Prevalence, Associated Factors and Predictors of Elder Abuse in Thailand

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Abstract: Little is known about elder abuse in Thailand. Yet, its prevalence is high compared to other countries. Thus, this descriptive cross-sectional study examined the prevalence, associated factors and predictors of elder abuse in Thailand. Data were collected, via interview using questionnaires, from 233 elderly living in metropolitan Bangkok and were analyzed by means of descriptive statistics, chi-square, and univariate and multiple logistic regression analyses.

Results revealed, based on newly developed diagnostic criteria, approximately 14.6% of the subjects had been victims of abuse. Factors associated with elder abuse included: gender; adequacy of income; perceptions of health; personal health compared to the health of other elders; and, family members' mental health, dependency and relationship issues. Predictors of elder abuse included: gender, family members' dependency and relationship with family members. These factors co-predicted 28.6% of elder abuse. The findings provide knowledge about elder abuse and associated factors that may prove helpful in development of effective interventions to prevent and manage abuse among the elderly in Thailand.

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Background and Significance of the Study

Elder abuse affects millions worldwide, regardless of whether it involves a single act, repeated acts or lack of appropriate actions in which an expectation of trust causes harm or distress.[1] Abuse of elderly has been recognized as including physical, psychological and financial abuse, as well as neglect.[2-6] All forms of elder abuse, both direct and indirect, affect the health and well-being of elders and can lead to increased health care costs.[7]

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Although elder abuse is an extremely complex phenomenon, prior research reveals only 2% to 6% of elderly in Australia, Britain, Canada, Costa Rica, the Netherlands and the United States of America have reported experiencing physical and psychological abuse, exploitation, and neglect.[8-13] On the other hand, nearly 50% of elders living with family members in Thailand report having been abused.[2] However, operational definitions, as well as details of actions or behaviors considered to constitute elder abuse, differ among various studies.[2,5,14] Therefore, development of a standard diagnotic criteria for elder abuse is necessary in order to accurately measure its incidence and prevalence.

In recent years, abuse of elderly in Thailand has come to be recognized as a social problem.[15] With changes in demographics, family structure and social patterns, there has been a tendency for increased elder abuse.[16,17] The elderly also have been found to become more at risk for abuse when they have at least one debilitating illness.[18] As the source of support for elders changes from the extended family to the nuclear family, increased responsibilities fall on the shoulders of fewer family members, which, potentially, could lead to elders receiving less care and more abuse.[16] In addtion, industrialization, throughout Thailand, has eroded long-standing patterns of interdependence between generations, and often resulted in elders experiencing material and emotional hardships.[2, 4] The current economic crisis has caused family members to work more and have less time for one another.[19] In addition, materialistic values and modernism has brought about change in how Thais honor and respect their elders. [2]

To better understand the incidence and prevalence of abuse of elderly Thais, there is a need to examine factors associated with abuse. Although those who have been abused demonstrate various behaviors and activities, characterisics of abused elders have been found to include poor health, lower levels of activities of daily living and cognitive impairment.[18, 20-22] In addition, provocative behavior, on the part of elders, has been noted to trigger an aggressive response on the part of caregivers.[23]

Prior researchers have speculated that the characteristics of abusers, who may be the elders' caregivers, might be better predictors of elder abuse than the characteristics of the victimized elders.[24,25] Characteristics of abusers have been found to include: drug and alcohol abuse; [10, 16, mental illness;[10] behavioral problems;[3] and, financial dependency.[10, 16, 18] Elder abuse also has been found to occur in conjunction with the elders relationships with their family members.[19, 26, 27] Those who perceive having a "very bad" relationship with family members have been found to more likely be abused, compared to other elders.[19]

As one would suspect, rarely does elder abuse only have one cause. Rather, abuse of the elderly is more likely to be influenced by multiple risk factors. However, studies of risk factors associated with elder abuse, conducted in Thailand and Western cultures, have focused primarily on characteristics of the elderly or their family members. Thus, this study sought to expand the examination of elder abuse by determining, in one district of metropolitan Bangkok, the prevalence, associated factors and predictors of elder abuse in Thailand.

Method

Design and Ethical Considerations: The study used a cross-sectional, case comparison design. Prior to data collection, approval to conduct the study was obtained from the Committee on Human Rights Related to Human Experimentation of the primary investigator's (PI) academic institution. Potential subjects were informed about

the study's objectives, data collection procedures and duration, and their right to refuse to continue or disclose information, at anytime, without repercussions. Subjects provided both verbal and written consent to participate in the study.

Sample: Because power analysis does not cover Logistic Regression, Cochran's sampling techinque [28] was used (N = 9,996; d = 0.5; p = 0.2; q = 0.8; Z = 1.96) to determine the need for a sample of 240 subjects. Subject selection criteria included male and female Thais who: a) were 60 years or age and older b) lived within five randomly selected communities in one District of metropolitan Bangkok; c) were able to read and write Thai; and, d) were not cognitively impaired.

Door to door recruitment of potential subjects occured once the primary investigator (PI) explained to the healthcare volunteers and local community leader of the five randomly selected communities the purpose, risks and benefits of the study. The volunteers and leaders then gave the PI a total of 321 names of elders residing within the five communities. The PI also asked the community leaders and healthcare volunteers if they had heard or seen situations in which elders in their respective communities: 1) did not receive care they should have from relatives, caregivers and/or family members; and/or, 2) had been hurt or become sick because of actions or expressions by family members or others. Follow-up regarding affirmative responses to either or both of these situations provided additional information about how to locate potential subjects. Three identified elders within the selected communities died prior to the beginning of the recruitment process, leaving a total of 318 potential subjects.

After the community leaders and healthcare volunteers directed the PI to each potential elder subject's home, each elder was informed about the study, including his/her rights, confidentiality and anonymity. Sixty-nine of the potential subjects refused to participate due to lack of available time (n = 10) or because their spouse already was involved in the study (n = 59). In addition, 16 potential subjects who were cognitively impaired (CMT<15) were excluded. A total of 233 cognitively functioning elders agreed to participate and signed an informed consent form

Subjects ranged in age from 60 to 90 years, with a mean of 69.71 years. The majority were female (n = 171; 73.4 %); had a primary school education (n = 175; 75%); and, although previously employed (n = 200; 85.8%), presently were unemployed (n = 169; 72.5%). Almost half were couples (n = 104; 44.6%). Even though 36.5% (n = 85) of the elders had an income of less than 3,000 baht (30 baht = 1USD) per month and 73.8% (n=172) received financial support from children/grandchildren, 45.9% (n = 107) perceived having a sufficient income for living expenses, but not enough to save. The majority (n = 153; 65.7%) indicated having health problems, with nearly half (n = 114; 48.9%) perceiving their health to be fair. However, 49.8% (n = 116) indicated their health was better than that of other elders. In addition, most (n = 179; 76.8%) of the elders were homeowners and lived with (100%) a spouse, child, grandchild or other relative.

Instruments: Data were collected via eight different instruments which included the: Demographic Questionnaire (DQ); Chula Mental Test (CMT); [29] Diagnostic Criteria for Elder Abuse (DCEA); Interview Guideline for Screening for Elder Abuse (IGSEA); Barthel ADL Index (BADLI); [30] Elder's Behavior Assessment (EBA); Family Member at Risk Abuse Questionnaire (FMRAQ); and, Family Relationship Scale (FRS).[31] The Thai standard versions of both the CMT[29] and BADLI[30] were used for data collection. For instruments developed by the (PI), a panel of

nine experts (an elder abuse nurse researcher, four gerontological nursing instructors, one neurologist, two sociologists and one psychiatrist) knowledgeable about elder abuse, evaluated the content validity (CVI) of the instruments. The nine experts determined the average CVI of the DCEA and IGSEA to be 0.97 and 0.92, respectively. Five of the experts (an elder abuse nurse researcher and four gerontological nursing instructors) determined the average CVI of the EBA and FMRAQ to be 0.88 and 0.87, respectively. Assessment of the instrument reliability and feasibility of the procedure was undertaken prior to the study, via a pilot test that used 30 subjects similar to those who participated in the study.

The 15-item, PI developed, demographic questionnaire (DQ) sought to obtain information regarding each participant's: age, gender, marital status, educational level, past and present occupation, income, source of income, adequacy of income, health status, health compared to health of other elders, living arrangements and home ownership. It took approximately 3-5 minutes to complete the questionnaire.

The 13-item Chula Mental Test (CMT) [29] was used to assess cognitive function of the elders. The CMT is designed to assess one's perception, memory, attention, language and recall though use of questions such as: "How old are you?" and "What time is it?" Item responses are coded on a dichotomous scale where: 0 = "incorrect" and 1= "correct." A total score is obtained by summing across items. Since some items generate two or three possible scores, a total of 19 scores is obtained from the 13 items. Thus, the total score can range from 0-19. A CMT ≥ 15 indicates normal cognitive function, while a CMT< 15 indicates cognitive impariment. Cronbach's alpha coefficient for both the pilot study and the actual study was 0.87. It took 3 - 10 minutes to complete the instrument.

The PI developed Diagnostic Criteria for Elder Abuse (DCEA) based on the WHO's definition and characteristics of elder abuse, including physical, psychological, financial and sexual abuse.[1] The DCEA was designed for use in identifying abused elders and based on whether there were conscious and intentional attempts to act regarding: (1) refusal or failure to fulfill a caregiving obligation; (2) causation of harm or distress to the elder; and, (3) violation, within a relationship, of an expectation of trust. A conscious and intentional attempt to act was considered to include: physical force; physical coercion; physical or drug induced restraints; verbal or non-verbal expressions; non-consensual sexual contact; illegal or improper exploitation; and, use of funds or resources of the elderly. Harm or distress was defined as physical (injury or illness) or mental/ emotional (threats, intimidation, humiliation or lack of concern) pain.

Using the DCEA as a guideline, the PI developed the Interview Guideline for Screening for Elder Abuse (IGSEA). The IGSEA consisted of six open-ended questions designed to capture information about abuse experienced over the past year. The questions included: 1) "Have you not received care that you should have received from relatives, caregivers or family members?" and "If so, what care was not received?"; 2) "Have you suffered or had difficulties caused by the actions of family members or others?" and "If so, in what way did you suffer or what difficulties have you had?"; 3) "Have you been sad, sorrowful or disappointed by actions or expressions of family members or others?" and "If so, in what way were you sad, sorrowful or disappointed?"; 4) "Have you been frightened by the actions or expressions of family members or others?" and "If so, in what way have you been frightened?"; 5) "Have you been hurt or become sick because of actions or expressions of

family members or others?" and "If so, in what way have you been hurt or sick?"; and, 6) "Have you been taken advantage of or been cheated by a family member or others?" and "If so, in what ways were you taken advantage of or cheated?" Responses to the IGSEA were audiotaped and transcribed verbatim. It took approximately 30 minutes to complete the IGSEA.

Two of the investigators made decisions, based on the IGSEA content and the diagnostic criteria for elder abuse, regarding each respondent's abuse status. Elder abuse was considered to have occurred when a subject's responses matched the diagnostic criteria for elder abuse. For example, a diagnosis of financial abuse was made when an elder stated her son had stolen money from her and he agreed, after being asked: "Have you been taken advantage of or been cheated by a family member or others?" and "If so, in what ways were you taken advantage of or cheated?" An example of a diagnosis of psychological abuse, by a spouse, was when an elder female responded, "Yes, he curses and uses harsh/rough words with me" to the question, "Have you been sad, sorrowful or disappointed by actions or expression of family members or others?" The same female elder indicated her husband slapped, beat and kicked her when she was asked: "Have you been hurt or become sick because of actions or expressions of family members or others?"and "If so, in what way have you been hurt or sick?" Thus, this female elder also was diagnosed as having experienced physical abuse.

Data obtained from the IGSEA were used to classify elders as either abused or non-abused. The classifications were assigned, via comparison of the situations and diagnostic criteria, after an independent, total agreement occurred between two of the investigators.

A modified 10-item version of the Barthel Activities of Daily Living Index (BADL)[30] was used to assess subjects' ability to engage in: self-feeding, grooming, transferring, toilet use, ambulating, dressing, walking up stairs, bathing, bowel control and bladder control. Possible scores, depending upon the item, could range from 0 to 3. For example, two items had score ranges of 0 – 1 (**i.e.** bathing: 0 = "need assistance"; and, 1= "do by myself"); six items had score ranges of 0 – 2 (i.e. feeding: 0 = "unable to feed myself"; 1 = "able to feed myself with assistance"; and, 2 ="completely able to feed myself"); and, two items had score ranges of 0 – 3 (**i.e.** Moving within the room/ home: 0 = "cannot move"; 1 = "able to move by myself by using a wheel chair"; 2 = "walk or move with assistance"; and, 3 = "able to walk or move myself"). To obtain a total score, values were summed across items, providing a score range of 0-20. A lower score indicated lower functional ability and higher dependency, while a higher score indicated higher functional ability and lower dependency. Cronbach's alpha, for both the pilot study and the actual study, was found to be 0.80 and 0.83, respectively. It took approximately 3 to 5 minutes to complete the instrument.

To determine each elder's behavior in comparison to other elders, the 6-item Elder's Behavior Assessment (EBA) was developed, by the PI, based on an extensive review of literature. Behavioral assessment focused on provocative actions or expressions, including moodiness, fussiness, complaining and cursing. Each instrument item was measured on a three-point Likert-like scale (1 = "never the same as other elders' behavior;" 2 = "sometimes the same as other elders' behavior;" and, 3 = "always the same as other elders' behavior"). Values summed across all items provided a total score range of 6 – 18. Higher scores reflected greater provocative behaviors, while

lower scores suggested lower provocative behavior. Total scores were categorized into three groups consisting of low, moderate and high provocative behavior (i.e. 6-10 = low; 10.1-14 = moderate; and, 14.1-18 = high). The values assigned to each of the three groups were determined by dividing the range between the highest and lowest observed value into three categories (max – min / 3).[32] Cronbach's alphas, for the pilot study and the actual study, were 0.81 and 0.83, respectively. It took 2 to 3 minutes to complete the instrument.

The 19-item Family Member at Risk of Abuse Questionnaire (FMRAQ), developed by the PI, addressed the elder's perception of three main family issues: behavioral problems (six items); mental health problems (eight items); and, dependency on the elder (five items). Behavioral problems included family members' actions regarding: alcohol use; gambling; destruction of property; blaming; cursing; and, drug abuse. Possible responses to each item were: 1 = "no"; 2 = "maybe"; and, 3 ="yes." A score was obtained by summing the values across all six items, providing a range of scores from 6 - 18. Higher scores indicated the presence of a greater number of family member behavioral problems. Mental health problems of family members included: downheartedness; discouragement; worry; moodiness; hot-temperedness; dissatisfaction with life; impatience; and, a history of mental illness. Possible item responses included: 1 = "no," 2 = "maybe" and 3 = "yes." A score was obtained by summing the values across all eight items, providing a possible range of 8 - 24. Higher scores suggested the presence of a greater number of mental health problems among family members. Family member dependency, on the elder, included assistance with: financial support; housing; household chores; childrearing; and, health care. Possible responses to each item were: 1 = "no," 2 = "maybe" and 3 = "yes." A score was obtained by summing the values across all five items, providing a score range of 5 - 15. Higher scores suggested the presence of greater family member dependency on the elder. A total score for the instrument was obtained by summing the values obtained for the three categories of family issues, providing a possible score range of 19 – 57. Total scores were categorized into three family behavioral problem groups (low, moderate and high). Group placement was determined by dividing the range between the highest and lowest observed value into three categories (max – min / 3).[32] Cronbach's alpha, for the pilot study and the actual study, were 0.74 and 0.76, respectively. It took 5 to 8 minutes to complete the instrument.

The 15-item Family Relationship Scale (FRS)[31] examined feelings and opinions of elders regarding family relationships. Each instrument item was measured on a three-point Likert-like scale (1 = "did not represent"; 2 = "not sure if represented"; and, 3 = "mostly represented"). A total score was obtained by summing the values across each item, providing a total score range of 1 – 45. Each elder's total score then was categorized into one of three possible levels of family relationship quality (poor = less than 60%; moderate = 60 - 80%; and, good = over 80%). Cronbach's alphas, for the pilot study and the actual study, were 0.80 and 0.72, respectively. It took 8 to 10 minutes to complete the instrument.

Procedure: Once a potential subject consented to be in the study and signed the informed consent form, a time and place were established for the PI to administer the questionnaires. To facilitate comfort and willingness, on the part of each potential subject, to share information regarding his/her abusive situations and family issues, the location of the each meeting was at the respective community's health center or in the elder's home.

Eight questionnaires were administered via interview. Initially, the Demographic Questionnaire (DQ) was administered to 249 elders who had agreed to participate in the study because the questions related to their demographic data and were considered non-threatening. Following completion of the DQ, each elder's cognitive function was assessed, via the CMT, [29] to determine his/her cognitive abilities and the reliability of his/her responses to the questionnaires. Sixteen of the elders, assessed as being cognitively impaired (CMT < 15), were thanked for their time and removed from the study.

The 233 elders, assessed as having normal cognitive functioning (CMT ≥ 15), were administered the: BAI[30]; EBA; FMRAQ; and, FRS.[31] Following completion of the questionnaires, the PI, using the ISEA, interviewed each subject to determine whether he/she had been abused. It took approximately one hour for the subjects to complete the interview and questionnaires.

The PI also asked the head of each local health center, the healthcare volunteers and the subjects' neighbors, without revealing any names, the six open-ended IGSEA questions in an effort to capture information about abuse experienced in the community the past year. The additional information was used to support and enhance the confidence level of the data regarding the presence of abuse.

Data Analysis: Demographic data, prevalence of elder abuse and factors related to elder abuse were analyzed using descriptive statistics. Chi-square was used to examine the preliminary association between each factor related to elder abuse and the presence of elder abuse. Univariate and multiple logistic regression analyses were employed to predict factors associated with elder abuse.

Results

The prevalence rate of elder abuse (percentage of subjects who had experienced at least one abusive behavior during the study period) was found to be 14.6% (n = 34). More specifically, 67.6% (n= 23) of the subjects reported having experienced elder abuse once, while 32.4% (n= 11) had been abused two or more times. As shown in **Table 1**, almost all subjects reported having experienced psychological abuse either alone or in combination with some other form of elder abuse.

Table 1 Number and percentage of abused elders (n = 34)

Elder Abuse	Number	Percentage
1. Psychological Abuse	14	41.18
2. Financial Abuse	7	20.59
3. Physical Abuse	1	2.94
4. Neglect	1	2.94
5. Psychological Abuse + Neglect	5	14.71
6. Psychological Abuse + Financial Abuse	2	5.88
7. Physical Abuse + Psychological Abuse	3	8.82
8. Physical Abuse + Psychological Abuse + Neglect	1	2.94

However, none of them reported having been sexually abused.

Factors Associated with Elder Abuse: Among the demographic characteristics, as shown in **Table 2**, significant associations were found between elder abuse, and adequacy of income, gender, perception of health and personal health compared to other elders. In addition, family members' mental health problems and dependency on elders, and family relationships were found to be significantly associated with elder abuse.

Multiple logistic regression revealed, as shown in **Table 3**, female elders were approximately five times more likely to have been abused by family members than were the elderly males. In addition, elders with family members who had high dependency on them were about six times more likely to have been abused than were elders with family members who had low dependency on them. The elders, who scored in the moderate range for family relationships, were approximately 12 times more likely to have been abused than were elders who had good family relationships.

Table 2 Factors associated with elder abuse (n = 233)

Factors		Abuse n = 34 (%)	Non-abuse n = 199 (%)	*p* value
Adequacy of income	Sufficient with savings	5 (14.71)	100 (50.25)	
	Sufficient with no savings	21 (61.76)	86 (43.22)	
	Insufficient	8 (23.53)	13 (6.53)	*.000
Perception of health	Good	9 (26.47)	84 (42.21)	
	Fair	17 (50.00)	97 (48.74)	
	Poor	8 (23.53)	18 (9.05)	*.026
Personal health compared to other elders	Better	15 (44.12)	101 (50.75)	
	Same	9 (26.47)	74 (37.19)	
	Worse	10 (29.41)	24 (12.06)	*.028
Gender	Male	3 (8,82)	59 (29.65)	
	Female	31 (91.18)	140 (70.35)	*.011
Age	60-69	17 (50.00)	103 (51.76)	
	≥ 70	17 (50.00)	96 (48.24)	.855
Functional status (ADL)	Independent (scores ≥ 17)	34 (100)	198 (99.50)	
	Dependent (scores < 17)	0 (0)	1 (0.50)	1.000
Elder behaviors	Low (scores = 6 – 10)	25 (73.53)	137 (68.84)	
	Moderate (scores = 10.1-14)	9 (26.47)	62 (31.16)	
	High (scores = 14.1-18)	0 (0)	0 (0)	.689
Family behavioral problems	Low (scores = 6 – 10)	23 (67.65)	161 (80.90)	
	Moderate (scores = 10.1-14)	11 (32.35)	38 (19.10)	
	Severe (scores = 14.1-18)	0 (0)	0 (0)	.109
Family mental health problems	Low (scores = 8-13.3)	14 (41.18)	111 (55.78)	
	Moderate (scores = 13.4-18.6)	6 (17.65)	52 (26.13)	
	High (scores = 18.7-24)	14 (41.18)	36 (18.09)	*.010
Family dependency	Low (scores = 5-8.3)	2 (5.88)	22 (11.06)	
	Moderate (scores = 8.4-11.6)	10 (29.41)	118 (59.30)	
	High (scores = 11.7-15)	22 (64.71)	59 (29.65)	*.000
Family relationships	Low (scores < 60%)	1 (2.94)	0 (0)	
	Moderate (scores 60-80%)	9 (26.47)	12 (6.03)	
	Good (scores > 80%)	24 (70.59)	187 (93.97)	*.000

Table 3 Summary of multivariate logistic regression analysis for elder abuse (n = 233)

Factors	B	S.E.	Wald	Sig.	OR	95% C.I.	
						Lower	Upper
Gender							
Male							
Female	1.613	.673	5.737	.017	5.016	1.341	18.768
Family dependency							
Low			14.635	.001			
Moderate	.136	.877	.024	.877	1.146	.205	6.395
High	1.843	.873	4.458	.035	6.317	1.141	34.965
Family relationships							
Good			17.108	.000			
Moderate	2.470	.599	17.007	.000	11.822	3.655	38.237
Poor	7.161	22.241	.104	.747	1287.946	0.000	1.101E+22
Constant	-4.417	1.034	18.254	.000			

Nagelkerke R Square = 0.286; Predictive power = 85.84%

Discussion

The findings revealed almost 15% of the elderly in this study had experienced some form of elder abuse, with almost one-third of them experiencing more than one type of elder abuse. Although participants reported having been physically and financially abused, as well as neglected, psychological abuse was the most common type of abuse they experienced. While the prevalence rate of elder abuse found in this study was higher than had been found among other populations, [8-13] it was lower than prevalence rates found in previous Thai studies.[5, 33] These differences may be because other studies used different operational definitions of elder abuse, [2, 33] had problems with tools or questions used to identify abuse cases, or did not definitely establish criteria regarding what constituted elder abuse.

Elder abuse is a phenomenon that reflects a society's distinction between acceptable and unacceptable interpersonal behaviors.[5, 34] The definition of elder abuse plays a critical role in research studies that focus on the nature and scope of elder abuse, and on their determination of what is, and is not, elder abuse. WHO's Toronto Declaration on Elder Abuse definition (acts or lack of appropriate actions by a person or persons within any relationship, where there is an expectation of trust that causes harm or distress to an elder) was used in this study.[1] Although WHO's definition of elder abuse does not specifically define details of the actions a person or persons may carry out, it emphasizes any action that causes harm or distress an elder is unacceptable and abusive. In fact, some elders have indicated certain behaviors are acceptable, although others have viewed the same behaviors as being unacceptable.[5, 33]

The difference, between what is considered acceptable and unacceptable behavior, might account for the low prevalence of elder abuse in prior studies. [2,5,33] In fact, some studies [5, 33] have reported elders being able to identify abusive behavior, yet indicate they did not perceive themselves as being abused. In addition, some questionnaires used in previous studies have included items that are not relevant to acts done to elders or to the issue of causing harm or distress to

the elderly.[5] Such irrelevant items might account for the high prevalence of elder abuse previously reported.[2,5,33] Therefore, the Interview Guideline for Screening for Elder Abuse (IGSEA) was considered more suitable for identifying elder abuse, since it paid attention to behaviors or actions that caused harm or distress and were directed towards the elderly. The IGSEA also allowed the researchers to make objective decisions as to whether abuse occurred.

Consistent with Lachs and associates'[35,36] findings, the results of this study revealed gender was significantly associated with elder abuse as evidenced by female participants being approximately five times more likely to have been abused than the men. This potentially was due to the women being more economically dependent on others than were the men.[37] In addition, the women may have been more willing to disclose the fact they had been abused than were the men.

Finding a greater likelihood of abuse among elders who had family members with more mental health problems than elders who had family members with fewer mental health problems is similar to prior research. Reis and Nahmiash [25] found caregivers' mental health is a strong predictor of the occurrence of abuse. It seems possible that family members who are moody and susceptible to losing their temper; have less ability to control their behaviors; and, tolerate conflicts or accept others' unpleasant or undesirable behavior are more likely to engaged in abusive behavior.

The positive association found between family members' dependency on the elderly and elder abuse is consistent with the research of Pillemer and Finkelhor [24] who found that elder abuse resulted not from the increased needs of the victims, but from the dependency of the abusers. Family members' over-dependency on aging parents may lead to conflicts and contribute to elder abuse. This also may explain why the elders' relationships with their respective family members were found to be significantly associated with elder abuse. Consistent with prior findings that revealed elders who perceived their family relationships to be bad were more likely to be abused [19] and report being abused in comparison to others, [38] elders, in this study, who perceived a moderate level of family relationships were found to more likely be abused than those who perceived a good family relationship. It appears that elder abuse occurs when negative relationships between the elderly and their family members accumulate, without resolution.

The positive association found between the perception of income adequacy and elder abuse is congruent with the findings of a longitudinal study, wherein poverty was noted to be a risk factor for elder abuse.[35] Thus, it seems probable that inadequate income may contribute to stress between the elderly and their adult children, and lead to increased family conflict and burden and eventual elder abuse.[5,33]

Similar to the findings of previous studies, the elders' perception of health and personal health compared to other elders was found to be positively associated with elder abuse.[2,8,12] Elders, who perceived poor health and thought their health was worse than that of other elders, were found to be more likely to be abused than elders who perceived having good health and believed their health was better than other elders. These findings may be due to those who perceived having poor health needing a great deal of care and financial support, which placed a greater demand on their family members and, thereby, lead to them being abused.[2] In addition, their poor health may have diminished the elders' ability to defend themselves or to escape from abusive situations.

Consistent with prior findings,[2,8,24] no significant association was found between age and

elder abuse. However, different from previous studies, [2, 8, 13, 35, 36] the findings of this study revealed no significant association between functional status and elder abuse. This may have occurred because the number of elders, who were dependent upon others for physical assistance, was too small to detect significant differences. Prior studies have revealed: a) greater functional impairment diminishes elders' capacity to escape from an abusive situation; [39] and, b) elders with functional disabilities may unavoidably increase stress or burden on family members, which leads to abuse. [31]

No significant association was found between the elders' provocative behavior and elder abuse. This finding is contradictory to prior research that noted the behaviors of the elderly were significantly related to elder abuse. [33] One plausible explanation is that Thai elders tend not to discuss their provocative behavior with others.

No significant association was found between family members' behavioral problems and elder abuse. This was not surprising given close to sixty-eight percent of the family members' behavior scores fell into the low score category, which suggest a lack of or low presence of family behavioral problems.

The multiple logistic regression analysis revealed gender, family dependency and family relationships to be significant predictors of elder abuse. These three factors provided a power of prediction of 85.84%. However, these three predictors were different from those found in prior studies.[2, 35, 36] This may be due to the fact that the conceptual framework used in this study included three categories of risk factors for elder abuse (elderly people, family member and family relationships), while prior studies focused only on the elderly [35, 36] and not on family relationships.[2]

Contribution to Knowledge Development

The results of this study provide information regarding abuse perpetrated by family members on their elders. The diagnostic criteria regarding elder abuse, developed and used in this study, should enable community health nurses and other healthcare team members to better assess the occurrence of elder abuse. In addition, the findings should enhance the body of knowledge regarding the factors associated with elder abuse and help in the development of an empirical model to predict elder abuse.

Implications for Further Research and Policy Makers

Not only should this study be replicated to confirm its findings, but the diagnostic criteria for elder abuse should be re-examined and compared among similar groups of elders throughout Thailand, so that standardized elder abuse diagnostic criteria can be developed and appropriately used. To increase public awareness, education programs regarding vulnerability to elder abuse should be developed, especially given the fact that elder abuse appears to be a significant health and social issue throughout Thai society. Finally, because risk factors for elder abuse have not been thoroughly examined, further research related to predictors for elder abuse should be conducted.

Limitations of the Study

This study was based on retrospective accounts of the elders, which necessitated their recall of prior events. Such recall may have been subjected to recall biases. Since the elders, in this study, resided in five specific communities in Thailand, the study findings may not be

generalizable to elders from other communities throughout Thailand. The limited number of elders with functional dependence may have limited the statistical power to detect an association between functional status and abuse, and the fact the desired number (240) of subjects was not obtained may have influenced the study findings. Finally, because Thai elders may be reluctant to disclose provocative behaviors on their part and the presence of abuse by others toward them, the actual magnitude of these issues is likely to be underestimated.

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ความชุก ปัจจัยที่เกี่ยวข้องและปัจจัยทำนายการทารุณกรรมผู้สูงอายุไทย*

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บทคัดย่อ : ความรู้และการศึกษาเกี่ยวกับพฤติกรรมทารุณกรรมต่อผู้สูงอายุไทยมีไม่มากนัก แต่กลับพบว่าความชุกของปัญหานี้สูงเมื่อเทียบกับประเทศอื่นๆ การวิจัยเชิงบรรยายแบบภาคตัดขวางครั้งนี้มีวัตถุประสงค์เพื่อศึกษาความชุกของพฤติกรรมทารุณกรรมต่อผู้สูงอายุและปัจจัยที่เกี่ยวข้อง กลุ่มตัวอย่าง คือผู้สูงอายุ จำนวน 233 ราย ที่อาศัยอยู่ในอำเภอลาดกระบัง เก็บข้อมูลด้วยการสัมภาษณ์โดยผู้วิจัย วิเคราะห์ข้อมูลด้วยค่าสถิติเชิงพรรณา การทดสอบไคสแควร์และการวิเคราะห์ความถดถอยโลจิสติค

การศึกษาพบว่า ร้อยละ14.6 ของผู้สูงอายุมีประสบการณ์ของพฤติกรรมทารุณกรรมต่อผู้สูงอายุตัดสินโดยใช้เกณฑ์การวินิจฉัยพฤติกรรมทารุณกรรม ปัจจัยที่เกี่ยวข้องกับพฤติกรรมทารุณกรรมต่อผู้สูงอายุ ได้แก่ เพศ ความเพียงพอของรายได้ การรับรู้ภาวะสุขภาพ การเปรียบเทียบสุขภาพกับผู้สูงอายุอื่น ปัญหาด้านจิตใจของสมาชิกในครอบครัว การพึ่งพาของสมาชิกในครอบครัว และสัมพันธภาพในครอบครัว มีความสัมพันธ์อย่างมีนัยทางสถิติที่ระดับ .05 ปัจจัยที่สามารถทำนายพฤติกรรมทารุณกรรมต่อผู้สูงอายุคือ เพศ ปัญหาของสมาชิกในครอบครัวด้านการพึ่งพา และสัมพันธภาพในครอบครัว โดยพยากรณ์ได้ร้อยละ 28.6 ผลจากการศึกษาทำให้ทราบถึงพฤติกรรมทารุณกรรมต่อผู้สูงอายุและปัจจัยที่เกี่ยวข้อง สามารถนำไปเพิ่มประสิทธิผลในการวางแผนและจัดกิจกรรมเพื่อป้องกันและจัดการกับปัญหาพฤติกรรมที่สร้างทุกข์ต่อผู้สูงอายุต่อไป

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คำสำคัญ: ความชุกของการทารุณกรรมผู้สูงอายุ; ปัจจัยที่เกี่ยวข้องกับการทารุณกรรมผู้สูงอายุ; ปัจจัยทำนายการทารุณกรรมผู้สูงอายุ; ประเทศไทย

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