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Original Article

A comparison of the nature and characteristics of elder abuse and community violence: a medico-legal analysis

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Keywords: elder abuse in Sri Lanka; community violence; violence against elders

Abstract

Introduction

In Sri Lanka, violence against the elderly (VAE) has emerged as a subject of public discussion in recent years. This study compares the nature and characteristics of elder abuse, reported to selected medico-legal units, with community violence involving elderly victims.

Methods

Patients 65 years and older were considered as elderly. A descriptive cross-sectional study was conducted during the period 01 January 2009 to 31 December 2013 in a few identified tertiary care hospitals. A total of 17,330 medico-legal examination forms (MLEF) of five Forensic Medical Officers were perused to identify victims of VAE. Violence committed by someone trusted by victims was classified as elder abuse (EA), while violence in general situations was classified as community violence (CV). The study aimed at comparing the nature and characteristics of EA with CV.

Results

Of 17,330 MLEFs, 127(0.7%) cases were VAE. Among victims of VAE, 91(71.7%) were men and 68(53.5%) were 65-69 years. A total of 125(98.4%) reported physical violence, 51(40.2%) occurred in the afternoons, 83(65.4%) occurred at home and 116(91.3%) were committed by persons known to the elder. Common alleged reasons for violence were financial 18(14.2%) and property issues 14(11.0%).

Of 127 victims, 51(40.2%) experienced EA and 76(59.8%) CV. When comparing EA and CV, 12(23.5%) EA and 59(77.6%) CV occurred outside the home. (χ^2 =8.512, df=1, p=0.004). Following CV, 62(81.6%) victims complained to the police or hospital staff by themselves while the corresponding figure in EA was only 20(39.2%). (χ^2 =27.677, df=1, p<0.001).

Conclusions

CV against elders, occurring outside the home, is more likely to be reported by victims. Many similarities exist between EA and CV indicating that both groups are based in a society breeding violence. Abuse of elders in Sri Lanka is an area that needs further investigation to develop evidence based interventions.

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Introduction

Violence against the elderly (VAE) is a human rights violation[1] and is ethically unacceptable. With the gradual shift from an extended to a nuclear family system, erosion of social values,

and modernisation, coupled with an ageing population, the problem of VAE has emerged as a concern in recent years in Sri Lanka.

Unfortunately, scientific evidence to quantify this problem or determine factors responsible for VAE is scarce. Further, knowledge of such aspects is vital to design and implement interventions that would prevent VAE. This study was undertaken as a preliminary attempt to bridge this gap in scientific knowledge. The objective of the study was to compare violence against elderly in general situations (community violence; CV) with violence against the elderly committed by persons known to the victim (elder abuse; EA).

Methods

A descriptive cross-sectional study was conducted during the period 1 January 2009 to 31 December 2013 in a few identified tertiary care hospitals. A total of 17,330 medico-legal examination forms (MLEFs) of five forensic medical officers were perused to identify victims of VAE. Patients 65 years and older were considered as elderly[1]. If the violence was committed by someone trusted by the victims, it was classified as 'elder abuse (EA)'while violence in general situations was classified as 'community violence against elders (CV)'. Fatal as well as traffic trauma cases were excluded.

SPSS software package 19.0 was used in analyzing data. Chi-square tests were performed in bi-variate tests and p-values<0.05 were considered as statistically significant.

Results

Of 17,330 MLEFs, 127(0.7%) cases were VAE. Among victims of VAE, 91(71.7%) victims were men and 68(53.5%) were in the age category of 65-69 years (Table 1). A total of 119(93.7%) were Sinhalese, 91(71.7%) were unemployed, 119(93.7%) were married and 107(84.3%) had two or more children.

Table 1: Age distribution of victims

Age group	Violence Against Elderly N (%)	Elder Abuse N (%)	Community Violence N (%)
65-69 years	68(53.5)	26 (52.9)	42(55.3)
70-74 years	24(18.9)	10(19.6)	14(18.4)
75-79 years	19(15.0)	9(17.6)	10(13.2)
80-84 years	12(9.5)	4(7.8)	7(9.2)
=>85 years	4(3.1)	2(3.9)	3(3.9)
Total	127(100)	51((100)	76(100)

A total of 125(98.4%) reported physical violence, of which 103(81.1%) resulted in non-grievous injuries. The commonest form of violence was assault 84(66.1%). Blunt force had been applied in 123(96.9%). Commonest injury was contusion 38(29.9%) with the commonest site being the head 50(39.4%). Of VAE incidents 51(40.2%) occurred in the afternoon, 83(65.4%) occurred at home and 116(91.3%) had been committed by persons known to elder. In 19(15.0%), multiple perpetrators had been involved. Common alleged reasons for violence were financial 18(14.2%) and property issues 14(11.0%).

Of 127 victims of VAE, 51(40.2%) were classified as elder abuse (EA) and 76(59.8%) as community violence against elders (CV). Of 51 victims of EA, 37(72.5%) were men and 26(52.9%) were aged 65-69 years (Table 1).

The majority EA victims 47(92.1%) were Sinhalese with 3(5.9%) Tamils and 1(2.0%) Muslims. Most 48(94.1%) had two or more children and 39(76.5%) were unemployed. In EA, the common instigators were financial 6(11.8%) and property issues 6(11.8%). Except for one victim of chronic negligence all reported were physical assaults. A total of 29(58.4%) reported being subjected to more than one type of abuse. Type of abuse is shown in Table 2.

Table 2: Types of elder abuse

Type of abuse	N (%))
Physical	50(98.0)
Psychological	12(23.5)
Financial	8(15.7)
Negligence	6(11.8)
Medication	1(2.0)

Table 3: Perpetrators in elder abuse

Perpetrator	N (%))
Son	22 (43.1)
Daughter	3(5.9)
Spouse	5(10.0)
Other relative	16(31.4)
Multiple perpetrators	5(10.0)

In EA, 41(80.4%) occurred at home, 29(56.9) in the afternoons. A son of the victim was the commonest perpetrator 22(43.1%) while 5(10.0%) had encountered multiple perpetrators (Table 3). The majority of victims of EA 36(70.5%) reported that they were physically assaulted and 15(29.4%) reported assault with a random instrument such as a wooden block or broom stick. Only 1((2.0%) had been attacked with a knife.

A total of 49(96.1%) victims of EA had received blunt force injuries. Other common injuries were contusions 22(43.1%), abrasions 9(17.6%) and lacerations 6(11.8%). The least common injury was fractures 2(3.9%). Common target regions were the head 20(39.2%), (Figures1 and 2), followed by the trunk 15(29.4%), (Figure 3) and upper limbs 7(13.2%) (Figure 4). A majority 43(84.3%) sustained non-grievous injuries. Grievous injuries occurred in 7(13.7%) while 1 (2.0%) had sustained injuries endangering life.

The ‘use of a random instrument or weapon’ was significantly higher in EA victims aged less than 70 years 11(42.3%), than in those aged 70 years or above 4(16.0%) (χ^2=4.249, df=1, p=0.039). Similarly, ‘use of a random instrument or weapon’ was significantly higher in incidents occurring in the morning 7(43.6%) compared to incidents which occurred in the evenings 4(26.7%) (χ^2=5.343, df=1, p=0.025). No significant differences was seen in the ‘use of a random instrument or weapon’ based on the sex, ethnicity, marital status or number of children of the victim or based on the number of perpetrators, presence of injuries, head injuries or severity of injuries. A total of 22(43.1%) victims of EA reported a previous history of abuse.

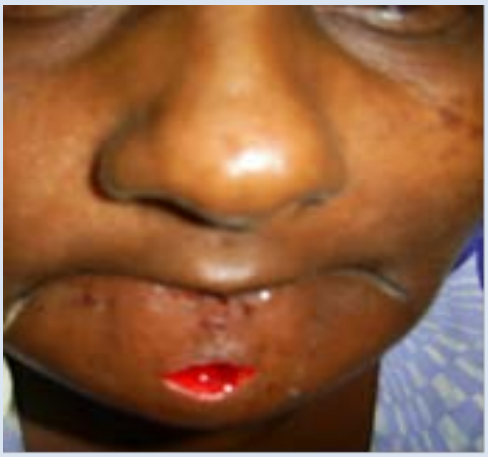

Figure1: Head injury in EA

Figure 2: Black eye with Sub-*conjunctival* haemorrhage in EA

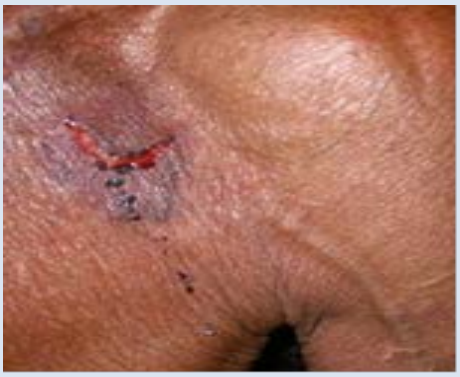

Figure 3: Laceration trunk in on EA

Figure 4: Contusion on limb in EA

In 76 victims of CV, 54(71.1%) were men. Most 42(55.3%) were in the age group of 65-69 years (Table 1). In CV, the leading instigators were financial 16(21.1%) and property issues 13(17.1%). Of the perpetrators, 56(73.7%) were known to the victim and 42(52.3%) occurred at home.

When EA and CV were compared, 12(23.5%) incidents of EA and 59(77.6%) incidents of CV occurred 'outside the home'. (χ^2 =8.512, df=1, p=0.004). Following CV, 62(81.6) complained to the Police or hospital staff themselves while the corresponding figure in EA was only 20(39.2%).

Comparison of victims of EA and CV, revealed no statistically significant differences in age, sex, ethnicity, marital status, number of children and status of employment. Time of incident, number of perpetrators, use of 'random instrument' or weapon, injuries, and severity of injuries were also similar in CV and EA.

Discussion

'Violence' is defined as "the intentional use of physical force or threat against a person or group which either results in injury, death, psychological harm, mal-development, or deprivation"[2]. When violence is committed against elders, it is termed VAE.

The American Psychological Association on aging estimates that 2.1 million older Americans are victims of some form of violence and claims that for every report of VAE, there are five

unreported cases[3]. Though VAE cases accounted for 0.7% of medico-legal cases reported to selected tertiary care hospitals in this study, most VAE incidents may not have been reported.

According to a UK definition, "EA is a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person"[4]. EA occurs at all socio-economic levels and in all racial groups.[1]In this study too, EA was found in all ethnic groups. In our study the majority of EA victims were men. According to the National Report on Violence and Health in Sri Lanka 2008[1], elderly women are more likely to get abused than men. The findings of this study may reflect a difference in the pattern of reporting of abuse among males and females. EA among women and men declines with age[5]. The present study confirmed this pattern.

According to the National Report on Violence and Health in Sri Lanka 2008, physical abuse is more likely to take place in institutions than at home[1]. However, none of the victims of the present study were from institutions. Thus, elder care institutions should be routinely visited and scrutinised for any un-reported incidents by authorised agencies. The commonest perpetrator in the present study was the son. The spouse was the perpetrator in 10% of instances. Late-life intimate partner violence (IPV) should be researched further for improved understanding of this issue.

Elders not having financial assets and entirely dependent on children are more likely to be abused than those who have some means of support[1]. In this study too, 18(14.2%) victims of VAE and 6(11.8%) of victims of EA alleged financial issues as one of the reasons for their experience.

EA can be classified as physical, psychological, or financial/material and several types of ill-treatment may occur simultaneously[6]. Similar to previous research findings[1], physical abuse was the most common form of VAE 125(98.4%) and comprised 36(70.5%) of EA in the study. Neglect is more common among elders living alone, in poor households[1]. A previous study in Sri Lanka revealed that only 47% of elderly are regularly visited by relatives[7]. In this study, 6(11.8%) EA victims were neglected. Financial abuse was alleged by 8(15.7%) victims of EA. Health and social care professionals must enhance their ability to detect elder financial abuse. A suitable a web resource may be accessed at www.elderfinancialabuse.co.uk[8].

Among EA victims, the commonest site of injury was the head 20(39.2%). This is similar to a study done in Brazil, where the prevalence of head injury was 25% of total injuries[6]. 'Use of a random instrument or weapon' in EA was more against 'young-olds' ($p<0.05$) and in the morning ($p<0.05$). Though, EA is more common in the afternoon, abuse using 'weapons' was seen more in the morning. These factors should be explored in more detail when designing prevention programmes.

Reported incidents of CV 76(59.8%) were more those of than EA 51(40.2%). When comparing EA with CV, CV was more common outside the home~~s~~ ($p=0.004$) and the victims were more likely to complain to the authorities themselves ($p<0.001$). EA was more likely to take place at home and victims were less likely to complain to authorities ~~by~~ themselves. This may be due to emotional and/or financial dependence of the victim on the perpetrator.

Further comparison of EA and CV revealed many similarities in the victims. Age, sex, ethnicity, marital status, number of children and employment status were similar socio-demographic characteristics of the victims. Time of incident, number of perpetrators, 'use of a random instrument or weapon', presence of injuries, head injuries and severity of injuries were also similar in the two categories of victims.

The segment of the population aged 65 and above is projected to increase from 1.9 million in 2001 to 4.7 million in 2031 in Sri Lanka[7]. With higher life expectancies at older ages the duration of co-residence of elderly with their children will increase further[9]. The problem of EA is likely to increase in the future, highlighting the importance of developing intervention and prevention programmes. Provision of supportive services for victims of negligence has been found to be the most effective intervention[10]. Assessment of elderly patients at risk by a multi-disciplinary team including a social worker with subsequent development of individualised intervention strategies can have a positive impact on this devastating problem[11]. The American Medical Association "Guidelines for diagnosis and treatment of elder abuse and neglect" recommend mandated reporting[6] and offers potential social, legal remedies[12].

Conclusions

Victims of elder abuse are reluctant to report abuse occurring at home. Many similarities are found between elder abuse and community violence, indicating that both groups have their basis in a society breeding violence. Elder abuse in Sri Lanka is an unmapped area needing further investigation to develop evidence based interventions. Guidelines should be developed for the diagnosis, treatment and management of elder abuse and neglect.

References

1. National report on violence and health in Sri Lanka, Ministry of Health care and nutrition in Sri Lanka and WHO country office, Sri Lanka, (2008), Colombo.
2. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R. "World report on violence and health", World Health Organization, 2002. Geneva.
3. Elder abuse and neglect. http://www.apa.org/pi/aging/resources/guides/elder-abuse.pdf (accessed on 20.01.2014)
4. Action on Elder Abuse (AEA) Bulletin. May-June 1995 (online), Cited on elder abuse in Europe. Available at: http://www.preventelderabuse.eu/doc/
5. Santos CM, De Marchi RJ, Martins AB, Hugo FN, Padilha DM et al. The prevalence of elder abuse in the Porto Alegre metropolitan area. Brazilian Oral Research 2013;**27**(3):197-202.
   doi: http://dx.doi.org/10.1590/S1806-83242013005000011
6. Paris BE, Meier DE, Goldstein T, Weiss M, Fein ED. Elder abuse and neglect: how to recognize warning signs and intervene. Geriatrics 1995;**50**(4):47-51.
7. Andrews GR, Hennink MM. The circumstance and contributions of older persons in the three Asian countries: Preliminary result of a cross-national study. Asia-Pacific Population Journal 1992;**7**(3):127-46Harries P, Davies M, Gilhooly K, Gilhooly M, Tomlinson C. Educating novice practitioners to detect elder financial abuse: a randomized controlled trial. BMC Medical Education 2014;14:21
   doi: http://dx.doi.org/10.1186/1472-6920-14-21
8. Abeykoon, ATPL. "Research, Data and Policy Issues on Ageing in Sri Lanka", in Ageing Population in Sri Lanka 2004, United Nations Population Fund, Colombo, Sri Lanka.
9. Alon S, Berg-Warman A. Treatment and prevention of elder abuse and neglect: where knowledge and practice meet-a model for intervention to prevent and treat elder abuse in Israel. Journal of Elder Abuse and Neglect 2014;**26**(2):150-71.
   doi: http://dx.doi.org/10.1080/08946566.2013.784087
11. Paris BE. Violence against elderly people. The Mt Sinai Journal of Medicine, New York. 1996;63(2):97-100.
12. Hirsch CH, Loewy R. The management of elder mistreatment: the physician's role. Wiener KlinischeWochenschrift 2001;**113**(10):384-92.