran, absorbed in his work, did little to help, often telling his wife that Mr. Ghulam's care was her responsibility.

The Abuse:

The neglect began gradually. Mrs. Nadia started missing Mr.Ghulam's medical appointments, citing her busy schedule as the reason. She also became lax in administering his medication, often forgetting doses or giving them at the wrong times. Mr. Ghulam's meals became irregular, with Mrs. Nadia sometimes forgetting to feed him or giving him food that was not suitable for his dietary restrictions.

As Mr. Ghulam's health declined, he became increasingly dependent on his family for basic needs, such as bathing, dressing, and mobility. However, Mrs. Nadia's neglect worsened. She began leaving Mr. Ghulam alone in the house for long periods while she went to visit her friends. On several occasions, Mr. Ghulam was left without access to food, water, or his medication for hours. His personal hygiene deteriorated as he struggled to bathe and change clothes on his own.

Mr. Ghulam's pleas for help were often met with indifference or irritation. Mrs. Nadia would sometimes scold him for being too demanding or tell him that she was too busy to assist him. Mr. Imran, when he was home, rarely interacted with his father and dismissed his complaints, assuming that Mrs. Nadia was taking care of everything.

Consequences:

Over time, the neglect took a severe toll on Mr. Ghulam's physical and mental health. He lost a significant amount of weight due to irregular meals and his diabetes became poorly managed, leading to frequent episodes of weakness and confusion. His arthritis worsened due to lack of movement and proper care, making it difficult for him to walk even short distances. The chronic pain from his untreated arthritis became unbearable, further limiting his mobility.

The emotional impact of the neglect was equally devastating. Mr. Ghulam became deeply depressed, feeling abandoned and unloved by his family. He lost interest in reading, gardening, and other activities that once brought him joy. He spent most of his days in bed, staring at the ceiling, feeling helpless and hopeless. His self-esteem plummeted, and he began to withdraw even further, avoiding any attempts at interaction. One day Mrs. Nadia argued Mr. Imran that she is unable to take care of his father and compel him to shift his father to old age home which he did.

Lessons Learned

Mr. Ghulam's case is a tragic example of elder neglect, particularly within a family setting where the victim is often too dependent or ashamed to speak out. It highlights the importance of recognizing the signs of neglect, such as physical deterioration, emotional withdrawal, and poor living conditions.

The case also underscores the need for family members to take an active role in the care of their elderly relatives, rather than leaving the responsibility to a single person who may be overwhelmed or resentful. Regular communication among family members, as well as checks on the elder's well-being, is essential to prevent neglect.

Considering the above, it is clarified that elder abuse is a matter of concern and necessary steps should be taken for its prevention, however, the results of our study are primary and needs to be verified through some other researches.

CONCLUSION

We conclude that neglect is a common elderly abuse in our population followed by financial and psychosocial abuse, however, our results are primary and needs its verification through other local trials.

The study also shows that there are multiple factors influencing the elderly to take refuge in the old home of which inappropriate family behavior, financial reasons and the absence of the care taker could be the major contributing factors. The changing socioeconomic conditions of the world and the present internal unstable political and security conditions in the country may affect the elderly population. The constitution of the Pakistan also provides protection in the form of retirement money and pension but there is no financial protection for the persons working in the private sector. The population living in the old home is small but the issue has to be addressed well in time to coup with it by allocating the appropriate budget for this dependent portion of the population.

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PATTERNS OF ELDER ABUSE IN PERSONS LIVING IN OLD AGE HOMES

PROFORMA

Name:

Age:

Gender: Male/Female/Transgender

Marital status: Married / Divorced / Dead spouse

Educational status: Uneducated/Primary/Middle/Matriculate/Intermediate/Graduation

Income resources: Dependent/Self-employed/Pension

Family structure: Joint/Extended/Nuclear/Alone

MAIN OUTCOME VARIABLE:

- Financial abuse Yes / No
- Psychological abuse Yes / No
- Physical abuse Yes / No
- Sexual abuse Yes / No
- Neglect Yes / No