

Scientific Background

The problem of abuse of the elderly has not received appropriate attention, although awareness of its existence has increased in the last 25 years (Gordon & Brill, 2001; Kleinschmidt, 1977; Tomlin, 1989; Welfel, Danzinger & Santoro, 2001). Even today it receives little attention compared with other abuse incidents, for example, of women or children (Kosberg, 1998). This lack of knowledge and information interferes with the awareness of and alertness to the problem, among professionals as well as people in the elders' surroundings. According to estimates in the western world, 3-6% of the population older than 65 suffer from abuse and/or neglect, mostly by family members (Pillemer & Finkelhor, 1988; Reis & Nahmiash, 1997). Ronen and Niekerger (1977) and Kosberg (1998) claim that the actual percentages of elder abuse are probably much higher than those reported in the studies. During hospitalization, physical harm is identified more than other abuse forms, but is still under-identified (Lachs, & Pillemer, 1997). Hospitals should become a point of identification and location of elder abuse.

The problem of elder abuse has intensified parallel to the rising elderly population and the lengthening of the life span. Elder abuse is common in all socio-economic strata and among all cultural and ethnical background (Pillemer & Finkelhor, 1988; Tomlin, 1989), but it is mostly found in multi- problematic populations that are known to the welfare agencies

Characteristics of elder abuse

Elder abuse is a complex phenomenon that includes different kinds and levels of severity. Six sub-categories of abuse are described: physical abuse, neglect, psychological abuse, financial abuse, sexual abuse, and violation of rights (Gordon & Btil, 2001; Aravanis et al. 1993; Welfel et al., 2001)

The risk factors for elder abuse

The risk factors for elder abuse are related to the characteristics of the older person, the characteristics of the caregiver, and the environment. The elder person's characteristics that endanger him or her are his or her physical, financial, and emotional dependence, his or her social loneliness, trans-generation conflicts, feelings of guilt, and being an abuser or abused in the past (Kosberg, 1988; Lachs & Pillemer, 1997). As for the caregivers, those who suffer from continuous stress, because of the caregiving or because of financial or psycho-social problems, are the main risk group (Campbell Reay & Browne, 2001; Kosberg, 1988; Lachs & Pillemer, 1997). Reis and Nahmiash (1998) found that the main predictors of abuse lie in the characteristics of the caregiver and less in those of the elder, for example, emotional problems, behavior problems, drug or alcohol addiction, interpersonal problems or lack of social support. Campbell Reay & Browne (2001) suggest that different risk factors are related to different kind of abuse.

However, professionals claim that the existing profile of the abuser as well as that of the abused is over-simplified, and arose through research being centered on multi-problematic populations (Neikrug, & Ronen, 1993).

Locating elders at high risk by professionals

Many incidents of elder abuse and/or neglect are not identified by professional workers (Welfel et al., 2001; Reis & Nahmiash, 1997). Only the more severe cases of physical abuse and active neglect are identified (Gordon & Brill, 2001; Levenstein & Ron, 2000). The location of elders at risk or elders that suffer from abuse without any physical evidence is much less common. Several reasons exist for the difficulties in location: the silent bond within the family and the attempt of the abuser and of the abused to hide the “family secret” (Kosberg, 1998). Often the caregiver isolates the older person from friends or professional workers. Also, the victims often refuse to report the abuse due to feelings of shame, guilt, and fear or because they are socially isolated or mentally or physically disabled (Lachs, & Pillemer, 1997; Penhale, 1993). The low identification rates also occur due to lack of alertness among professional workers and due to the difficulty to create a distinction between symptoms of abuse and neglect and symptoms related to physical diseases. Also, Many professionals hesitate to penetrate the private family sphere (Fulmer, Street, & Carr, 1984).

Tools for identifying and locating elders at high risk of being abused and/or neglected

The literature on this subject emphasizes the need for efficient tools for identifying and locating the symptoms and signs of abuse (Bloom, Ansell, & Bloom, 1989; Fulmer et al., 1984; Lachs & Pillemer, 1997; Matlaw & Spence, 1994; Penhale, 1993; Rosenblatt, 1997; Welfel et al., 2001). Nevertheless, some professional tools do exist, and they focus on locating signs of active abuse (Fulmer, 1984; Lachs & Pillemer, 1997; Reis & Nahmiash, 1997; Sengstock & Hawalek, 1987; Welfel et al., 2001). One of the few tools applied to locate the risk of abuse is the Consequence of Care Index developed by Kosberg and Clair (1986). This index identifies the caregivers who have difficulties coping with the physical as well as the emotional burden of care, so that the risk of abuse increases (Kosberg and Clair, 1986). Another tool is the Indicators of Abuse (IOA) questionnaire developed by Reis and Nahmiash in Canada (Reis & Nahmiash, 1998). Of the 48 items comprising the primary questionnaire, based on Kosberg’s survey of causes for abuse (Kosberg, 1988), 27 were chosen. These were the items most efficient in predicting abuse and were relating to the psycho-social characteristics of the elder and the caregiver. The questionnaire was administered to 341 people. 99% of the elders suffering abuse (as reported by professional workers) were identified by the IOA. The most efficient aspect of this tool is its attempt to identify the risk for abuse before it has actually occurred, and therefore to prevent the potential abuse (Reis & Nahmiash, 1998). A relative score is

attached to each item; this makes it possible to calculate the general score, which serves as a criterion for substantial future risk of abuse

The deficiency of the IOA system is that it is based on a clinical interview and not on a constructed questionnaire.

The aims of the study

The overall goal was to improve strategies for identifying and locating elders at risk, and as a result, to provide professional interventions for stopping or preventing the abuse or neglect.

The specific aims:

A. To develop and improve the diagnosing tool, namely IOA (Indicators of Abuse Screen), which is used to identify elders at risk of being abused or neglected.

B. To examine the efficiency of the tool in medical centers when the primary reason for hospitalization or visit may not be related to abuse.

C. To identify the characteristics of elders at risk who are hospitalized, their distribution according to geographical, socio-economical variables, reasons or patterns of hospitalization, diseases, and physical situation.

Participants

Thirty eight elderly patients (aged 70+) who live in the community and were hospitalized in the internal departments, during and their main caregivers participated in the first phase of the study. Eligible patients were Hebrew speaking, able to communicate and give coherent information without evident of emotional impairment, and them and their caregivers willing to participate.

Measures

1. The expanded IOA (EIOA) questionnaire, comprising 27 abuse indicators. The questions were formulated on the basis of the DSM – IV (American Psychiatric Association, (1994) and General Psychiatry textbook (Goldman, 1994) (e.g., for the indicator “Behavior problems of the caregiver” 11 questions were devised concerning the scope of relevant behavioral problems).

The validity and reliability of the questionnaire has been tested in a multi-phases procedure ($\alpha=.92$) and assured. The original questionnaire was based on a clinical interview. In order to overcome the differences among interviewers concerning their diagnosing abilities, we developed for each indicator a set of questions that cover all aspects of the indicator.

2. A list of signs of actual abuse, meaning mental, physical, sexual, and financial abuse, and neglect. This list was developed at Mount Sinai hospital and was translated by us into Hebrew. Responses for each sign are dichotomous: the sign was not identified (0); the sign was identified (1) (appendix 3)

3. A demographic questionnaire on the elder and caregiver.

4. A questionnaire on the elder's health situation that was completed according to the patients' medical files.

Procedure

The interviewers were hospital social worker, with one year at least of experience in the hospital social work, and who participated in a workshop aimed to educate them for conducting the interviews. All patients eligible for the study were interviewed in this time period.

Preliminary Results

Socio-Demographic Characteristics of Elders and Caregivers.

Most of the elders assessed share their lives with a female/male partner (44.7%), 21.1% live with one of their children, 18.4% live alone, and 7.9% live with their brother or sister. 21% of the elders were independent in activities of daily living (ADL) before they were hospitalized, 26.3% were partially impaired in ADL living or instrumental activities (IADL), 13.2% were disabled, 7.9% were mentally disabled, and 32.6% were confined to nursing situations. 31.6% of the caregivers were spouses, 18% were children, 13.2% were daughters in law, 5.3 were nieces or nephew, and 2.5 were sisters. 73% of the caregivers were living together with the elder person.

Signs of actual abuse

Table 1 shows the distribution of the signs of actual abuse, divided into categories of physical abuse, mental abuse, financial exploitation, neglect, and sexual abuse. Due to the small number of participants in the pre-test, the six sub-categories of abuse were unified to one variable of existing actual abuse, for the following analysis.

Attention must be drawn to the psychological signs of abuse which are hard to distinguish from demented processes or emotional problems as late age depression. Also, signs of neglect could be intertwined with physical deterioration or illness, result in higher than the actual state.

Table 1: Identified Signs of Actual Abuse on the Elderly

	N	%
Actual signs physical abuse	6	15.8
Actual signs of psychological abuse	8	21.0
Actual signs of financial exploitation	8	21.0
Actual signs of neglect	13	34.2

Abuse indicators

Figures 1 and 2 show differences in the profile of abuse indicators, on the basis of EIOA, between elders who were and were not abused as revealed by a Man–Whitney test. The figures indicate the existence of differences in some of the indicators for abuse among elders as well as caregivers, though due to the small number of participants in the preliminary test, not all of the differences were statistically significant. More family problems and poor interpersonal relationships of the elder and the caregiver were significant indicators of abuse. Elders' mental difficulties and absence of a regular doctor and behavioral problems of the caregivers, caregivers having cognitive difficulties or unrealistic expectations were the other indicators. Also, repeated hospitalizations of the elders, and a low level of albumin in their blood distinguished elders who were abused from those who were not. The last two factors may be characteristics of abused elder that are hospitalized and may be of special importance for identifying abuse in hospital settings. Not all the indicators pointed to significant differences between the groups, which may be explained by the small number of the preliminary study participants or may be that some of the indicators may not be suitable for the Israeli population.

Figure 1: Elders' indicators of abuse

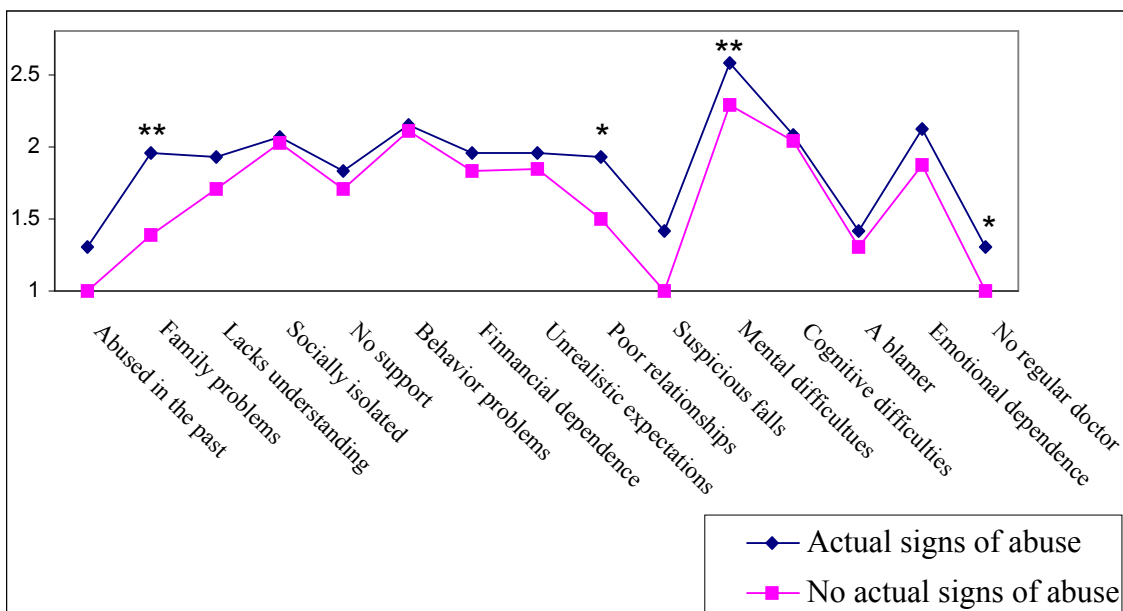
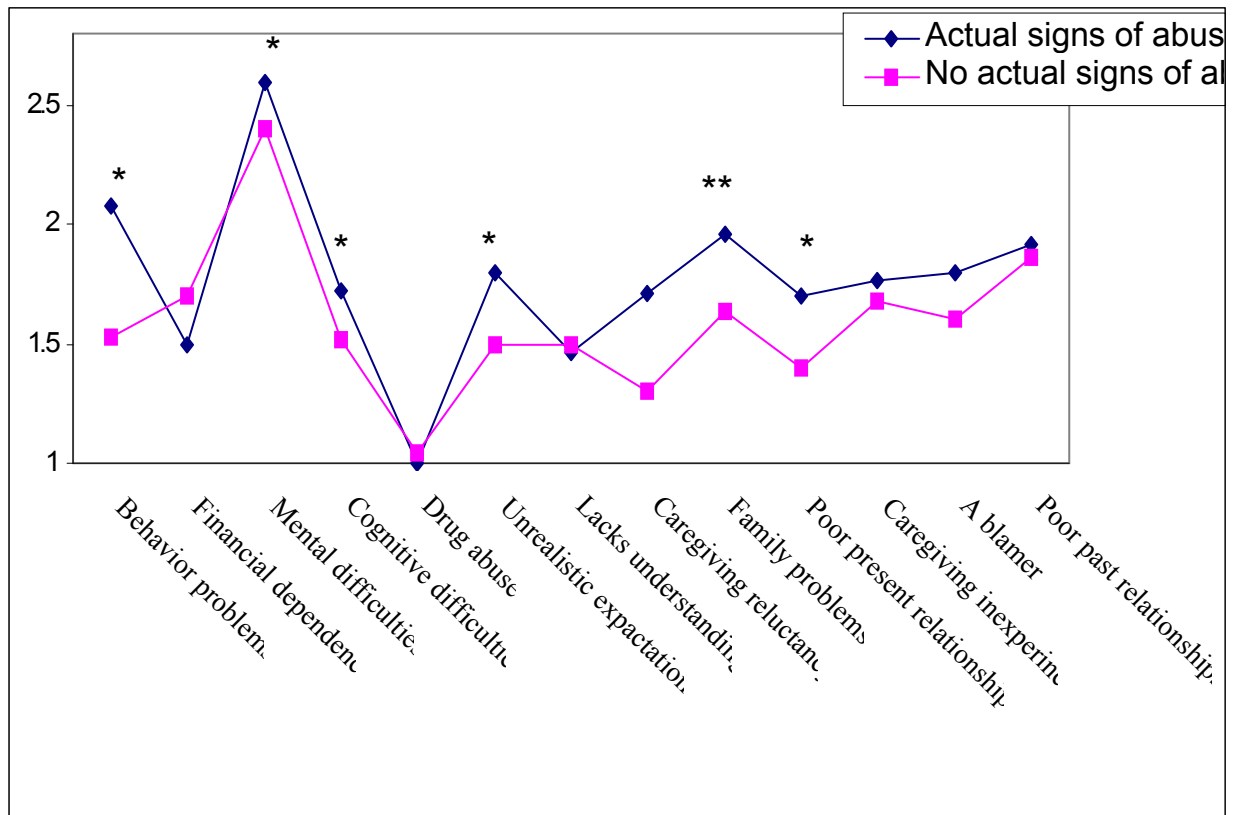


Figure 2: Caregivers' indicators of abuse



Discussion and conclusions

Abuse of elder persons by their caregivers is a wide existing phenomena that does not receive the appropriate attention, resulting in under-identification of the abusers and abused persons and thus, appropriate help is not given (Gordon & Brill, 2001; Kleinschmidt, 1977; Tomlin, 1989; Welfel, Danzinger & Santoro, 2001). The preliminary results of the present study show that when special efforts are invested, more elders at risk are identified. However, to do so, a special and well-validated tools are necessary. The proposed EIOA may be an example for such a tool, although, it still requires experienced professionals to conducting it.

Each year many elders attend the emergency room and the internal departments in the hospitals, so hospitals may fulfill a vital role in locating elders at risk. It is assumed that higher rate of elder persons at risk are hospitalized, as was evident from the higher rate of low albumin level in blood and numerous repeated hospitalizations. Also, even if the reason for hospitalization is not directly connected to abuse, it is an opportunity to locate those at risk (Lachs, & Pillemer, 1997). When an

efficient location method is practiced in hospitals and emergency departments, it will be possible to construct appropriate discharge plans and offer continuity of treatment at home.

Nevertheless, the EIOA needs to be further checked and improved by further research on various ethnic groups.

Elder abuse exerts an invidious effect on the dignity of human beings and especially infringes their right to proper treatment. Our professional duty is to see that elders can maintain a dignified existence and that after their discharge they return to a safe and supporting environment.

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