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The Frequency of and Contributing Factors to the Psychological Abuse of Older People in Nursing Homes in Turkey

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ABSTRACT

Objective: This study investigated the frequency of the psychological abuse of older people in nursing homes and contributing factors.

Methods: The population for this methodological and descriptive study was 161 elderly individuals living in two nursing homes in Istanbul. The data were collected using Barthel's Index, the Standardized Mini Mental Test (SMMT) and the Elders' Psychological Abuse Scale (EPAS). The scale's reliability was tested using the Kuder–Richardson Formula 20 (KR–20) and test–retest analysis. Its validity was tested using the Content Validity Index (CVI) and concurrent validity. The frequency of abuse is presented using numbers, percentages, and means. The relationship between the independent variables and abuse was evaluated using the t-test and Kruskal–Wallis variance analysis.

Results: The participants' mean age was 73.5 years (42.2% were older than 80 years); 44.7% were female. The mean scores were 5.57 ± 4.12 on the EPAS and 89.13 ± 17.13 on Barthel's Index. The KR-20 reliability coefficient for the scale was 0.80. The test–retest reliability was 0.97; p=0.000, and the content validity index was 90%. Of the participants, 14.3% were exposed to psychological abuse. Individuals with high dependency and low levels of income, education and mental capacity were exposed to psychological abuse more frequently (p <0.05).

Conclusion: The Turkish version of the originally English EPAS is reliable and valid.

Keywords: Psychological abuse, older people, nursing homes, scale

1. INTRODUCTION

Abuse is a preventable social problem that leaves physical, psychological, and social scars on elderly individuals. According to the World Health Organization (WHO), elder abuse is defined as 'a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person' (1). The global prevalence of elder abuse in the community setting is 15.7%, or approximately one in six older adults (2). Abuse takes on many different forms that include physical, sexual, emotional, and financial abuse as well as neglect. Abuse is often observed in co-occurrence with other adverse situations. When older people become dependent or semi-dependent upon another for their care, they may become defenseless in the face of physical, psychological, emotional, sexual, and, economic abuse and neglect (3,4).

Studies conducted in Turkey have found that the rate of physical abuse among elderly individuals ranged between 4.2% and 25.7% whereas the rate of psychological abuse was between 5.9% and 40.5% (4-7). In various but limited number of studies conducted in Turkey on this matter, rates have been reported as being between 2.1%-33% for economic exploitation, between 0.4%-9% for sexual abuse, and between 7.6%-8.2% for neglect of older individuals (6,8,9). It has been determined that older individuals are more likely to be victims of psychological abuse (40.5%) and economic exploitation (33%) (5,8). An Australian study determined the rate of physical abuse as 30% and the rate of psychological abuse as 55% (10). A literature review reported the rates of psychological abuse in the US and Thailand as ranging between 1.1% and 41.18% (11). Another research prevalence for abuse reported by older residents were highest for psychological abuse (33.4%), and were somewhat lower for physical (14.1%), financial (13.8%), and sexual abuse (1.9%) and neglect (11.6%) (12).

Although physical abuse is among the types of abuse that can easily be detected, acts of neglect and psychological abuse cannot be as readily spotted. Psychological abuse is single or repetitive inappropriate behavior that psychologically harms elderly individuals when in a relationship with the expectancy of trust (13). Verbal assault, humiliation, threats, embarrassment, criticism, frightening, calling names, and pushing away are examples of psychological abuse (5,14). Psychological abuse has negative effects on an elderly individual's self-esteem, dignity, decision-making processes, and general well-being (15).

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Abuse of elderly individuals is usually observed in at-home or long-stay nursing homes and generally meted out by close relatives or caring staff and caregivers (11,16). Psychological abuse is often difficult to detect because it is usually kept hidden. In particular, health professionals cannot easily detect the psychological abuse of elderly individuals (16,17). Psychological abuse cannot be identified through concrete behavioral criteria and direct questioning alone. Instead, direct questioning, inspecting for signs of abuse, and assessing risk factors of abuse must be used together (18).

A review of the literature shows that most studies focus on physical abuse of elderly individuals (5-8,14). However, recent literature indicates that psychological abuse is particularly common among elderly individuals, suggesting that more studies are needed (2,5). Valid and reliable measurement tools that make a multidimensional assessment of psychological abuse are required for these studies. Currently, there are no valid and reliable measurement tools that can be used for assessing psychological abuse (19).

In a scan of the literature, it was found that Wang et al. (2017) developed and used the 'Elders' Psychological Abuse Scale (EPAS)' to evaluate cases of psychological abuse of older individuals (2,20). The instrument contains 32 items that have yes or no responses and since it can be administered in 10 minutes, it is a user-friendly scale. EPAS is single-dimensional, having no factor construct but three different approaches set up for its administration. The scale is made up of questions regarding psychological abuse directed towards the older individual, healthcare providers and the older individual's caregivers. The questions are addressed directly to the older individual (Q1-Q7), to healthcare personnel for their active observations (Q8-Q13), and to the individual's caregivers (Q14 – Q32). A response of 'yes' indicates the presence of abuse and is scored as '1', while a response of 'no' is scored as '0'. The individual's total psychological abuse score is the sum of the statements receiving a positive response and a high score indicates a high potential for psychological abuse. The cut-off point of the scale has been determined as 10 (17,20).

Nurses have the opportunity to evaluate elderly individuals in their living environments (e.g., homes, nursing homes, primary health care centers, and hospitals). Thus, they play an important role in detecting and intervening in cases where elderly individuals are abused (21,22). This study aims to determine the frequency of psychological abuse in elderly individuals at nursing homes and the factors that contribute to this. The Elders' Psychological Abuse Scale was adapted to the Turkish language and culture to determine the frequency of psychological abuse.

2. METHODS

2.1 Design

This methodological and descriptive study was conducted between December 2014 and April 2015. It was carried out in two nursing homes in Istanbul, Turkey, which are qualified as Elderly Care and Rehabilitation Centers. Both centers are staffed with healthcare professionals 24 hours a day. In nursing home A, there were 279 elderly individuals and 110 elderly individuals resided in nursing home B.

2.2 Participants

In total, 389 individuals in two nursing homes formed the population of the study, with 161 individuals (nursing home A = 120, nursing home B = 41) meeting the sample inclusion criteria. The inclusion criteria were as follows: age ≥ 65 years, Standardized Mini Mental Test (SMMT) score to be 19 and above, having no communication disability, being partially dependent on a caregiver, and agreeing to participate in the study

2.3 Ethical Considerations

The researcher obtained written permission from Wang to adapt the scale into Turkish, from the Ethical Board of Marmara University Institute of Health Sciences (protocol code: 09.2014.0270 – 70737436-050.06.04; date: 12/18/2014), as well as from the nursing homes. Elderly individuals and their caregivers provided written consent.

2.4 Data Collection Tools

The dependent variable of the study is the EPAS score. The independent variables of the study are the Modified Barthel's Index score; the SMMT score; and sociodemographic variables, including age, gender, education level, marital status, and income level.

Study data were collected using a sociodemographic characteristics description form, SMMT, Modified Barthel's Index and EPAS. The researchers created a sociodemographic characteristics description form to inquire about the individuals' sociodemographic characteristics. It included 11 closed-ended questions.

SMMT was adapted to the Turkish culture by Gungen et al. (23). The test includes five main sections: orientation, recording memory, attention and calculation, recollection, and language. It has 11 items, and a full score of 30. Scores of 24–30 indicate a normal mental state; scores of 18–23 indicate mild dementia; scores of 12–17 indicate moderate dementia; and scores of ≤12 indicate severe dementia (23).

The Modified Barthel's Index was adapted to the Turkish culture by Kuçukdeveci et al. The index assesses how dependent on others the individual is in all the parameters of carrying out the activities of daily life. These activities are categories under 10 sub-headings: eating, bathing, self-care, dressing, bladder control, bowel control, use of the toilet, transferring between chair/bed, mobility, use of stairs. Scale scores of between 0 and 20; 21 and 61; 62 and 90; and 91 and 100 correspond to the states of being 'totally dependent', 'semi-dependent', 'moderately dependent', and 'totally independent', respectively (24).

EPAS was created by Wang et al. It includes 32 items. Items 1–7 are directly addressed to elderly participants, items 8–13 are completed by the researcher based on observation, and items 14–32 are marked as 'yes' or 'no' by the researcher based on the responses provided by the caregivers. The cut-off score for the scale is 10. Scores >10 indicate that the elderly individual is being psychologically abused (17).

Study data were collected from elderly individuals and their caregivers during face-to-face interviews and by observation. The observers first received training and were then asked to make observations about the responses given to EPAS statements 8-13. These observations involved notice of: facial expressions of dissatisfaction toward the caregiver, no response to an alert about health problems, verbal description of the abusive situation, privacy not respected, irrelevant answers to questions or unresponsive, unexplained problems with verbal expression or language. The scale items were guidelines for the observers. In this study, two separate researchers worked at two different nursing homes using the same measuring tool but since the evaluations were made only of the older adults at the nursing homes at which the researchers worked, inter-rater reliability could not be tested.

Data were collected again from 39 individuals and their caregivers 2 weeks later to ensure test-retest reliability.

2.5 Adaptation Process of the Elders' Psychological Abuse Scale (the EPAS)

The EPAS was translated from English into Turkish and back translated from Turkish into English (25). Three academics in nursing compared the original to the translated scales. The academics focused on term equivalence, clarity, and cultural adaptation. The researcher took their opinions into account when revising the scale.

The researcher also conducted a pilot study with 10 participants. The purpose of the pilot study was to evaluate the items' clarity and suitability, decide on the duration, and determine the reliability and readability of the tool for a Turkish sample. The tool was determined to be explicit, readable, reliable, and understandable for Turkish participants.

The reliability of the scale was tested using KR–20 and test-retest analysis (n = 39), which demonstrated its unchanging quality over time.

The validity of the scale was evaluated in terms of content validity, hypothesis testing and confirmatory factor analysis. Content validity was analyzed with the Content Validity Index (CVI). The CVI was the chosen method of assessment so that the opinions of the experts could be verified and both language and cultural equivalence and content validity could be evaluated. The experts rated each item on a scale of 1-4 such that a score of 1 meant that the statement was not appropriate in terms of language, culture and content, 2 meant that the statement would have to be made relevant in terms of language, culture and content, 3 indicated that the statement was appropriate in terms of language, culture and content but small revisions would have to be made, 4 indicated that the statement was clearly appropriate and relevant in terms of language, culture and content.

For hypothesis testing, Pearson's correlation test was used to assess the correlation between EPAS and SMMT and the Modified Barthel's Index.

2.6 Data Analysis

The study used descriptive statistics, parametric tests (independent group t-test and ANOVA), and non-parametric tests (Mann–Whitney U test and Kruskal–Wallis variance analysis). The Tukey test was used for advanced analyses. The significance level of the study was $p < 0.05$.

3. RESULTS

Of the elderly individuals in the sample, 44.7% were female and 55.3% were male. A large number of these individuals (42.2%) were aged ≥80 years, and 72% were widows or widowers. Of the elderly participants, 13.7% perceived their income as sufficient whereas 46.6% did not. Two-thirds (67.7%) had between one and three chronic diseases (Table 1).

The mean score of the individuals on SMMT was 23.18 ± 1.67. Of the individuals, 39.8% had mild dementia and 60.2% had normal mental states. Their mean score on the Barthel's Index was 89.13 ± 17.13. Of the elderly individuals, 8.1% were semi-dependent, 32.9% were moderately dependent, and 59.0% were totally independent (Table 1).

Table 1. *Sociodemographic Characteristics of the Participants (n=161)*

Characteristics		n	%
Gender	Female	72	44.7
	Male	89	55.3
Age Group	65–69	39	24.2
	70–74	33	20.5
	75–79	21	13.0
	80 and older	68	42.2
Education Level	Illiterate	37	23.0
	Middle school	73	45.3
	High school	33	20.5
	Higher education	18	11.2
Marital Status	Married	9	5.6
	Single	36	22.4
	Widow/widower	116	72.0
Economic Level	Very high	22	13.7
	High	64	39.8
	Low	75	46.6
Chronic Diseases	No	45	28.0
	1–3	109	67.7
	4 or more	7	4.3
Barthhel's Index Score	Semi-dependent (21–61)	13	8.1
	Moderately dependent (62–90)	53	32.9
	Totally independent (91–100)	95	59.0
Standardized Mini Mental Test Score	Mild dementia	64	39.75
	Normal	97	60.25

3.1 Findings Related to the Validity and Reliability of the EPAS

Ten experts in this study area evaluated the understandability and scope of the scale items used in the study and determined that the CVI value was 0.90. The test of hypothesis showed that the value of correlation (r) between SMMT and EPAS scores was −0.174 (p <0.02). The value of correlation (r) between Barthel's Index and EPAS scores was −0.255 (p <0.00). The KR–20 value, which was calculated to check for internal consistency of the scale, was determined to be 0.80.

The scale was re-administered to 39 of the elderly participants 2 weeks after the implementation for the purpose of testing the unchanging quality of the scale over time. The test-retest analysis showed that there was a highly significant correlation between the mean scores on the scale (r = 0.97; p=0.00).

The confirmatory factor analysis (CFA) values obtained from the goodness of fit indexes are estimated. The correlation coefficients on the scale varied between 0.10 – 0.74. When CFA was estimated it was found that X^2/sd=2.09. Goodness of fit indexes are NNFI=0.46, CFI=0.61 GFI=0.71 AGFI=0.67, IFI=0.62, TLI=0.58, RMR=0.01, RMSEA=0.83. Following modification indices suggestions, error covariances between items 19 and 28, 22 and 31, 34 and 44, as well as 44 and 45 were added.

3.2 Frequency of Elderly Individuals' Being Exposed to Psychological Abuse

EPAS scores of the elderly individuals in the sample ranged between 0 and 22, with 14.3% (n=23) obtaining scores higher than 10, the cut-off score of the scale (Table 2). The mean score on EPAS was 5.57 ± 4.12.

Table 2. *Individual Exposure to Psychological Abuse Based on EPAS Scores*

Exposure to abuse	n	%
Yes (0–10)	138	85.7
No (11–24)	23	14.3

Nearly half of the elderly individuals (44.7%) stated that they were 'left alone involuntarily'. Researchers observed that 20.5% of elderly individuals showed a facial expression of dissatisfaction toward the caregiver. According to the caregivers, 54% elderly individuals were 'emotionally confused, dispirited, and anxious' (Table 3).

There were significant differences between EPAS scores and gender (t=3.22, p=0.002), education level (kwx^2 = 12.93; p=0.005), and income level (kwx^2 = 26.86; p=0.00) (Table 4). The study found that the women residents, individuals with lower education levels, and those who had low incomes were more often exposed to abuse.

There was a statistically significant difference between dependency levels determined with Barthel's Index and those determined with EPAS mean scores (kwx^2 = 22.65; p=0.000). The group that created this difference was the group with total independence (p <0.05).

According to the SMMT score, there was a significant difference between individuals who had mild dementia and those with a normal mental state in terms of their EPAS scores (t=3.44; p=0.001). Individuals with mild dementia were more frequently exposed to psychological abuse (Table 4).

Table 3. *Frequency of Individuals Who Answered 'Yes' to All EPAS Items (n=161)*

	No	Scale items	n	%
Questions asked to elderly individuals	**1**	Left alone involuntarily	72	**44.7**
	6	Poor sleep for unknown reasons	66	**41.0**
	4	Dependent on others economically	44	**27.3**
	3	Angry at caregiver	36	22.4
	5	Expectation to see relatives unfulfilled	26	16.1
	2	Personal belongings used without permission	15	9.3
	7	Unable to make own decisions	11	6.8
Researcher observations	**10**	Facial expression of dissatisfaction toward caregiver	33	**20.5**
	8	No response to alert for health problems	24	**14.9**
	13	Verbal description of abuse situation	9	**5.6**
	12	Privacy not respected	8	5.0
	9	Irrelevant answers to questions or unresponsive	6	3.7
	11	Unexplained problems with verbal expression or language	3	1.9
Questions asked to the caregivers	**15**	Emotionally confused, dispirited, and anxious	87	**54.0**
	16	Isolation and withdrawal from social activities and unwillingness to talk with others	86	**53.4**
	29	Dissatisfied with current conditions	63	**39.1**
	21	Unexplained irritability	43	26.7
	24	Unreasonably inflexible viewpoint	37	23.0
	23	Eating difficulties	33	20.5
	14	Nightmares	29	18.0
	17	Unnecessary suspicions and ideation of being harmed	22	13.7
	20	Fear of specific persons or events	20	12.4
	22	Low self-esteem	19	11.8
	30	Unreasonable demands	19	11.8
	18	Feelings of shame, powerlessness, and loss of dignity	18	11.2
	26	Pleasure in blaming others	18	11.2
	32	Sudden loss of trust in an acquaintance	13	8.1
	25	Unexplained ideation of harm and murder of others	10	6.2
	31	Timidity and fearfulness	9	5.6
	27	Taking of improper medication for unknown reasons	8	5.0
	28	Excessive dependence on caregiver	7	4.3
	19	Destroyed own belongings	2	1.2

Table 4. *Comparison of Mean EPAS Scores between Different Levels of Independent Variables*

Variables	Mean EPAS Scores		Statistics	
	Mean	SD	t/ kwx^2	p
Sex			t = 3.22	**0.002**
Female	6.69	4.82		
Male	4.65	3.18		
Educational Level			kwx^2 = 12.93	**0.002**
No school education (illiterate)	*6.83	4.63		
Middle school	5.17	3.75		
High school	6.30	4.18		
Higher education	*3.16	3.14		
Income Level			kwx^2 = 26.86	**0.000**
Very high	*2.54	1.62		
High	4.59	2.85		
Low	*7.28	4.74		
Barthel's Index Score			kwx^2 = 22.65	**0.000**
Semi-dependent (n = 13)	7.58	2.77		
Moderately dependent(n = 53)	6.83	4.37		
Totally independent (n = 95)	*4.54	3.81		
Standardized Mini Mental Test Score			t = 3.44	**0.001**
Mild dementia (n = 64)	6.44	4.44		
Normal (n = 97)	4.23	3.15		

**The group that created the difference based on the Tukey test; SD: standard deviation*

4. DISCUSSION

A valid and reliable measurement tool was required for assessing psychological abuse. Therefore, EPAS, developed by Wang et al., (17) was adapted to the Turkish language and culture.

As a result of the adaptation of the scale to Turkish, CVI proved that there was a 90% consistency among the experts, and the criteria for content validity were met. The CVI of the original scale was 92%, and there was a high similarity between the original and translated scales (17). The study concluded that the linguistic structure of the scale was understandable and that the content was suitable.

The test for concurrent validity that was administered for construct validity evaluated the direction and level of correlations that had been anticipated before using the correlation analysis based on sources and observation (25). As in the study by Wang et al., (17) a negative weak correlation was found between SMMT, Barthel's Index, mean scores, and EPAS ($p < 0.001$). However, these findings also showed that the scale was valid according to concurrent validity. Parametric and non-parametric tests also showed that there was a significant difference between the individuals' exposure to psychological abuse and dependence levels and mental capacities ($p < 0.01$). These results confirm the hypothesis that those who are semi-dependent and those who have mild dementia are exposed to more psychological abuse, and this is a statistically significant result.

Reliability refers to the consistency of an assessment tool (25,26). Because items on this scale had two options (yes and no) and assessed one structure, internal consistency was assessed using the KR-20 formula. This type of reliability will be increased when the characteristics assessed by the test items are similar to the behaviors they measure. If the K–20 formula is used for information tests comprising a small number of items (e.g., 10–15 items), small values such as 0.50 will also be accepted as reliable. The value of reliability increases in direct proportion with the number of items on the test (20). The KR-20 value of the original scale, which included 32 items, was 0.82 and that of the adapted scale used in this study was 0.80 (18). The internal consistency of the scale was high.

Test-retest analysis was performed to assess the quality of consistency of the test over time. It is recommended that there should be at least 2 weeks between the first and second assessments (4 weeks at most) and the test should be administered to at least 30 individuals (26). The researchers did not check the test-retest correlations of the original scale. In this study, the test-retest correlation was significantly high, and it was very clear that there was consistency over time ($p < 0.001$).

When confirmatory factor analysis indicates that $X^2/df < 3$, this points to an excellent model fit (27,28). Accordingly then, it can be accepted that scale displaying this quality fit the model at a high level.

In the review of the DFA goodness of fit indexes, it is accepted that a value of <0.08 in RMSEA and a value of >0.80 or >0.95 in NFI indicates a good fit. A value of >0.95 in TLI, of 0.90 and, according to some research, of >0.95 in CFI indicates a good fit. Other indications of good fit are an IFI value of 0.90 and over, of over 0.90 in GFI and over 0.90 in AGFI. Although PNFI and PGFI do not have definitive limits, a minimum value of 0.50, and a value of 0.90 in RFI indicate a good fit (26,29). RMR value is sensitive to the scale and is not considered an indication in assessing good fit (29).

According to these goodness of fit values, it was decided that the scale was under good model fit values. This result was associated with the fact that it was below 10 people per scale item proposed for scale adaptation studies.

Of the participants, 14.3% achieved a score of ≥10 on EPAS, which indicates exposure to psychological abuse. Wang et al. (17) reported that 22.6% participants and Acharya et al. (15) reported that 33% participants were exposed to psychological abuse. The difference may be attributable to the sociocultural differences between the countries.

Mean scores on EPAS were 5.57 ± 17.13 in this study, 6.32 ± 4.59 in the study by Wang et al. (17), and 6.92 ± 4.57 in the study by Acharya et al. (15). These mean scores were different but close to each other.

Risk factors related to the individual, the environment and to caregivers are involved in the abuse of older adults. Being of an advanced age, a woman, dependency on others for

carrying out activities of daily living, failing mental capacity, a low level of education, chronic diseases, social isolation, poverty, alcohol or substance addiction can be cited as risk factors related to the individual. Living in a nursing home, a shortage of nursing home personnel, limited resources, living in isolation from the community are among the environmental risk factors. Other risk factors relate to caregivers who are themselves victims of abuse, poorly educated, alcohol and substance users, or afflicted with a psychological disorder (30).

In this study, female participants, participants with low levels of income and education, those with mild dementia, and semi-dependent participants were exposed to psychological abuse to a greater extent than the other participants. Consistent with this finding, Acharya et al. (15) found that gender, income level, education level, dependency level, and mental capacity affected psychological abuse. In addition, Wang et al. also reported that elderly individuals with low-income levels were exposed to psychological abuse to a greater extent than others (20). These similar findings show that gender, educational level, income, and physical and mental capacity affect the risk of psychological abuse in elderly individuals.

In the study by Wang et al, there was a statistically significant difference between EPAS mean scores and chronic disease status (20). On the other hand, this study found no significant difference in this regard ($p > 0.05$). This difference may also be related to other characteristics of the individuals with chronic diseases (such as gender, dependency level, and disease management capacity).

The literature indicates that psychological abuse is difficult to recognize. It cannot be detected by merely engaging in directly questioning elderly individuals or those around them (18). Cohen stipulated that different occupational groups (e.g., elderly care personnel, physicians, and nurses) should be involved in the evaluation process, a holistic approach should be adopted, and culturally appropriate measurement tools should be used for identifying abuse of elderly individuals (18). EPAS, as adapted to Turkish language and culture, provides an opportunity for multidimensional assessment and diagnosis of psychological abuse among elderly individuals. It enables researchers to diagnose emotional abuse by directly asking elderly individuals questions (for example, "Are your personal belongings being used without your permission"?) and includes the researchers' observations (for example, 'facial expression of dissatisfaction towards the caregiver'), and the caregivers' opinions (for example, 'nightmares'). EPAS is easily administered because it has a yes/no question format and can be completed in 10 minutes (18).

Certain interventions may provide an opportunity to prevent psychological abuse in nursing homes. The first of these might be adopting a policy of hiring nursing home personnel after evaluating these individuals for characteristics (having a history of suffering from violence, low educational level, psychological issues, alcohol and substance addiction, etc.) that may constitute a risk for abuse. Another precaution that can be taken is to ensure that healthcare personnel working at nursing homes (doctors, nurses, social workers, etc.) and other employees (dieticians, cleaning personnel, personal support providers, etc.) are provided with an in-house program of education on the prevention of abuse and interventions that can be implemented. Additionally, the number of personnel hired per nursing home resident should be consistent with recommendations (31). Finally, it is of vital importance that older individuals are screened (through physical examinations, observations, interviews, the use of assessment tools such as EPAS, etc.) in order to achieve early detection of psychological abuse and that in the event of a determination of psychological abuse, these individuals are provided with early treatment and rehabilitation (30).

5. CONCLUSION

This study found that the Turkish version of EPAS, which was created in English by Wang et. al. (17) was reliable and valid. This scale will help in detecting elderly individuals at risk of psychological abuse. However, in order to improve the exploratory factor analysis results, it can be suggested that the scale be applied to a larger elderly sample group.

Of the participants, 14.3% were exposed to psychological abuse. The factors that increase the frequency of psychological abuse included female gender, low income and education levels, being semi-dependent, and having mild dementia. Therefore, it is recommended that these groups be monitored more closely using EPAS for signs of psychological abuse.

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