Elder Abuse Among Older Adults With Chronic Illness in Northern Thailand: Causes, Consequences, and Coping Strategies

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Abstract

Older adults with chronic illnesses are vulnerable to experiencing abuse due to their reliance on others for their care. A sequential explanatory mixed-method approach encompassing a survey involving 462 older adults with chronic illnesses to examine the nature of elder abuse and predictive factors, and conducting in-depth interviews with a cohort of 30 older adult victims to gain insights into the causes and consequences of elder abuse and their strategies for coping with it. Descriptive statistics and logistic regression were used to analyze the quantitative data, while the qualitative data were analyzed through content analysis. The most prevalent form of elder abuse was psychological abuse at 58.4%. Elder abuse results from a combination of factors specific to both the victims and perpetrators. The outcomes of elder abuse encompass physical pain, emotional pain, diminished self-worth, and a lack of desire to live. Strategies employed to address abuse encompassed running away from home, confiding in trusted individuals, and increased self-reliance. Elder abuse has negative consequences on the physical and psychological well-being of older adult victims. Healthcare professionals, including nurses, play an essential role in prevention by identifying potential abuse, enhancing caregiver skills, promoting healthy family relationships, and working with communities to establish surveillance systems for at-risk older adults. These efforts should be supported by interdisciplinary collaboration with local leaders and government agencies to address issues such as substance abuse.

Keywords

Chronic illness; elder abuse; explanatory mixed-methods; Northern Thailand; older adults

Introduction

Elder abuse is commonly defined as either a single occurrence or repeated acts, as well as the failure to take appropriate action within any relationship characterized by trust, resulting in harm or distress to an older adult (World Health Organization [WHO], 2024). Five forms, including physical, psychological, sexual, financial, and neglect abuse, have increasingly emerged as a global public health concern (Ho et al., 2017; WHO, 2024). A review estimates that approximately 1 in 6 older adults experienced some form of abuse (Yon et al., 2017). Among the different forms of elder abuse, psychological abuse has the highest prevalence (11.6%), followed by financial abuse (6.8%), neglect abuse (4.2%), physical abuse (2.6%), and sexual abuse (0.9%). In Thailand, 14.6% of the older population has experienced elder abuse, with the highest prevalence being psychological abuse (Whangmahaporn, 2019).

Experiencing elder abuse is associated with severe outcomes for victims, including psychological and physical suffering, as well as elevated mortality rates (Ong et al., 2016; Yunus et al., 2019). As people age, they experience changes that cause their functioning to decline, ultimately leading to the development of chronic illnesses (Fong, 2019). Chronic illnesses persist for a year or longer, necessitating continual medical attention (Centers for Disease Control and Prevention [CDC], 2024). In this study, major chronic illnesses are defined to include stroke, heart disease, cancer, diabetes, hypertension, and renal failure. Chronic illnesses often lead to reduced physical functioning and are the primary causes of disability (Fong, 2019; Hou et al., 2018). A disability refers to conditions that affect an individual's ability to perform specific activities and engage with their surrounding environment, such as vision loss (CDC, 2025). This circumstance can lead to a heightened reliance on family and caregivers.

Family caregivers provide unpaid practical assistance to ill or older family members. They are responsible for tasks such as managing medications and medical appointments (Jika et al., 2021; Schulz et al., 2020), which can be stressful and tiring (Isac et al., 2021). As the responsibilities of caring for older people increase physically, emotionally, and cognitively, caregivers may also blame them and act aggressively or violently (Acob, 2018; Kulachai, 2018). The underreporting of cases may prevent victims and abusers from receiving help (Burnes et al., 2019). Older people often do not report violence, especially when it is committed by family or friends (Dow et al., 2020; Fraga Dominguez, 2021). This may be because they regard family violence as private or fear more injury (Acob, 2018). Elder abuse causes physical and mental harm to older people, including depression and injury (Kulachai, 2018). Addressing and preventing it is relatively complex; this may lead older adults with chronic conditions to be more vulnerable to assault.

Previous research confirmed that functional dependence, chronic illness, gender, poor physical health, cognitive impairment, mental health, low income, and bad family relationships have been associated with elder abuse (Du & Chen, 2021; Timalsina, 2021; Whangmahaporn, 2019). Moreover, some studies have focused on caregivers and risk factors for abuse, such as living with older dependents, relationship conflicts, high stress, a history of mental illness, alcohol abuse, or drug abuse (Conrad et al., 2019; Kohn & Verhoek-Oftedahl, 2011; Orfila et al., 2018; Pinyopornpanish et al., 2022). These characteristics of both abusers and victims raise the risk of elder abuse.

In Thailand, elder abuse occurs in a unique sociocultural context. Most older adults live in

extended families and depend heavily on family members for daily care due to traditional values of filial piety and limited access to institutional care. However, socioeconomic changes such as urbanization and the migration of younger family members for work can lead to neglect, abandonment, or unintentional abuse. Forms of abuse reported in Thailand include verbal abuse, financial exploitation (e.g., scams or fraud), abandonment, and even physical abuse. Older adults often feel shame and fear of social stigma, which prevents them from disclosing abuse. As such, abuse is frequently underreported and hidden within households or communities (Kulachai, 2018; Pinyopornpanish et al., 2022; Whangmahaporn, 2019).

A brief synthesis of international and Thai literature reveals differences in perpetrators and contextual factors—family members are the most common perpetrators in domestic settings, while community-based abuse often involves fraud or neglect from neighbors or acquaintances, and institutional abuse may arise from overburdened caregivers or systemic neglect. This study, therefore, focuses on all forms of elder abuse occurring in community settings in Thailand.

However, previous research has primarily focused on investigating the prevalence, risk factors (Du & Chen, 2021; Whangmahaporn, 2019), and types of elder abuse among the general older population (Acob, 2018; Ludvigsson et al., 2022; Whangmahaporn, 2019), rather than explicitly addressing individuals with chronic illnesses. There is a significant gap in our understanding of how elder abuse affects older adults with chronic illnesses, who often experience declining health and dependence on others. In addition, prevalence studies regarding elder abuse among older adults with chronic illness in Thailand have not been conducted.

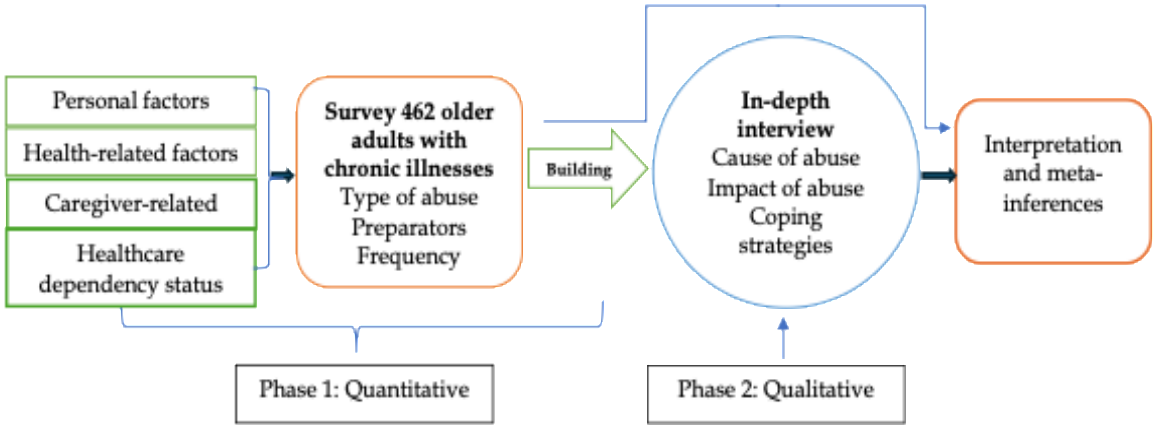
As such, this study aimed to examine elder abuse among older adults with chronic illness, employing an explanatory mixed-methods approach. The study was conducted in two phases. The first phase was a quantitative study to investigate the prevalence and contributing factors of elder abuse. In this phase, we reviewed existing literature and previous studies to identify four categories of factors that contribute to elder abuse, including personal factors, health-related factors, caregiver-related factors, and healthcare dependency status. In the second phase, we conducted a qualitative study to gain a deeper understanding of the causes and consequences of elder abuse in order to explore further strategies to manage and address elder abuse.

Methods

Study design

This research employs an explanatory sequential mixed-method approach (Creswell & Plano Clark, 2017). This design involved a quantitative cross-sectional survey, followed by the collection of qualitative data through individual semi-structured interviews in the second phase to elucidate the quantitative findings. The qualitative findings were ultimately integrated with the quantitative results (Figure 1).

Figure 1: An Explanatory Sequential Mixed-Method Research Design for This Study



Note: Adapted from Cresswell and Plano Clark (2017)

The quantitative phase

Sample and participants

The sample size of the first phase was determined using Cochran's *d* formula, where *N* was assumed to be known, as they were experiencing elder abuse, with a 95% confidence level to find the number of older adults with chronic illness and factors that contribute to elder abuse. The researchers increased the sample size by 20% to account for potential attrition. The sample group consisted of 462 older adults with chronic illnesses from provinces in the northern region of Thailand. The participants were selected using a multi-stage sampling method.

The use of multi-stage sampling enabled the inclusion of districts and sub-districts with varying community contexts, ranging from urban to rural areas, which supports the diversity and generalizability of the findings. In the first stage of the multi-stage sampling process, a random sampling method was employed to select the provinces, districts, and sub-districts for the study. Four provinces in the northern region of Thailand—Uttaradit, Lampang, Lamphun, and Chiang Mai—were selected for this study. Then, the proportion of sample groups was determined, and data collection was carried out among older adults with chronic illnesses according to the ratio of each province, with an equal number from each province, to ensure that there would be no bias.

The sample size was deemed appropriate for examining ten factors contributing to abuse based on the rule of events per variable, which recommends a minimum of twenty observations per variable for regression analysis (Austin & Steyerberg, 2017). The inclusion criteria were: (1) those aged 60 years or older, (2) diagnosed with chronic disorders for a minimum duration of one year, such as heart and cerebrovascular diseases, and (3) proficiency in the Thai language. Nevertheless, older adults with dementia, confusion, Activities of Daily Living (ADL) with scores less than 12, alcohol dependence, or communication impairments were excluded. Older adults with alcoholism and lower ADL scores needed special attention from their caregivers, making interviews impractical. Some individuals also experienced confusion and communication difficulties, further complicating data collection.

Data collection

Data collection for the study began in September 2022 and continued until January 2023. Inclusion criteria were established to select the sample group, and screen questionnaires were used, such as the Activities of Daily Living (ADL) and the Alcohol Use Disorders Identification Test (AUDIT), a WHO-developed tool to assess alcohol use behavior and risk (Saunders et al., 1993). After selecting the sample group, coordinators from each area visited the designated health promotion hospitals to meet with the group and extend an invitation to participate in the next stage of the study.

Research teams conducted a survey involving 462 older adults with chronic illnesses—the first step in initiating the data collection process involved home visits for each older adult. The researcher behaved like a typical house visitor with a chronic condition. Begin by conducting a health check, respecting their private time, and ensuring that all information is disclosed openly and honestly. The researchers instructed the older adults to complete the questionnaire, allowing them to respond independently. If family members were present during data collection, researchers would accommodate the wishes of the older person or their companion.

During the survey process, research assistants read questions aloud to older persons and assisted them in responding if they had visual impairments. The survey had 462 respondents. The data were gathered through questionnaires, including:

1) Experiences of elder abuse: The study employed a researcher-created questionnaire, informed by an extensive literature analysis, to evaluate the experience of elder abuse (Van Royen et al., 2020; Whangmahaporn, 2019). The elder abuse survey encompasses five categories: physical, psychological, sexual, financial, and neglect. The survey comprises 27 inquiries regarding abuse incidents from the previous year. Self-reported elder abuse was answered by indicating whether they had experienced abuse or not.

    - For psychological abuse, participants were asked, "Has anyone spoken to you in a way that made you feel humiliated, threatened, or worthless?"
    - For physical abuse, the question was, "Has anyone ever hit, pushed, or physically hurt you in any way?"
    - For financial abuse, participants were asked, "Has anyone taken your money, possessions, or controlled your finances without your consent?"
    - For neglect, the question was, "Has anyone failed to provide you with necessary care, such as food, medication, or help with daily activities?"

    If the participants had experienced abuse, they were asked to rate the frequency of their experiences on a 3-point Likert-type scale ranging from 1 (*1–2 times*) to 3 (*> 5 times*). The questionnaire also asked participants to identify the perpetrators for each type of abuse they experienced within the last year by selecting from a predefined list. This list included family members, healthcare workers, neighbors, and other community members. The total score ranged from 0 to 81 points. This questionnaire had content validity ranging from 0.67 to 1.00 and a Cronbach's alpha of 0.81.

2) Personal factors: Sociodemographic characteristics, including sex, age, occupation, and number of family members, were collected. The occupation was divided into four categories: "Unemployed," "Employee," "Farmer," and "Self-employed or merchant." The number of family members was classified as "≤ 2 people" or "> 2 people."

3) Health-related factors: The two components of health-related factors are disability and health status. Health status was classified as "1 to 2 comorbidities" and "> 2 comorbidities." Disability such as vision loss, loss of a limb, and cognitive impairment were classified as either "yes" or "no."

4) Caregiver-related factor: Caregiver-related factors were the primary caregivers and family relationships. The simple question from primary caregivers, "Do you have primary caregivers or not?" is categorized as either "yes" or "no." The feelings of older people were rated according to the level of their family relationships. The participants answered "poor," "fairly good," and "good."

5) Healthcare dependency status: Hospitalization and treatment histories were used as indicators of older people's dependence on their caregivers. Hospitalization within the past year was categorized as either "yes" or "no." Meanwhile, the type of care for chronic conditions was determined based on treatment history and categorized as either "continuous care" or "intermittent care."

Data analysis

Data were analyzed using SPSS version 27. Descriptive statistics, such as frequency and percentage, were used to analyze personal information. The factors influencing elder abuse were examined using logistic regression analysis. To identify variables independently associated with elder abuse, multivariable models included variables with a p value of .25 or less in the unadjusted analyses. A univariate (unadjusted) logistic regression model was applied for each factor individually, as well as a multiple logistic regression model that included all relevant factors. The variance inflation factor (VIF) was used to assess multicollinearity prior to model testing. Any VIF value below 10 indicates no evidence of multicollinearity (Schroeder, 1990). The test for confounding was assessed by the coefficient (β) and standardized residuals.

The qualitative phase

Sample and participants

A purposive sampling technique was used to select participants from a subset of the same quantitative sample based on their experience with elder abuse scores. Older adults with a score of 27 or higher for experiencing elder abuse were chosen to participate in interviews (27 points: 23 participants, 28 points: 5 participants, 31 points: 2 participants). A threshold score of 27 indicates that the participant, on average, reported experiencing at least one type of abuse across all items, with some at a frequency of more than once. This cutoff point was determined to ensure the inclusion of participants who had clear and relevant experiences to share, thereby contributing to the depth and richness of the qualitative findings. This study initially achieved interview saturation with Participants 27, 28, and 29. Therefore, the total number of key informants in this phase is 30.

Data collection

Qualitative data was collected between February 2023 and April 2023. The recruitment process was facilitated by nurses at health promotion hospitals. Before the researchers' visit, nurses screened potential participants who expressed interest and deliberately selected those who met the inclusion criteria. The researchers conducted in-depth interviews with participants at convenient times and places and recorded the interviews only after obtaining permission from the participants. Examples of open-ended interview questions included: "Could you tell me a little more about what you've been through?" "Could you share any experiences where you felt abandoned, ignored, or not taken care of? "Could you describe how the experience has affected your overall well-being?" "Did you seek help or talk to anyone about what happened? Why or why not?" and "What did you do because of your experience?". Probing and respective questions were also asked. Each interview lasted between 45 and 60 minutes.

Data analysis

The qualitative data were analyzed using content analysis (Hsieh & Shannon, 2005). The researchers transcribed the audio recordings verbatim, capturing the exact words spoken, and typed them into a Microsoft Word document. Both researchers simultaneously assigned codes to the transcript using Microsoft Word's comment tool, reaching a consensus. Then, the researchers organized codes into categories within three predefined themes—causes, consequences, and management of elder abuse—using a Microsoft Excel sheet until an agreement was reached. However, the process of assigning the codes was inductive, driven by the data from our study. Subsequently, we convened with an external expert to deliberate and reach a consensus on the list of categories. The emerging categories from the data were shared with participants to confirm the authenticity of their experiences and ensure that they were accurately represented in the data.

Ethical considerations

This study obtained ethical approval from the Ethics Committee in Thailand (Approval BCNCT No. 02/2567, from August 2022 to August 2023). The researchers ensured that they prioritized the rights of the participants, particularly by obtaining their informed consent. All participants were informed that their participation was voluntary and that they could withdraw from the study at any time without providing a reason. If the participants felt uneasy sharing their stories during the data collection process, the researcher would pause, give them space to relax, and then inquire whether they wanted to continue. Any personally identifiable data was anonymized. All information was kept private, and passwords were protected between the older adults and the researchers.

Results

Quantitative findings

According to Table 1, the study sample consisted of 462 chronically ill older adults. More than 60% of elder abuse victims were female; the mean age was 70.5 years (SD = 8.7). Most participants had two or fewer family members (64.3%) and were unemployed (66.4%).

Table 1: Sample Characteristics (*N* = 462)

Characteristic	Experience of elder abuse	
	No (*n* = 192)	Yes (*n* = 270)
	n (%)	*n* (%)
Gender		
Male	102 (44. 3%)	128 (55.7%)
Female	90 (38.8%)	142 (61.2%)
Age		
≤ 70 years	105 (42.9%)	140 (57.1%)
> 70 years	87 (40.1%)	130 (59.9%)
Number of family members		
≤ 2 people	92 (35.7%)	166 (64.3%)
> 2 people	100 (49.0%)	104 (51.0%)
Occupation		
Unemployed	72 (33.6%)	142 (66.4%)
Employee	37 (39.8%)	56 (60.2%)
Farmer	67 (55.8%)	53 (44.2%)
Self-employed /merchant	16 (45.7%)	19 (54.3%)
Primary caregiver		
None	28 (20.1%)	111 (79.9%)
Son	44 (49.4%)	45 (50.6%)
Daughter	37 (74.0%)	13 (26.0%)
Daughter-in-law/ Son-in-law	21 (36.8%)	36 (63.2%)
Grandchildren	25 (46.3%)	29 (53.7%)
Spouse	37 (50.7%)	36 (49.3%)
Level of family relationships		
Poor	11 (11.6%)	84 (88.4%)
Fairly good	136 (53.1%)	120 (46.9%)
Good	45 (40.5%)	66 (59.5%)
Health status		
Hypertension	59 (60.2%)	39 (39.8%)
Diabetes	41 (48.2%)	44 (51.8%)
Heart disease	15 (33.3%)	30 (66.7%)
Other diseases (e.g., renal failure, stroke, cancer)	19 (24.4%)	59 (75.6%)
> 2 diseases	58 (37.2%)	98 (62.8%)
Disability		
No	179 (44.4%)	224 (55.6%)
Yes (e.g., vision, hearing, mild cognitive impairment)	13 (22.0%)	46 (78.0%)
Treatment history		
Continuous care	145 (43.5%)	188 (56.5%)
Intermittent care	47 (36.4%)	82 (63.6%)
Hospitalization history		
No	180 (48.4%)	192 (51.6%)
Yes	12 (33.3%)	78 (86.7%)

Psychology was the most common form of elder abuse among chronically ill older adults at 58.44%, while physical abuse was the least common at 7.58%. The survey found no sexual abuse (Table 2).

Table 2: Number and Percentage of Abused Elders (*N* = 462)

Form of elder abuse	Number	Percentage
Psychological abuse	270	58.44
Neglect	186	40.26
Financial abuse	122	26.41
Physical abuse	35	7.58

Sons-in-law and daughters-in-law were the most common perpetrators of psychological abuse (38.15%) and neglect (39.78%). Relatives were the most common perpetrators of financial abuse (29.51%), while spouses were the most common perpetrators of physical abuse (60%) (Table 3).

Table 3: Number and Percentage of Perpetrators

Perpetrator	Form of elder abuse			
	Psychological abuse (*n* = 270)	**Physical abuse (*n* = 35)**	**Financial abuse (*n* = 122)**	**Neglect (*n* = 186)**
Son/daughter	77 (28.52%)	14 (40%)	29 (23.77%)	43 (23.12%)
Daughter-in-law/son-in-law	103 (38.15%)	-	-	74 (39.78%)
Grandchild	39 (14.44%)	-	10 (8.20%)	14 (7.53%)
Relative	-	-	36 (29.51%)	40 (21.51%)
Spouse	17 (6.30%)	21 (60%)	-	-
Healthcare provider	34 (12.59%)	-	-	-
Stranger	-	-	24 (19.67%)	15 (8.06%)

Table 4 indicates strong correlations ($p < .05$) between elder abuse in older adults with chronic illnesses and factors such as family size, primary caregiver, familial relationships, occupation, health status, treatment history, and hospitalization history. Older adults with a history of hospitalization had nearly three times the chance of experiencing violence compared to those without such a history (95% CI [1.56, 5.47]). Older adults with one or two chronic health conditions had 74% reduced odds of experiencing abuse compared to those with more than two chronic health conditions (95% CI [0.09, 0.76]). Participants with relatively positive parental relationships exhibited a 90% reduction in the likelihood of adult aggression compared to those lacking such relationships (95% CI [0.03, 0.37]). Older adults with a history of continuous treatment had 98% reduced odds of encountering violence compared to those with a history of intermittent care (95% CI [0.00, 0.10]). Self-employed or merchant individuals exhibited an 88% reduced risk of encountering violence compared to the unemployed (95% CI [0.02, 0.93]).

Table 4: Multiple Logistic Regression Analysis of Factors Associated with Elder Abuse among Older Adults

Variable	Unadjusted logistic regression	*p* value	Adjusted logistic regression	*p* value
	OR (95% CI)		OR (95% CI)	
Personal factor				
Gender				
Male				
Female	0.97 (0.63, 1.48)	.872	-	-

Variable	Unadjusted logistic regression	*p* value	Adjusted logistic regression	*p* value
	OR (95% CI)		OR (95% CI)	
Age				
≤ 70 years				
> 70 years	1.14 (0.75, 1.76)	.538	-	-
Number of family members				
≤ 2 people				
> 2 people	0.51 (0.28, 0.92)	.025*	0.09 (0.03, 0.26)	.000*
Occupation				
Unemployed				
Employee	0.77 (0.46, 1.27)	.302	0.34 (0.12, 0.94)	.038*
Farmer	0.40 (0.25, 0.63)	.000*	0.23 (0.08, 0.68)	.008*
Self-employed/ merchant	0.60 (0.29, 1.24)	.166	0.12 (0.02, 0.93)	.000*
Caregiver-related factor				
Primary caregiver				
None				
Yes	0.25 (0.15, 0.39)	.000*	0.03 (0.01, 0.14)	.000*
Family relationships				
Poor				
Fairly good	0.16 (0.06, 0.23)	.000*	0.10 (0.03, 0.37)	.001*
Good	0.19 (0.09, 0.40)	.000*	0.44 (0.09, 2.18)	.317
Health-related factor				
Health status				
> 2 comorbidities				
1–2 comorbidities	2.02 (1.59, 2.56)	.01*	0.26 (0.09, 0.76)	.012*
Disability				
Yes				
None	0.59 (1.01, 3.26)	.048*	0.55 (0.23, 1.30)	.173
Healthcare dependency status				
Treatment history				
Intermittent care				
Continuous care	3.10 (1.97, 4.87)	.001*	0.02 (0.00, 0.10)	.000*
Hospitalization history				
No				
Yes	2.40 (1.47, 3.95)	.001*	2.92 (1.56, 5.47)	.001*

Note: Number of observations = 462; Nagelkerke R^2 = 0.44; $p < .05$*; OR = odds ratio; CI = confidence interval*

Qualitative findings

In the qualitative phase of the study, 30 older adults (17 women and 13 men) with chronic illness participated. The participants' age range was between 60 and 81. The data collected from the interviews provides valuable information about the participants' experiences of abuse. The data were organized into three themes: the causes and consequences of elder abuse, as well as management strategies for addressing these issues.

The causes of elder abuse

Older adults shared the causes of elder abuse in five main categories. These categories encompass causes attributed to the perpetrators themselves and those attributed to the individuals perpetrating the violence.

Dependency on family caregivers: Older adults explained that, due to chronic illnesses or disabilities, they relied on their family members for assistance with daily activities. This dependence can lead to dissatisfaction and occasional outbursts, exemplified as

> *"I asked my daughter to prepare my meals with less sugar, oil, or salt. She complained because it took extra time, and everyone else ate regular meals."*
> (Participant 22, male, 62, diabetes mellitus (DM) and hypertension (HT), unemployed, lives with daughter)

Older adults with disabilities, like those who are bedridden, depend significantly on family for daily care. This can strain caregivers, leading to exhaustion and, sometimes, physical abuse, or it may result in inadequate daily care for older adults. One participant said,

> *"I was unable to help myself for several years since I had a stroke. I depended on my son for everything. He complained, and sometimes he became frustrated and hit me."*
> (Participant 11, male, 68, post-stroke, DM and HT, unemployed, living with son)

Financial difficulties: Some older adults reflected on their financial problems, including joblessness, unemployment, and lack of assets. This can result in their children showing little interest in taking care of them or refusing to provide care, exemplified as

> *"My son hasn't visited me since he received his share of the land. Now that I have no assets left, he did not come to take care of me, leaving me alone."*
> (Participant 9, female, 72, DM, HT, dyslipidemia (DLP), and chronic kidney disease (CKD), unemployed, living with son)

Caregiver burden: Some older adults experience occasional neglect, lack proper medical treatment and medications, especially those with intermittent care or a history of hospitalization. Older adults reported that their family members frequently expressed concerns about having limited time to meet their needs. Family members were often reluctant to stay overnight with them in the hospital, such as

> *"When it came to doctor's appointments for medication refills, I asked my son to escort me early in the morning. He complained that I was a burden to him and did not take me to the appointments."*
> (Participant 7, male, 71, DM, HT, DLP, and benign prostatic hyperplasia (BPH), unemployed, living with son)

Family conflict: Older adults provided information about conflicts within the family regarding family property, which their children often perceive as unjust. These conflicts involved hurtful words and arguments, and when asked for assistance, the children responded with indifference and a lack of concern. One participant mentioned,

> *"The younger child was also dissatisfied, wondering why their older brother had more property. They often used hurtful language when I requested assistance, leaving me at a loss for words."*
> (Participant 23, female, 75, HT and CKD, self-employed, living with nephew)

Desire for property: Some older adults reported that their grandchildren or descendants expressed a strong interest in acquiring assets, such as money or land. Their descendants deceived them into signing documents or exploiting their assets. Moreover, some older adults have had their money stolen, and once their assets were taken, they were left abandoned.

> *"Before, I had land and money. My nephew deceived me into signing documents transferring the land. Now, I have no assets and no money to use."*
> (Participant 17, female, 67, DM, self-employed, living with nephew)

The consequences of elder abuse

Elder abuse inflicts physical injuries and profound psychological trauma on victims. Physical harm is evident, while emotionally, victims often display avoidance behaviors and express a diminished will to live, reflecting the severe psychological impact of abuse.

Physical pain: Older adults indicated that physical assault leads to bruises, soreness, and discomfort throughout the body. Some participants even required hospitalization if they were struck with a hard object by their children or grandchildren, leading to wounds and broken bones. One participant declared,

> *"When he hit me, my arm was completely bruised. He hit my head, too; it hurts. Then there were these greenish bruises. I had to take medication."*
> (Participant 8, female, 72, HT and DM, unemployed, living with nephew)

Emotional pain: Some older adults experience being spoken to disrespectfully by family members, causing them to feel sadness, disappointment, and heartache. Sometimes, they feel so angry that they cannot forgive their offspring for their actions and feel a deep sense of burden. One participant claimed,

> *"They have no sympathy left for me…I secretly cry regularly. I feel frustrated and don't know what to do. I can't speak. We argue again."*
> (Participant 20, male, 69, stroke, DM, and HT, self-employed, lives with daughter and son-in-law)

Moreover, the participants had stress when they were subjected to violence by family members. They experience anxiety and fear that they will be subjected to abuse again, such as,

> *"I feel scared when I see him drink alcohol because if he gets drunk, he'll think about the land that I gave his brother…he will hit me again."*
> (Participant 16, female, 62, gouty arthritis, HT, and DLP, farmer, living with son and niece)

Diminished self-worth: Some older adults experience a diminished feeling of self-worth when they are unable to work or possess fewer possessions, particularly during illness, when they depend on others for care. This may result in emotions of worthlessness due to a lack of equivalent care or attention from family members. One participant said,

> *"I had to stay home and couldn't work. I had no money. I became no different from a stray dog on the street. I had to beg for food and water from them. I become a burden to them. They can't help me..."*
>
> (Participant 22, male, 62, DM and HT, unemployed, living with daughter)

No desire to live: Some older adults experience abuse, deceit, and loss of possessions from family members. These experiences are often accompanied by health issues that make it difficult for them to care for themselves and express a desire to end their lives. This led them to attempt suicide multiple times, as one older person described, such as

> *"When will I die? I just want to die. I'm only living because I must, not because I have any money to spend…I can't do anything about it. I've even thought about ending it all several times, but my neighbors and relatives have seen me before."*
>
> (Participant 17, female, 82, stroke, HT, and DLP, unemployed, living with son and niece)

The management strategies

When elder abuse occurred within the family, the older adults employed various coping techniques. They expressed that when coping with experiences of abuse, they have to handle things on their own.

Running away from home: The older adults provided information that they had to leave their homes to escape from the problems they were facing. By staying with relatives, they prevented the abusers from causing harm in the presence of others, exemplified by,

> *"I couldn't live there. If I had stayed at home, my son would have hit me again. Now, I had to stay with my older sister, and my son cannot hit me. I was scared and didn't want to go back."*
>
> (Participant 19, female, 66, HT, farmer, living with son)

Confiding in a trusted individual: Some older adults were too afraid and ashamed to ask for help. They told reliable relatives or family members their feelings:

> *"I was unable to talk with anyone else. I could express myself and share with a close family. That was my only choice. I couldn't approach anyone else. It was embarrassing."*
>
> (Participant 26, female, 64, DM and DLP, employee, living with daughter and son-in-law)

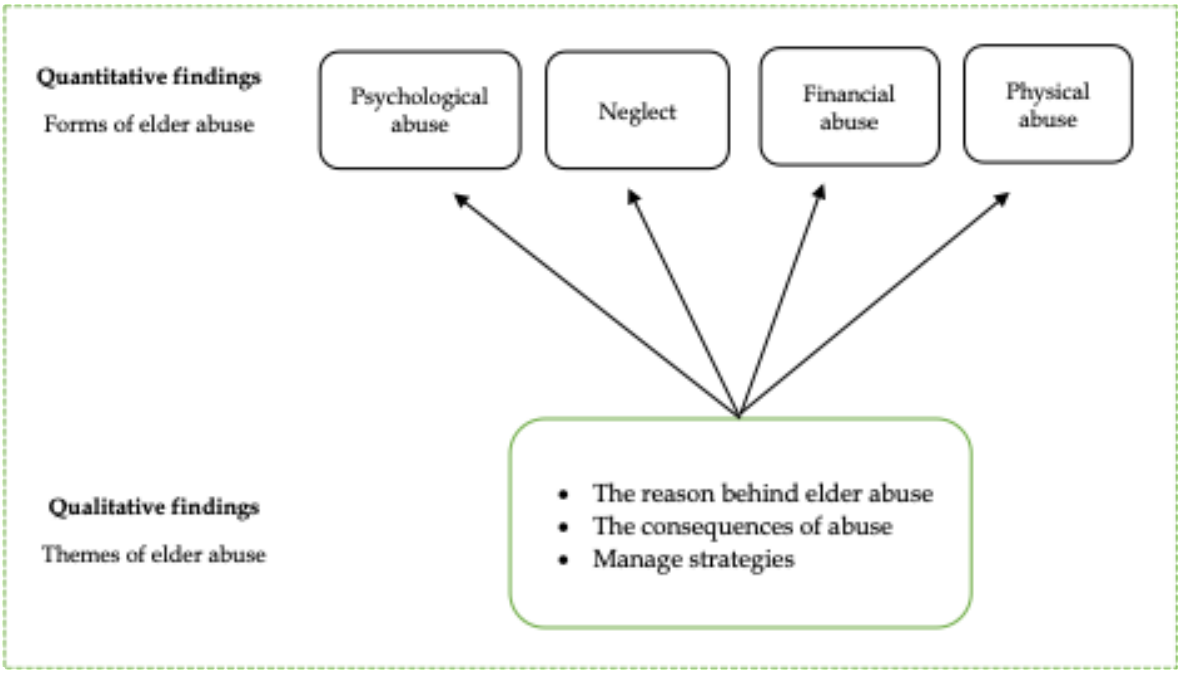
Increased self-reliance: Some older adults accept their situation and focus on maintaining as much independence as possible. They took on tasks like dressing and eating to reduce the burden on their caregivers. One participant voiced,

> *"I tried to do many things by myself, such as eating and going to the bathroom, because I didn't want to burden my grandchildren."*
> (Participant 15, male, 66, with HT and right leg weakness, farmer, living with son and daughter-in-law)

Mixed-method results

Four forms of elder abuse emerged through the combination of quantitative and qualitative results, elucidating the similarities and differences between each form of abuse. Additionally, qualitative findings provide explanations for the quantitative manifestations of elder abuse (Figure 2).

Figure 2: Illustration of Mixed Methods Results



Psychological abuse: Psychological abuse occurs when older adults need family assistance with medication administration. Long-term dependency caused caregiver difficulties, leading to psychological abuse, such as harsh accusations and scolding, disagreements among older family members over assets, and aggressive language and tension. Psychological abuse lowered their self-esteem and caused misery. However, they attempted to manage daily tasks and their chronic illnesses on their own.

Neglect: Older adults may experience neglect due to financial issues, including a lack of assets or insufficient funds. They were also overlooked as caregivers perceived them as burdensome, leading to feelings of worthlessness, similar to older adults who had experienced psychological abuse. They endeavor to carry out daily tasks independently, including managing chronic illnesses, such as arranging for someone to pick up medication and attend medical appointments, to minimize their reliance on caregivers.

Financial abuse: In contrast to previous forms, older adults were faced with financial abuse, specifically when other people, such as family members or relatives-in-law, desire their

property. Those people were deceived and had their belongings, including money and land, taken away from them. They felt sad and did not want to continue living because life became challenging, especially when they had lost everything. However, they coped with their negative experiences and emotions by talking to trusted individuals.

Physical abuse: Physical abuse was caused by the same factors as psychological abuse. Older adults were hit and pushed, resulting in scrapes, scratches, shattered bones, and suffering. They felt anger and insecurity and decided to flee from home. They were fearful of facing abuse again, prompting them to escape the situation by seeking refuge with relatives who could assist in ensuring their safety.

Discussion

This study investigates elder abuse among older adults with chronic illness in Thailand from the perspective of the older victims. It provides valuable insights into the underlying causes of elder abuse, the effects it can have, and the coping strategies used by victims.

This study highlights psychological abuse as the most common form experienced by older adults with chronic illnesses, consistent with prior research (Acob, 2018; Whangmahaporn, 2019). This form of abuse frequently happens to older adults who depend on others for care, leading to conflicts and potential aggression. In the qualitative interview, we learned that family caregivers, especially daughters or sons-in-law, frequently used words that made the older adults feel sad, such as scolding or criticizing their self-care or expressing that the older adults were a burden. This finding might reflect that verbal abuse is often perceived as a behavioral characteristic of psychological abuse.

The study findings indicate that elder abuse in older adults with chronic illness is influenced by personal, health-related, and caregiver-related factors, as well as dependency status, such as health status. These findings support prior research linking elder mistreatment to illness and dependency (Atim et al., 2023; Kulachai, 2018; Ludvigsson et al., 2022; Whangmahaporn, 2019). Older adults were prone to maltreatment since they relied on caretakers for their chronic illnesses. According to interviewees, family members ridiculed, blamed, disregarded, and refused to care for them, such as hospitalization or follow-up. Therefore, developing interventions to reduce the burden on caregivers of older adults with chronic illnesses and ensuring they receive adequate baseline care for their conditions is crucial.

Strengthening better relationships among family members may help reduce vulnerability to abuse among older adults with chronic illness in this study. The qualitative data showed that family property issues caused poor relationships and a propensity to elder abuse. In many Thai families, family members who care for the older inherit more property, which can lead to jealousy and abuse from other family members. When older adults wish to share their assets equitably among their descendants, it can make their caregivers unhappy, as they may have hopes of inheriting these assets. Dissatisfaction may lead to misuse (Whangmahaporn, 2019). Envy and conflict may arise in Thai extended families. Members may neglect older people because they value others more. Family intervention to prevent elder abuse requires understanding and supportive relationships within families.

The quantitative and qualitative data from this study showed that elder abuse has significant physical and psychological consequences. The qualitative data revealed that physical abuse

can cause injuries and terror, while psychological neglect and financial abuse can cause mental misery and a lack of desire to live. Abused older individuals had impairment and depression, as supported by prior research (Kumar & Patra, 2019; Ludvigsson et al., 2022; Yunus et al., 2019). Our research advocates for the implementation of psychological interventions to safeguard the well-being and mental health of older adults with chronic illnesses, emphasizing prevention and assistance for victims.

It has been emphasized that older adults with chronic illnesses who are experiencing abuse employ coping strategies that involve avoiding problems, self-reliance, and disclosing their experiences to trusted individuals. However, they often rely on self-reliant coping mechanisms, such as self-care and fleeing home (Acob, 2018; Burnes et al., 2019; Simmons et al., 2022; Whangmahaporn, 2019). Some older adults often sought emotional support and secure housing from trusted relatives or family members, imagining their situation to be better than it was (Kumar & Patra, 2019). In this study, they are experiencing any form of abuse, whether verbal or physical abuse, which can lead older people to feel ashamed and prevent them from disclosing their experiences to others, particularly to healthcare providers. In the Thai context, such topics are considered sensitive (Whangmahaporn, 2019). Private family matters should be kept confidential to prevent potential damage to one's reputation. Confident older adults may perceive themselves as insufficient in self-care, while others may seek to evade society's unfavorable judgments regarding their grandchildren. Establishing a healthcare environment where older adults feel at ease sharing their experiences may enhance their access to necessary assistance when confronting abuse.

Limitations of the study

This study has several limitations. First, it focused solely on older adults with chronic illnesses in Thailand, which may limit the generalizability of the findings to other populations or contexts due to cultural, social, economic, and healthcare system differences. Second, older individuals with significant dependency (ADL score < 12), confusion, or disabilities were excluded, potentially omitting those most vulnerable to abuse. Third, as elder abuse is a sensitive topic, underreporting may have occurred despite confidentiality assurances. Lastly, while household income and family relationship quality were included to reflect the caregiving burden, specific caregiver characteristics, such as education and occupation, were not directly measured. Future research should incorporate these socioeconomic variables to provide a more comprehensive understanding of elder abuse risk.

Conclusion

Psychological abuse is prevalent among older adults with chronic illnesses, followed by neglect, financial abuse, and physical abuse. The underlying reasons for elder abuse were attributed to both the older adults themselves and the perpetrators. Experiencing abuse has consequences not only on physical health but also on psychological well-being. Coping strategies included running away from home, confiding in trusted individuals, and increasing self-reliance. Preventative strategies should involve individually tailored interventions aimed at reducing vulnerability and ensuring an acceptable minimum standard of care for older adults with chronic illnesses.

This study highlights the need for nursing interventions aimed at preventing and reducing elder abuse by emphasizing screening efforts and understanding its underlying causes and contributing factors. Targeted interventions for caregivers can help alleviate the burden on primary informal caregivers of dependent older adults by assessing their needs and linking them to appropriate support services. Nurses and healthcare providers should develop educational programs to enhance caregiving skills and foster healthy family dynamics, thereby minimizing the risk of abuse. Establishing a community-based surveillance system, such as "Age Watch," supported by interdisciplinary collaboration, is crucial for identifying older adults at risk. The implementation of clear reporting procedures involving community leaders and government agencies, along with strategies to address substance abuse, is also vital. Future research should focus on high-risk caregivers and explore how to tailor interventions best to prevent elder abuse effectively.

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