Screening Tools for the Identification of Elder Abuse

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ABSTRACT

- *Objective:* To review existing tools for screening for elder abuse.
- *Methods:* Search of international databases and a review of validated tools for identifying abuse and screening for abuse.
- *Results:* Elder abuse prevalence rates are underestimated in the literature, and many abuse victims fail to receive the professional help that could improve their quality of life. A number of structured and validated tools can be used to identify abuse victims. Three types of tools are discussed: direct questioning, inspecting for signs of abuse, and evaluating for risk factors for abuse. An integrative model that encompasses the 3 screening modes is described. Considerations regarding special populations and cultural aspects should be incorporated into the screening process.
- *Conclusion:* Brief screening tools have many advantages, but they also have weaknesses. Further research is needed to assess their validity, applicability, and accuracy for use in different settings and by different professionals.

Elder abuse is defined as a single or repeated act, or lack of appropriate action, occurring in any relationship where there is an expectation of trust, that causes harm or stress to an older person [1]. It includes physical, psychological, and sexual abuse, financial exploitation, and neglect. Abused older persons often suffer from several types of abuse [2]. The 3 most common are psychological abuse [3,4], financial exploitation [2,3,4], and neglect [2,4,5].

Although the prevalence of elder abuse has been the focus of many studies that furnish a wide range of results and estimates, broad agreement exists that these numbers are only the tip of the iceberg. It is reasonable to assume that a large proportion of elder persons asked in surveys to disclose abuse choose not to do so [6,7]. Moreover, different prevalence rates of abuse of older adults in community settings have been obtained in various international stud-

ies: 2.6% [8], 11% [4], 18% [9], 21% [10], and 29% [5], while the prevalence rate substantially increased in vulnerable groups of older adults, even up to 42% [11]. This variability in prevalence rates was previously ascribed to a wide range of factors, such as different definitions of abuse, different sampling or recruiting methodologies, different levels of vulnerability of the surveyed older adults and high variability in communities' characteristics and cultural aspects.

Especially notable is the variability in the tools used and in their degree of validation and standardization [11,12]. With the improvement in research tools for identifying abuse and a more rigorous methodology (population-based surveys, face-to-face interviews), the reported rates tend to increase [3,4]. Higher rates of abuse were more systematically obtained with the expansion of the definition of abuse [9] or when patients with dementia were assessed [12]. Cohen et al [2], in a systematic screening conducted among hospitalized older adults, found higher rates of abuse, especially neglect, than those reported in population-based surveys.

In actuality, most cases of elder abuse go unidentified and hence unreported by health and welfare practitioners [13,14]. Consequently, many victims of abuse or neglect do not receive the help that might improve their quality of life and their psychological and physical health. Abuse in older adults is related to increased morbidity and reduced survival even after adjustment for other risk factors for mortality [15].

Accordingly, the focus should be on increasing evidence-based knowledge on which professionals may rely to improve identification of older persons suffering abuse [6,16]. Based on a literature review, the present paper highlights several related topics: the difficulties and obstacles of identifying older persons suffering abuse; the rationale of screening for abuse; the main screening tools; specific considerations in screening; and the link between screening and intervention. The paper mainly surveys studies on community-dwelling older adults. Abuse in institutions is briefly discussed.

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Table. Tools for Screening for Elder Abuse

Direct questioning

    H-S/EAST

    VASS

    Self-disclosure tool

    EASI

    CASE

Signs of abuse

    EAI

    Signs of abuse inventory

Indicators of risk for abuse

    Bass et al

    Neale et al

    IOA

    E-IOA

Obstacles to Identification of Elder Abuse

Professional encounters with older persons, especially in health care settings, provide an opportunity for evaluating signs and risk factors for abuse [2,17,18]. Contrary to what might be expected, rates of abuse identification by health care providers are usually low [18,19]. For example, studies in the United States reported that more than 60% of physicians surveyed said that they had never asked their patients about abuse [20], and more than half of them had never identified a case of abuse [20] or had not identified a case in the previous 12 months [21]. Physicians in the emergency department [22] and geriatricians [17] showed higher awareness and identification ability, although the reported rate of identification of abuse in these studies was still far below the rates of older adults suffering abuse as indicated in prevalence studies.

Several explanations have been given for the under-identification of abuse among older adults. Lack of education or formal training about the problem, its scope and signs, identification skills, and reporting procedures have been mentioned [7,23,24]. Practitioners' lack of education is often said to account for their not being aware of the possibility of abuse or their not believing that elders can actually suffer abuse within the family [25]. Many professionals may feel uneasy probing patients about being abused, or they may not be convinced that they have the right to penetrate the privacy of the family [13,25]. Time restraints might be another barrier for professionals, who are mostly overloaded with work [22,25]. Skepticism and disbelief in the possibility of making a change once elder abuse is identified and reported may be an additional hindrance [13]. In addition, elder adults are frequently reluctant to tell health care or welfare practitioners of the mistreatment they suffer [6,14] out of fear, shame, or a sense of hopelessness.

Identification of abuse is not clear-cut [24]. Its diagnosis is mostly uncertain, which increases practitioners' fear that they may do more harm by taking any action. Moreover, due to the complexity of health problems in the old age, signs of abuse may overlap with symptoms and outcomes of various diseases or side effects of medications [14]. For example, bruises may be due to high doses of anticoagulants. Malnutrition, which may be due to neglect, may just as well be caused by variety of physical and psychological and age-related changes, many of them unidentifiable [26].

The Need to Screen

The many obstacles to identification of older adults suffering abuse, and the fact that most victims of elder abuse go unidentified, has resulted in vigorous advocacy of screening for abuse [14,27]. Often elders are isolated and lonely, and the encounter with a professional may be their only chance to change the abusive situation and prevent its continuation and even exacerbation. [2,19,28]. Hence the use of structured tools to identify elder abuse has been proposed [6,13,29,30]. Studies show that professionals' identification using structured tools elicited rates of abuse higher than those found in prevalence studies [2,27,28,31].

Typology of Screening Tools

A search was conducted in PubMed, ProQuest, AgeLine, and PsycNET for screening tools for abuse, using the following keywords: tool, instrument, questionnaire, checklist, screen; abuse, neglect, victimization, exploitation, violence; older, old, adult, elder(ly). Articles published in English between 1980 and 2011 were included in the search. Validated tools are described in the present review.

The tools are classified according to the 3-dimensional model of screening for abuse proposed by Cohen et al [31]: (1) direct questioning or self-reports of the older adult, (2) inspecting for signs of abuse, and (3) evaluating risk of abuse (**Table**). A single tool may fall into more than 1 category. Ejaz et al [32] assert that "the separation (of tools) is conceptually critical in light of helping practitioners to refer cases for appropriate follow up and further investigation."

Direct Questioning Tools

These tools consist of a set of questions to be asked directly by practitioners in encounters with older adults or administered as self-reports. They are aimed at eliciting disclosure of abusive behaviors by caregivers or others, if such behav-

iors are experienced. These tools are suitable for identifying abuse in cognitively intact older adults [27,31].

H-S/EAST

The earliest and well known tool is the Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST) [33]. The original consists of 15 items developed from a pool of over 1000 items from already existing elder abuse assessment protocols used throughout the United States [33]. Through factor analysis the 15 H-S/EAST items proved to cover 3 major domains of elder abuse: overt violation of personal rights or direct abuse ("Has anyone close to you tried to hurt you or harm you recently?"), characteristics of vulnerability ("Are you sad or lonely often?"), and characteristics of potentially abusive situations ("Are you helping to support someone?"). The tool was assessed with 3 groups of participants: (1) 120 elders whose reported abuse was substantiated by adult protective services case workers, (2) 47 elders whose reported abuse was not substantiated, and (3) 47 elders in a community-based comparison group. The authors showed satisfactory content, criterion, and construct validity. Using discriminant function analysis they found that 9- and 6-item versions had the best discriminating ability between the abused and non-abused participants. The discriminant validity was further confirmed in a small study with 100 older adults [34]. The final score is the sum of positive replies for the items, and is indicative of risk of abuse. A score of 3 was suggested as a cut-off score for risk of abuse, but it was not determined based on a statistical method. Another issue that may be a limitation of the tool is that its final score is composed of signs of abuse and of risk factors, all receiving the same unweighted scoring. Also, the authors report a very high false-negative rate. They conclude that the tool should be used with caution and only as a preliminary step in identifying cases that warrant further investigation. Also, further assessment using the receiver-operator characteristic (ROC) curve demonstrated that the H-S/EAST had no discriminating power for screening for elder abuse [11].

VASS

A decade later the self-report Vulnerability to Abuse Screening Scale (VASS) was introduced. It used the H-S/EAST with 2 additional questions ("Has anyone close to you called you names or put you down or made you feel bad recently?" and "Are you afraid of anyone in your family?"). Construct validity was confirmed and positive correlations were found with various risk factors of abuse. The sample was more than 12,000 women in Australia [35,36].

Self-Disclosure Tool

A 10-item tool for self disclosure of abuse was introduced by Cohen et al [31]. It was adapted from the National Survey on Elder Abuse and Neglect in Israel [9]. The items relate to whether during the previous year the individual suffered from abusive behaviors, covering psychological and physical abuse, neglect, emotional exploitation, limitation of freedom, and sexual maltreatment. The questions are read to the individual, and he/she is asked to rate the frequency of any abusive behavior that occurred. A score of 2 or higher for 2 items or more was defined as probable abuse. Internal consistency of the subscale was 0.88. The tool was assessed for content validity by 5 experts from different professions. It also showed high criterion validity, as more than 70% of those who disclosed abuse were also identified as suffering from abuse.

EASI

A more recent tool is the Elder Abuse Suspicion Index (EASI). It was created by Yaffe et al [27] to assist physicians with identifying patients who might be experiencing abuse. It originally consisted of 9 items. These were subjected to content validity assessment in 3 focus groups of clinical and research professionals involved in elder abuse. The final tool consists of 6 items, 5 of them direct yes/no questions asked of the patient; the 6th item asks the physician if he/she has noticed behaviors that may indicate abuse.

The screening tool was administered by physicians to 663 elder patients. The criterion for EASI's validity was its accord with an evaluation by trained social workers as to whether abuse was present through an interview using a recognized protocol for this purpose. The EASI showed a sensitivity and specificity of 0.47 and 0.75. These relatively low figures are a limitation that may be because of variability in content between items. Five items ask about actual abusive behaviors or signs of abuse and 1 item asks about dependency (ie, has the patient relied on people for activities of daily living). This item asks about a single risk factor among many other and more prominent risk factors described in the literature [37]. The authors explain that a single risk factor was included as the professionals in the focus groups who constructed the questionnaire ranked items focusing on risk factors lower than items without risk factors. In addition, the physicians (for whose use the tool was designed) raised concerns over the efficiency of screening for risk factors, and it was important that they felt at ease with the tool in order to use it [27]. As the authors summarize, the EASI was the first step in the development of a fuser-friendly tool to raise a physician's suspicion about elder abuse and make the referral, and it achieved its secondary aim of increasing their awareness of elder abuse.

CASE

A different approach to self-report tools is represented by the Caregiver Abuse Screen (CASE). This is an 8-item screening questionnaire answered by caregivers. It is worded in a non-confrontational way to help respondents feel comfortable

answering it. CASE was assessed with 139 caregivers and was reported to have good construct validity and concurrent and convergent validity and reliability [38].

The direct questioning tools are an important element in screening; although most older persons suffering abuse will not initiate telling someone about their problem, some will admit being abused when asked directly by a trusted professional [13,28,31,39]. Yet others may continue denying being abused [6]. Another limitation of direct questioning is that it can be applied only with mentally intact individuals [6]. Caution is also needed as false-positive results may be obtained due to family conflicts, feelings of anger and hostility toward family members, and dissatisfaction with familial relationships.

Signs of Abuse Tools

The second group of tools consist mainly of lists of actual signs of different types of abuse, such as suspicious bruises and burns (physical abuse), transfer of property (financial exploitation), and poor hygiene or dehydration (neglect) [33,40]. In the literature several protocols that include lists of signs of abuse are described, most of them without any validation procedure. Rather, they were constructed and reconstructed out of the rich experience of social workers and other practitioners. Examples include the Guidelines for Health Care Professionals for Detection and Assessment of Elder Mistreatment, created at Mount Sinai Medical Center [40], the Illinois statewide elder abuse assessment guidelines [41], and Bass et al's list of risk indicators [42].

EAI

The Elder Assessment Instrument (EAI) was composed and validated by Fulmer [6,28,43,44]. It is a 41-item screening tool comprising 7 subscales for identifying signs of abuse, neglect, exploitation, and abandonment. Practitioners complete the items on a 4-point scale from no evidence to definite evidence based on clinical interview and physical assessment. The tool has good internal and test-retest reliability, as determined with a sample of 500 older adults admitted to an emergency unit [14]. Also, good sensitivity but weaker specificity were reported [6,14,44]. The first 4 items were categorized as general assessment but actually relate to possible signs of neglect if evaluated as negative (nutrition, hygiene); they are followed by 6 signs of possible abuse (bruising, lacerations), a list of signs of neglect (decubiti, dehydration) and exploitation (evidence of financial exploitation, misuse of money), and a summary of the practitioner's impression of whether there is evidence of abuse. The tool does not furnish a score indicative of probability of abuse; instead the authors recommend that if the screening does yield any evidence of mistreatment, the patient should be referred to social services [6,14].

Signs of Abuse Inventory

The evident signs of abuse inventory [2,6,28,31,39] lists items indicating signs of physical, psychological, and sexual abuse, financial exploitation, and neglect. It was adapted from the Mount Sinai Hospital guidelines for assessment of abuse [40] and from the list of signs of abuse compiled by Neale et al [41]. The severity of each sign of abuse is scored for each item on a scale from 0 (not at all) to 4 (extreme). Physical abuse is identified through 7 items (eg, suspicious bruises, burns, welts, scars). Scores of 3 and higher in one category or more, and scores of 1 to 2 in one of the more definitive items (ie, bilateral bruises, bruises or burns in shape of objects), are coded as positive signs of abuse. Financial exploitation is assessed by means of 7 items, of which the first 4 yield indirect evidence of exploitation (eg, cannot satisfy basic needs even though sufficient financial resources exist, lack of orientation regarding bank account [if cognitively capable]). For these items, scores of 1 to 2 are counted only if positive scores are obtained for all 4 items. For categories 5 to 7, which produce direct evidence of exploitation (enforced transfer of property, signing documents, giving money), every score is recorded as positive.

Conclusive signs of psychological abuse are difficult to assess. In the past, this type of abuse was usually assessed by its psychological consequences, such as depression or apathy [40]. However, these psychological symptoms may be related to many prevalent situations of the old age, and cannot be used as signs of abuse. With this tool, assessment of psychological abuse is based on observation (when applicable) of older person–caregiver interactions, using 4 items (indifference, anger, not answering needs, trying to prevent the older person from conversing with staff). A score of 1 or 2 on three of the 4 items, or of 3 or higher on 1 item, is coded as possible psychological abuse.

Neglect is assessed using 12 items (eg, under- or over-medication, hypothermia, low hygiene, signs of dehydration, decubiti). A score of 1 or 2 on at least three items, or 3 or higher on at least 1 category, defines neglect. Sexual abuse is measured by 4 items (eg, torn or stained underwear, disease or infection of genitals). A score of 1 or 2 on all 4 items, or 3 or 4 on three items, or if the patient complains of sexual abuse, is coded as sexual abuse.

Internal consistency of the subcategories of 0.67–0.91 was reported. The list of evident abuse is completed by social workers and nurses using a personal interview, a physical checkup, and a detailed overall evaluation of the patients' condition.

Identification of signs of abuse requires skills in nonthreatening and nonjudgmental interviewing. Assessment of signs of abuse is often bound up with uncertainty and ambiguity for the practitioner, as signs of abuse in later

life are frequently difficult to distinguish from symptoms of illness [7]. Even more problematic is identification of psychological abuse, which usually shows in psychological outcomes such as apathy, depression, and fearfulness [40], congruent with the reactions of older people to loss, illness, or cognitive deterioration. Also, screening for signs of neglect does not allow differentiation between neglect and self-neglect, even though both these types of neglect need immediate intervention [45]. Tools for identification of signs of abuse are also of value in increasing practitioners' awareness and alertness to the various possible signs of abuse.

Risk of Abuse Indicators

This group of tools focuses on screening for risk of abuse indicators even in the absence of evident signs of abuse or when the older person does not report it [2,37]. The need for this kind of screening arises from the gap between the estimated number of elder persons suffering abuse and the actual figures for identified abuse among the elderly. Moreover, as previous studies have shown that many of those at high risk are actually abused [31,37,39,46], accurate identification of risk indicators can assist in identifying those individuals and then conducting a more thorough evaluation. The presence of risk indicators is by no means equivalent to identification of abuse, but is more like a warning sign flashing [2]. Ejaz et al [32] state that identifying risk indicators is intricate because of the difficulty in interpreting the risk factors and evaluating them in the specific context of the older person and family circumstances. Also, more research is needed to expand our understanding of risk indicators that might be gender-specific or culture-specific.

Several points should be raised in a review of tools that screen for risk of abuse indicators. First, risk indicators are often confused with correlates of abuse. For example, although women were often found to be abused more often than men, gender in itself is not a risk of abuse factor [37]. The same applies to age, which cannot be constituted as a risk factor, although older elders are more often abused than younger adults [6]. Other characteristics of older adults and their caregivers exist that may be evident in abusive situations, but still are not specific risk factors. For example, Reis and Nahmiash state that many caregivers, abusers and non-abusers, are stressed, so stress in itself cannot be deemed a risk factor [37]. Secondly, the list of possible risk indicators is long. Screening tools should include risk indicators found to be the strongest predictors of actual abuse as proved by rigorous research procedures [37]. Also, some controversy exists between different professional groups regarding the need to screen for risk factors [27]. Describing the construction of the Elder Abuse Suspicion Index (EASI), the authors report that social workers and physicians have different attitudes to the need to screen for risk factors; the physicians

raised concerns regarding the ability of risk factors to predict abuse [27]. Several screening tools for identifying risk indicators are described in the literature [2,37,42].

Bass et al and Neale et al

Bass et al [42] put forward a list of 27 risk factors aggregated to 4 categories (past neglect, abuse or criminal offenses; relationship problems between possible victim and perpetrator; physical, emotional or mental health-related problems; caregiving and social support). The tool is based on a literature review and clinical experience, but validation of the tool has not been reported. Similarly, Neale et al [41] list 22 risk factors, including client factors, environmental factors, transportation and support system, and perpetrator factors; this program is used by the Illinois social services.

IOA

The Indicators of Abuse (IOA) screen is the first validated tool specifically directed to identifying risk factors. For this tool, 48 initial indicators of abuse (and 12 demographic items) were developed based on the theoretical model of Kosberg and Nahmiash [47]. It was assessed with 341 older persons through a diagnostic interview conducted by social workers. The IOA was assessed for divergent and concurrent validity. Discriminant function analysis confirmed the discriminate validity of the final 27 indicators, which were found to discriminate the best between abused and non-abused participants. The discriminant function analysis showed that the tool identified 84% of the abuse cases and 99% of the non-abuse cases. High internal reliability was also reported [37]. However, the IOA is completed by means of an open clinical interview, so practitioners may produce diverse results due to differences in interviewing and diagnostic skills [37,48].

E-IOA

Recently described was the expanded IOA (E-IOA), in which the IOA items are broken down into a series of subindicators on which the evaluation of high risk rests [2]; this facilitates quantification of the degree of risk for each indicator. The subindicators contain the substance of the indicators and are based on the *Diagnostic and Statistical Manual of Mental Disorders* [49], the *Review of General Psychiatry* textbook [50], and a model of biopsychosocial assessment in geriatric social work [51]. Degree of risk is marked on a 4-step scale from 1 indicating not at all to 4 indicating very much, or on a frequency of behaviors scale. For each item an additional category, "Not possible to elicit information," is optional. Several measures have been applied to validate the E-IOA. After a panel of experts affirmed content validity, criterion validity was confirmed in a small sample of 22 older persons, half of whom were known to suffer abuse; the E-IOA was

further tested in a sample of 108 [2] and then 730 participants [31]. Discriminant validity was confirmed using discriminant factor analysis. The E-IOA correctly classified 92.9% of the probably abused and 97.9% of the probably not abused. Twenty-one items significantly discriminated between probably abused and non-abused participants. The E-IOA mean score then underwent ROC analysis to assess its diagnostic performance. The area under the ROC curve of 0.92 (95% confidence interval, 0.82–1.02) demonstrated that the E-IOA discriminated well between the probably abused and the not abused cases. Construct validity was also confirmed by means of a confirmatory factor analysis. Four factors emerged: caregiver's personal characteristics, caregiver's interpersonal characteristics, elder's personal characteristics, and elder's interpersonal characteristics [2]. The E-IOA was further assessed with a population-based sample of 1317 people aged 70 and older throughout Israel and in various social and health care services. Good validity and reliability properties were found [39].

An Integrative Model of Screening for Abuse

It was previously demonstrated that ideally the 3 foregoing screening modes are needed to optimize identification of cases of abuse [31]. Ejaz et al [32] similarly recommended use of specific tools for identifying signs of abuse, suspicion of abuse, and risk indicators. The different modes of screening may overlap considerably in their identification of abuse, but it has been shown that each mode identifies cases not identified by the other 2. A comparison of the 3 modes [31] reported that 5.9% of 730 older persons disclosed experiencing abusive behaviors during the previous year, while 21.4% were identified with evident signs of abuse, and 32.6% were classified as being at high risk for abuse. Only about 70% of those who disclosed abuse were identified with evident signs and were at high risk of abuse. Moreover, those who disclosed being abused tended to report physical and sexual abuse in particular. Moreover, often decisions to further pursue a case of suspected abuse are made in situations of uncertainty. It is frequently a difficult task to discriminate, for example, between giving money or assets willingly or under pressure, or between limiting access to specific places by reason of personal security or as an act of abuse. So the more modes of screening that can be applied, the less ambiguous the choice will be. However, it is recognized that practitioners generally do not have the time, conditions, or skills to perform 3-level screening.

Two integrative screening tools have undergone validation: the 3 modes of screening described above by Cohen et al [28,31,39], namely the direct disclosure, signs of abuse, and risk indicator tools; and the Ohio Elder Abuse and Domestic Violence in Late Life screening tool [32]. These tools offer comprehensive screening but also recommend using separate elements according to the circumstances.

Screening for Abuse Among Individuals with Dementia

Rates of abuse among older adults with cognitive decline are substantially higher than among mentally intact individuals. Studies report rates of between 20% to 60% [12,52], depending on types of abuse assessed and methodologies used. These higher rates may be due to more intense care needs and more behavior problems, but also to the abused individuals' inability to insist on their rights or complain [12]. Furthermore, identification of abuse is more complicated due to inability to use interviews or direct questioning, with reliance mainly on signs of abuse or evaluation of caregiver and environmental risk factors [12]. Most screening and identification tools have not been validated for individuals with dementia [53]. One report is available on adaptation of a tool screening for abuse in individuals with dementia, namely a Modified Conflict Tactics Scale [52], which identifies maltreatment by intimate partners and is administered to family caregivers (5 items each for psychologically and physically abusive acts). It was tested in 86 individuals with Alzheimer's disease and their family carers. Validity was assessed by comparing scores with those of other evaluative tools [12]. Using the evident signs of abuse and the caregivers' risk indicators section from the E-IOA, it was found that 89% of demented participants were correctly classified according to the comparison with evident signs of abuse, but while it had a very good sensitivity, the specificity was low. Further efforts are needed to construct and validate tools specifically for screening for abuse in people with dementia

Screening for Abuse in Institutions

Precise data on the prevalence of abuse or neglect in long-term care institutions are lacking because of the hidden nature of abuse in institutions and inadequate procedures for its assessment and identification [54]. Studies in various countries found that between 11% and 91% of staff in nursing homes had observed incidents of physical, psychological, financial, and sexual abuse or neglect perpetrated by staff, and 2% to 87% of staff admitted committing abusive behaviors [55–58]. In a study among older adults from a nursing home, during their hospitalization in a general hospital 31% reported experiencing some form of maltreatment, mostly disrespectful behavior. Signs of abuse, mostly neglect, were detected in 22.5% of the sample [37].

The elderly residents of long-term care institutions are at higher risk of abuse as a result of their physical and mental frailties, dependency, and social isolation [55]. Abusive behavior by nursing home staff has been shown to be related to the highly stressful nature of the work and high burnout rates as well as to residents' aggressive behavior [57,59,60], and to attitudes condoning potentially abusive behaviors

[61].

Several tools for identification of abuse, with varying degrees of validation, are reported in the literature [39,62–64], but they constitute only an initial step. Wang et al [63] constructed the Elders' Psychological Abuse Scale (EPAS) to screen for psychological abuse among elders in long-term care facilities and domestic settings. However, it was validated for a Taiwanese population only. Also, its items are a combination of questions for detection of abusive behaviors, residents' characteristics, and situational characteristics that could be risk factors. Another instrument is the Caregiver Psychological Elder Abuse Behavior Scale (CPEAB), developed by the same group [64]. It focuses on identifying abusive behaviors reported by nursing home staff. Kottwitz and Bowling [62] developed the Elder Abuse Questionnaire (EAQ) to measure elder abuse as perceived by residents' family members and by staff, but not directly. Cohen et al [39] described a 24-item list of maltreatment/abuse acts. It prompts respondents in long-term facilities to disclose if they have suffered any of them that might have been committed by staff. Factor analysis showed 4 factors: neglect of personal basic needs, humiliating/dehumanizing behaviors, psychological abuse, and physical abuse. The tools need to be constructed and further validated to encompass possible abusive behaviors that may be characteristic of institutions [39].

Discussion

Routine and systematic use of tools to screen for abuse has a valuable part to play in the clinical setting. It provides the framework for at least a primary evaluation of risk in older adults in their encounters with physicians, nurses, social workers, and other health care practitioners. It is recommended that the screening be conducted at the various clinics and services in the community that older persons attend, and in emergency departments [18,22] and hospital wards [2,39].

Implementing the 3 modes of screening—direct questioning, evident signs of abuse, and risk indicators—may provide a comprehensive means of identifying more individuals exposed to abuse. As noted, although the 3 modes partially overlap in their identification of abused elderly people, each of them identifies some who are missed by the other 2 [31]. Also, while the direct questions and the evident signs identify cases of certain or suspected abuse, the risk indicator tool only points to risk of abuse and the need for referral for further assessment. Future research should assess a possible graduated escalated approach to the use of the direct questioning and the risk indicators modes, starting from a single question and then increasing, if there is a suspicion, to more intensive screening.

Brief screening tools have many advantages, but they also have several disadvantages. Complexity of individual behaviors calls for specific attention to the unique nature of personality and of relationships, which no screening tool can encompass. Sensitivity to this uniqueness and inviting professional judgment in each case are needed whenever screening is performed.

Most of the existing screening tools have fair sensitivity but poorer specificity [2,27,38]. In case of low specificity, there is a substantial risk for false-positive identification of abuse; ie, the screening will single out a considerable number of individuals suspected of suffering abuse or found to be at high risk who actually are not experiencing any abuse. The consequences of such a situation may be an increase in referrals and in the workload of social welfare or adult protective services and discomfort and stress for the older person and his family. Although most tools showed reasonable sensitivity, a false-negative risk—not identifying a person actually experiencing abuse—is still possible. This may sometimes result in a failure to consider the possibility of abuse in further encounters with those individuals. Thus, professionals should not develop overreliance on screening instruments. Moreover, in case of greater ambiguity or when the older individual do not cooperate with the screening, a more intensive interview by a social worker or other experienced professional may be needed.

Optimal screening is not achieved as a single act and should be done periodically. Many cases of abuse will not be identified the first time; furthermore, abuse can develop as a condition worsens or the caregiver's stressors increase over time.

In the screening, some older adults will find themselves being asked about being abused for the first time. To be able to disclose, and give details, they should feel that the practitioner is trustworthy, empathetic, sensitive to their difficulties, and not judgmental. Often it takes time and effort to achieve this favorable atmosphere, which is also limited by time constraints [13].

Screening for abuse is often hindered by lack of knowledge and skills for intervention [20,25,65]. The question "What should I do once I suspect abuse?" is often raised by physicians and other health care professionals. A review of the different interventions in cases of abuse, suspected abuse, or risk of abuse [32] is beyond the scope of this paper. Each of the 3 possibilities should be followed by prompt and proactive acts, with priority given to patient's safety [25]. These are different for each profession and every country. In a more general sense, training programs should be provided to convey this knowledge and to establish a sense of competence in handling cases of identified or suspected abuse or risk of abuse [65]. An additional general point is that the basic attitude of practitioners when dealing with older adults and their families should not be one of blame and criticism but of problem-solving and devising the most appropriate solution [25]. A multi-professional and collaborative approach should be adapted and fostered [65].

Another question that should be raised is the applicabil-

ity of the screening tools for multicultural groups of older adults [65–67]. Behaviors within family relationships are conducted in a cultural context [67–69]. Behaviors that may be appropriate or normative in one culture may be interpreted as abuse by persons of a different culture [68]. For example, taking control of mother's financial affairs after the death of father is normative in some traditional or patriarchal families but can be evaluated as exploitation from the Western perspective. Taking over decision making related to health problems of an older parent can again be a normative act, but it can be perceived as an abusive act by a practitioner with a Western attitude to the individual's rights over his or her own body. No research has probed the sensitivity of screening tools to cultural differences.

Several limitations of this review should be underscored. It covered only the leading tools found in the literature, with the focus on validated ones, and did not encompass all that exist. Also, most of the studies did not report the time needed to administer the tools. Thus, this information could not be taken into account when comparing between screening tools. Other relevant issues such as ethical considerations or forensic aspects were omitted as they are beyond the scope of this paper, but it is important to address them.

It is recommended that future research reassess the tools for validity and assess their applicability and accuracy for use for identification of abuse in different settings and by different professionals (eg, physicians, social workers, nurses). Long-term follow-up studies of the individuals who were identified or suspected of being subject to abuse, and of those who were not, may provide a better perspective on the efficiency of these tools. Determining the suitability of the screening tools for different cultural groups and in different countries is also warranted. Another fruitful research direction may be a search for biomarkers related to abuse, as revealed in blood tests. Although biomarkers are related to diseases and conditions characteristic of old age, there is a preliminary evidence of higher albumin level in older adults identified as subject to abuse [2,39] and neglect [28]. This direction should also be followed further.

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