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YEDİTEPE UNIVERSITY
INSTITUTE OF HEALTH SCIENCES
DEPARTMENT OF PUBLIC HEALTH

VALIDITY AND RELIABILITY OF THE TURKISH VERSION OF THE ELDER ABUSE SUSPICION INDEX (EASI)

MASTER THESIS

SEVDE KARAKUŞ, PT

İSTANBUL, 2022

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SUPERVISOR

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DECLARATION

I hereby declare that this thesis is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which has been accepted for the award of any other degree except where due acknowledgment has been made in the text.

08.02.2022

Sevde KARAKUŞ

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LIST OF SYMBOLS AND ABBREVIATIONS

CDC	Center Disease Control
EA	Elder Abuse
EASI	Elder Abuse Suspicion Index
H-S/EAST	Hwalek-Sengstock Elder Abuse Screening Test
INPEA	International Network for the Prevention of Elder Abuse
SMMTE	Standardized Mini Mental State Examination for Educated
SMMTE-E	Standardized Mini Mental State Examination for Uneducated
WHO	World Health Organization

ABSTRACT

Karakuş, S. (2022). Validity and Reliability of the Turkish Version of the Elder Abuse Suspicion Index (EASI). Yeditepe University, Institute of Health Science, Department of Public Health, MSc thesis, İstanbul.

This study aims to determine the validity and reliability of the Turkish Version of Elder Abuse Suspicion Index (EASI). EASI is a 6-item screening tool designed to increase family physicians' suspicion of elder abuse. A total of 75 community dwelling, 65 and over aged, cognitively well-conditioned elders who were visited their primary healthcare physician were included the study. The mean age for the participants was 70.44±4.20 years. Thirty-seven (49.3%) female and thirty-eight (50.7%) male were included in the study. Data was collected by using a sociodemographic and abuse related variables form, Standardized Mini Mental State Examination Test for both educated and uneducated (SMMTE/SMMTE-E), Turkish version of Elder Abuse Suspicion Index (EASI) and Hwalek-Sengstock Elder Abuse Screening Test(H-S/EAST). Language validity was ensured by Beaton's protocol for cross-cultural adaptations. Contend validity index were computed according to Expert Panel to assess contend validity. To assess convergent validity, correlation between H-S/EAST and EASI were examined. SPSS version 25.0 was used for statistical analysis. To adapt the scale into Turkish version, language validity was performed according to forward translation-backward translation method initially. Content validity index was found 0.967 for total items. Suspicion elder abuse had a moderate positive correlation within EASI and H-S/EAST ($r=0.313$, $p<0.01$). Total H-S/EAST score, direct abuse and potential abuse situation subdivision scores had a moderate positive correlation with the EASI, providing evidence for convergent validity. Sensitivity of the Turkish version was calculated 58.33% and the specificity was 79.37%. It was concluded that, the Turkish version of EASI is a valid and reliable measure which can be used for screening elder abuse in primary healthcare settings and to raise awareness for both elders and physicians.

Key Words: Elder Abuse, Elder Abuse Suspicion Index (EASI), Adaptation, Validity and Reliability Studies

ÖZET

Karakuş, S. (2022) Yaşlı İstismarı Şüphe İndeksi(EASI) Türkçe Versiyonunun Geçerlilik ve Güvenilirlik Çalışması. Yeditepe Üniversitesi, Sağlık Bilimleri Enstitüsü, Halk Sağlığı Bölümü, Yüksek Lisans Tezi, İstanbul

Bu çalışma ile Yaşlı İstismarı Şüphe İndeksi(EASI) Türkçe Versiyonunun geçerlilik ve güvenilirliğini belirlemek amaçlandı. EASI; 6 maddeden oluşan ve aile hekimlerinin yaşlı istismar şüphesini artırmak için dizayn edilmiş bir tarama aracıdır. Çalışmaya 65 yaş ve üstünde, kognitif durumu iyi olan ve birinci basamak hekimine başvuran toplam 75 toplumda yaşayan kişi dahil edildi. Katılımcıların yaş ortalaması 70.44±4.20 yıldır. Otuz yedi (%49.3) kadın ve otuz sekiz (%50.7) erkek çalışmaya dahil edildi. Bu çalışmada; sosyodemografik bilgiler ve istismarla ilgili bilgiler formu, Standardize Mini Mental Test eğitimli ve eğitimsizler için, Hwalek-Sengstock Yaşlı İstismarı Testi ve Yaşlı İstismarı Şüphe İndeksinin Türkçe versiyonu veri toplama aracı olarak kullanıldı. Dil geçerliliği Beaton'un kültürler arası uyarlamalar için hazırladığı protokole göre sağlandı. Kapsam geçerliliğini değerlendirmek için, uzman paneline göre İçerik Geçerlilik İndeksi hesaplandı. İçerik geçerliğini değerlendirmek için H-S/EAST ve EASI arasındaki korrelasyona bakıldı. İstatistiksel analiz için SPSS 25.0 versiyonu kullanıldı. Ölçeğin Türkçe versiyonunu adaptasyonu için öncelikle ileri ve geri çeviri yöntemi ile dil geçerliliği sağlandı. İçerik Geçerlilik katsayısı bütün ölçek için 0.967 olarak bulundu. EASI ve H-S/EAST ($r=0.313$, $p<0.01$) korrelasyonuna göre orta derecede ve istatistiksel olarak anlamlı korrelasyon bulundu. Ölçeğin içerik geçerliliğinin göstergesi olarak, EASI ile H-S/EAST toplam puanı, direk istismar ve potansiyel istismar bölümleri ile istatistiksel olarak anlamlı pozitif bir korrelasyon bulundu. Türkçe versiyonunun sensitivitesi %58,33 ve spesifitesi %79.37 olarak hesaplandı. Sonuç olarak, Yaşlı İstismarı Şüphe İndeksi Türkçe Versiyonunun geçerli ve güvenilir bir ölçme aracıdır ve birinci basamakta tarama yapmak ve yaşlı ve doktorların farkındalığını arttırmak için kullanılabilir.

Anahtar Sözcükler: Yaşlı İstismarı, Yaşlı İstismarı Şüphe İndeksi (EASI), Adaptasyon, Geçerlilik ve Güvenilirlik

1. INTRODUCTION and PURPOSE

Elder abuse (EA) gains importance as a global public health problem due to the progressively raising elder population and improvements in life expectancy worldwide.[1] It is defined by World Health Organization (WHO) and International Network for the Prevention of Elder Abuse (INPEA) 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".[2] Main types of EA can be categorized as physical, emotional, financial, sexual and neglect. Also, numerous risk factors identified for each victims, perpetrators, their relationship and cultural factors. [3,4]

EA is identified as a violation of fundamental rights.[2,5]It can cause both short term and long term consequences for victims like; physical and physiological problems, worsening in health conditions, social isolation, decrease in quality of life and even early mortality.[1,2] It also lasting effects on families and health care, criminal justice, and social services systems by increasing health care costs, long term care facilities needs etc.[6]

According to WHO, one in every 6 elder was abused worldwide.[7] Available evidences show that, prevalence of EA ranges between 3% to 25% in the European Region.[1] Likewise, a recent study in Turkey found that 13.6% of the elders living in community settings were exposed to any type of abuse over the past year and the numbers likely to be underestimated. [8]

Thereby, in order to overcome globally expected consequences of elder abuse, WHO and INPEA came together in 2002 and they commenced an action plan on the Toronto Declaration Global Prevention of Elder Abuse.[2] After that, Turkey Healthy Aging Action Plan and Implementation Program 2015-2020, included elder abuse identification and prevention strategies into their targets. For that purpose; activities were planned for each society, healthcare workers, policy providers and other relevant professionals.[9] Accordingly, primary healthcare services stated as in a unique position to identify and prevent elder abuse due to their close and repetitive contact with elders.[2,10,11] Within this context, as a strategy, systematic and periodic screening of the elders with a qualified tool in healthcare settings is recommended to detect and report EA.[12,13]

Accordingly, numerous screening instruments exist and recommended to use for different conditions. [4,12] Although there are some validated screening tools used in Turkey like Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST), Vulnerability Abuse Screening Scale(VASS), Elder Self-Neglect Scale, Geriatric Mistreatment Scale(GMS); Elder Abuse Suspicion Index (EASI) as a unique tool has not validated for Turkish population.[14–18]

Elder Abuse Suspicion Index (EASI) was developed by Yaffe et al. in 2008 in order to use as a screening tool to raise family physicians' suspicion of elder abuse who are in unique position for both prevent and detect elder abuse in primary healthcare settings.[10,11,19] It is brief, user friendly tool and it only takes 2 -5 min to administer. There are also validated self-administered and long term care versions of EASI.[20,21] It is translated into more than 10 languages and it is called as culturally modifiable. Besides that, it has been already recommended by the related authorities like WHO and NPEA to screen EA.[22]

Therefore, the main aim of this thesis is to determine validity and reliability of the Turkish version of the "Elder Abuse Suspicion Index (EASI) to use by family physicians for raising their suspicion and awareness to detect and prevent elder abuse in the first place.

2. LITERATURE REVIEW

2.1. Population Ageing and Decade of Healthy Ageing

2.1.1. World Population Prospects

According to 2019 World Population Prospects, World has a rapidly aging population through the number of 65 and over adults is growing faster than other age groups. İt is estimated that, by 2050, 1 in 6 people will be over age 65 in the world. The global population of older adults is projected to increase 7 per cent about 16% of the world's population in 2050, from 9% in 2019. Besides, the population of 80 years or over named oldest-old adults is expected to triple and reached to 426 million in the next 30 years. Furthermore, global fertility rate is projected to decline further to 2.2 and life expectancy at birth is expected to increase nearly 77 years.[23]

According to Turkish Statistical Institute 2020 report, the number of people aged 65 and older was increased 22.5% in five years and reached approximately 8 million. According to report, Turkey lines on 66 among the worldwide highest elderly population percentage ranking. It is also projected that by 2030, 12.9% of the total population will be aged 65 and over by increasing almost 5 percent from 8.2% in 2015. Besides that, life expectancy has risen to the current average of about 75.9 years for men and 81.3 years for women. In line, average life expectancy for persons aged 65 is found to be 18 years.[24]

2.1.2. Healthy Ageing

Projections of rapid increase in the elder population raise concerns about the consequences of ageing worldwide. In 2015 World Report on Ageing and Health, ageing was considered as urgent topic needs a comprehensive public health action. Also, healthy ageing is defined as more than just the absence of disease, is a process of developing and maintaining the functional ability that enables well-being in older age. [25] After that, Sixty-ninth World Health Assembly in May 2016 stated The Global Strategy and Action Plan on Ageing and Health. It declares that everyone has the opportunity to have long and healthy life.[26]

Recently, aligned with the Global Strategy and Action Plan on Ageing and Health and 2030 Sustainable Development and the Sustainable Development Goals; United Nations General Assembly declared 2021–2030 the Decade of Healthy Ageing which seeks a global collaboration and multi-sectorial action to foster longer and healthier lives of older people, their families, and the communities in which they live worldwide. The Decade calls action in 4 main areas; combating ageism, age-friendly environments, integrated care and long term [27,28]

2.1.3. Ageing and Consequences

Ageing is considered as a natural phenomenon associated with various changes in the elder's life. Reduced physical, cognitive and mental functions, increased risk of disorders and functional limitations associated with ageing. Also, elder adults are at an increased risk of social challenges like isolation, dependence, financial problems and reduced social support. Due to the transformation in physical and social functions elders are considered as more vulnerable to external environmental challenges like elder abuse.[25]

2.2. Elder Abuse

Elder abuse, which was firstly described in 1970s as a "granny battering" is a type of interpersonal violence. It remained hidden until population ageing globally has led to increased concerns about elder problems.[29] Later in 2002 active ageing framework, elder abuse was declared by WHO as "a violation of Human Rights and a significant cause of injury, illness, lost productivity, isolation and despair".[30] After that, it was started to be identified by authorities and discussed in the national and international organizations.[31]

Thereafter, as a milestone "The Toronto Declaration on the Global Prevention of Elder Abuse" was launched to call action to prevent elder abuse globally which was focused on missing legal frameworks, need of a multi-sectorial involvement, promoting knowledge through education and media, primary health care providers' role on identification and prevention.[2] Since then, elder abuse was recognized as a global public

health problem causing serious health, social and economic consequences for both elders and societies.[1] And it is declared that urgent action on health care systems, social welfare agencies, policymakers, and the general public was needed.[4]

Researches shown that; elder abuse occurs in every country without any borders or cultural, religious, ethnic, economic differences.[2,7] Also it occurs in both in community and institutional settings.[32] It is estimated that affects at least 140 million elder annually.[33] With a rapidly ageing population in countries around the world, the number of elder adults vulnerable to elder abuse is expected to grow further.[5]

2.2.1. Definitions

While several global terms are used as elder mistreatment, maltreatment, elder abuse and neglect; "Elder Abuse" was decided by the Centers for Disease Control (CDC) and the experts to use as a uniform term globally because of the broadest recognition and the covering of the concept.[34]

Likewise, there are several widely accepted definitions for elder abuse. Recently, it is accepted as a uniform definition by CDC as defined as "an intentional act, or failure to act, by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult." [34]

Besides, as one of the most commonly used definition which was developed by Action on Elder Abuse in the United Kingdom and then adopted by WHO and INPEA; "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".[2]

2.2.2. Types of Elder Abuse

Generally elder abuse was categorized into 5 major types as; physical, deliberately causing pain, harm or injury to an older person; sexual, any kind of forced and/or unwanted sexual interaction with an older person; psychological, verbal or nonverbal behaviors intended to cause psychological and emotional pain and distress to

older person; financial, illegal, unauthorized, or improper use of an older person's resources and neglect, refusal or failure to fulfill older persons basic needs like; food, clothing, hygiene, housing, medical care, emotional needs.[35]

Table 1. outlines the definitions and examples of elder abuse according to types. Definitions and contents of types may vary according to cultural backgrounds of the communities.[36] Different forms of abuse often occur together: in particular, psychological/emotional abuse often suspects other forms of abuse by isolating elder to the comunity.[37]

Table 1. Definitions and Examples of Elder abuse According to Types[34,37,38]

Physical Abuse:	"Deliberately causing pain, harm or injury to an older person" • Hitting, kicking, pushing, beating, scratching, biting, choking, shaking, slapping, pinching, burning • Arm twisting, hair pulling • Force feeding • Physical punishment • Misuse of drugs and restraint
Sexual Abuse:	"Any kind of forced and/or unwanted sexual interaction with an older person" • Forced and/or unwanted sexual contact/attempted to contact or penetration • Forced and/or unwanted non-contact acts such as sexual harassment, • Language or exploitative behavior • Exposure to pornography, enforced nudity

Psychological/ Emotional Abuse:	"Verbal or nonverbal behaviors intended to cause psychological and emotional pain and distress to older person" • Humiliation, disrespect or insulting like name-calling, treating as child • Verbal and non-verbal threats like withdraw affection or access to loved ones, to harm loved ones to put in a nursing home • Harassment, preventing the person from speaking, repeatedly telling the older person that they are not capable or have impairment • Geographic or interpersonal isolation; preventing contact with family and friends or an access to services, preventing the person from engaging in religious or cultural activities, moving an older person away from their immediate family
Financial Abuse:	"Illegal, unauthorized, or improper use of an older person's resources" • Stealing money, goods or possessions • Occupying, selling, or transferring property against their will or conscious • Using banking and financial documents without permission • Opening or using bank accounts, credit cards • Forcing to sign documents or contracts • Forcing to buy or sell possessions • Taking control of elder's finances
Neglect:	"Refusal or failure to fulfill older persons basic needs like; food, clothing, hygiene, housing, medical care, emotional needs" • Failure to provide food, water, heat, clean clothing and housing • Failure to provide medical care • Failure to provide medical aids like eyeglasses or dentures, or health-related services • Failure to provide appropriate care • Failure to provide emotional needs • Left alone or abandonment • Refusal to permit others to provide appropriate care

2.2.3. Risk Factors

Elder abuse is the result of the complex interaction of individual, relationship, social, cultural and environmental factors.[1] Numerous individual (victim, perpetrator), relationship, community and society level risk factors identified to increase the risk of elder abuse. Although there were some risk factors identified as constantly associated with risk of abuse, some of them are lack of evidence or have conflicts on it.[1,4] Table 2 summarizes risk factors for elder abuse in 4 levels with the strength of the evidence levels (Strong: substantial evidence; Potential risk: mixed or limited; Contested risk lack of clear evidence). On the other hand social support and living arrangement were found protective factors for elder abuse.[4]

Table 2. Elder Abuse Risk Factors and Strength of Evidence[4]

Level	Risk Factors	Strength
Individual (Victim)	Functional dependence/ disability	Strong
	Poor physical health	Strong
	Cognitive impairment	Strong
	Poor mental health	Strong
	Low income/SES	Strong
	Gender	Potential
	Age	Potential
	Financial dependence	Potential
	Race/ethnicity	Potential
Individual (perpetrator)	Mental illness	Strong
	Substance abuse	Strong
	Abuser dependency	Strong
Relationship	Victim–perpetrator relationship	Potential
	Marital status	Potential
Community	Geographic location	Potential
Societal	Negative stereotypes on aging	Contested
	Cultural norms	Contested

Victim- Perpetrator Relationship

According to victim-perpetrator relationship elder abuse categorized into family members and non-family members like care givers, neighbors and friends. Between them family members were found more common perpetrators of elder abuse except financial and sexual abuse. Besides that, it is suggested within the family members; partners/spouses are more likely to perpetrate physical and psychological abuse while adult children are more likely to perpetrate neglect. [39] Besides, according to The 2004 Survey of Adult Protective Services the most common relationships of victims to alleged perpetrators were adult child (32.6%) followed by other family member (21.5%), unknown relationship(16.3%) and spouse/intimate partner (21.5%).[40,41]

Institutional Setting

Within institutional settings, abuse can be categorized into resident-to- resident aggression and staff-to-resident abuse.[42] It is suggested that due to their physical and cognitive problems elders residing in the institutions are more vulnerable to elder abuse.[43] Physical impairments, activities of daily life limitations and behavior problems are found as significant risk factors for elder abuse in the long term care settings.[44]

According to a study, resident-to- resident aggression prevalence was 20.2%.[45] Behind that, an overall estimate of staff-to-resident abuse was found 64.2% based on the staff self-reports of the staffs. Also, the prevalence estimates were found 33.4% for psychological, 14.1% for physical, 13.8% for financial, 11.6% for neglect and 1.9% for sexual abuse based on data from older residents' self-reports. On the other hand, it is found there was insufficient data to calculate overall prevalence according to self-reported data from elder residents.[32]

According to a recent study; causes of abuse in the institutional settings were categorized according to characteristics of institutions (improper work organizations, understaffing, workload), caregivers (burnouts, personal issues, acknowledge of elder abuse) and residents (personality, isolation).[46] Also it is suggested that by increasing knowledge about abuse and risk factors, developing positive organizational environment and quality control of the given care; elder abuse can be prevented in the institutional settings.[42]

2.2.4. Prevalence in World

According to WHO, about 1 in 6 community-dwelling older adults aged 60 and older experience some form of elder abuse annually.[7] Prevalence of elder abuse varies in the researches widely because of the differences in study populations, settings, definitions and research metododologies.[47] However, it is suggested that published studies are likely to underestimates the true population prevalence's because many cases of elder abuse go unrecognized or unreported.[41,48]

According to a meta-analysis based on 44 studies from 28 different countries, it is revealed that the pooled prevalence of elder abuse was estimated to be 15.7% in community settings globally. It is also concluded that the most common subtype is psychological/emotional (11.6%), followed by financial (6.8.0%), neglect (4.2.0%), physical (2.6%) and sexual abuse (0.9%) according to the studies past-year pooled prevalence estimates. Besides, they revealed some geographical differences in prevalence estimates with, Asia at 20.2%, Europe at 15.4%, and the Americas at 11.7%.[33]

In United States, according to a computer assisted real time telephone interview of 5777 responders, it is found that more than one in 10 cognitively intact 60 years or older adult experienced some form of emotional, physical, or sexual abuse or neglect in the past year. [49]

European report on preventing elder maltreatment suggest that each year approximately 4 million physical, 1 million sexual, 29 million psychological and 6 million financial abuse case experiencing by 60 years and older elders in the European Region. It is also concluded that the prevalence and risk factors of elder abuse varies according to countries and cultures.[1] According to a cross sectional study in seven cities in Europe (Italy, Germany, Greece, Lithuania, Portugal, Spain, Sweden) prevalence rates of elder abuse differ between countries according to types. It is concluded that elders residing in Germany, Lithuania, and Sweden was associated with higher prevalence rates. It is suggested that the differences between countries caused because of the different awareness levels, collective life events and methodological reasons.[50]

Also, a meta-analysis by Ho and colleagues revealed that adults living in non-western countries were 10.1% more likely to be abused than those living in western countries (17.4% for Non-Western countries vs. 7.3% for Western countries). It is suggested that hierarchical family structure and cultural expectations, like to care for respect, might have associated with the increase the risk of perpetration in the Non-Western countries. [51] A random sampling of 7,466 adults residing 6 different regions in China revealed that 10% of the participant's parent have experienced at least 1 episode of abuse during the previous year on multiple occasions. They also concluded that 40% victims were suffered more than two types of abuse last year.[52]

A 2019 systematic review and meta-analysis in Iran shows that the overall prevalence of elder abuse was 48.3%: physical 11.6%, psychological 26.7%, financial 26.7%, and care neglect 38.4% .[53] On the other hand in some regions like South Africa, there were no reliable data found about the prevalence and they suggest that because of the multicultural nation, poverty and other kind of problems like HIV/AIDS crisis.[54]

2.2.5. Elder Abuse in Turkey

Like worldwide, Turkey has been giving priority to elder problems recently because of the increasing older population and differentiating sociocultural and economic structure.[55]

According to a recent systematic review, the prevalence rates of elder abuse were varying widely between 14.2% and 70.9% according to prevalence studies in Turkey. It is also concluded that the prevalence rates of elder abuse ranged between; for psychological 5.9% and 78.0%, for physical 1.3% and 63.0%, for sexual 0.3% and 3.2%, for financial 0.8% and 33.3% and for neglect 5.3% and 80.0%.[56]

In regard to risk factors in Turkey it is found that being female, older than 70 years, low education status, living with spouses and children, and bad familial relationships, being alone, insufficient income, physical disability and dependence were increase the risk of abuse among elders.[8,55,57] It is also concluded that depression and dependence on activities of daily life were associated with elder abuse among elders.[58,59]

2.2.6. Consequences of Elder Abuse

Consequences of elder abuse can be serious and have some long- and short-term effects on individuals and societies. Although many victims suffer from some minor injuries like bruises or cuts; others may face with more serious disabilities or even premature death. [1]

According to a recent systematic review about the consequences of elder abuse, it is found that elder abuse is likely to be associated with decline in physical and mental health of victims. Physical consequences were included as; general and musculoskeletal pain, poor general health, digestive problem/gastrointestinal symptoms. It is also concluded that depression, emotional problems like anger and fear, poor mental health, distress, anxiety and thoughts of suicide are the mental health consequences associated with elder abuse respectively to strength of evidence levels.[60]

Higher risk of premature mortality is consequence of elder abuse. According to a prospective cohort Chicago Health and Aging Project (CHAP) study, based on 9,318 community dwelling elders, after 13 year of follow up period, it is found that elder abuse was also associated with increased risk of mortality after adjustments for any covariates like demographics, chronic diseases, cognitive status and mental illness they may have.[61]

Later, it is also reported that elder abuse has been linked to increased rate of emergency department visit and hospitalization in the community settings.[62,63] Similarly, is it found that the rate of admission to skilled nursing facilities and longer stay time was also increased with elder abuse.[64] Thereby, it is estimated to cost of tens of billions dollars annually through increased hospitalization and health care costs.[65,66]

2.3. İdentification, Diagnosis and Signs of Elder Abuse

Each abuse case has unique properties. Through the far reaching consequences of elder abuse it was defined as a complex situation to identify, treat and prevent it.[67] According to a study which was done to determine the professionals and their roles and responsibilities on elder abuse, more than 20 professionals and numerous roles and responsibilities were retained. And it is concluded that a collaboration of healthcare,

community and legal services are needed to be involved to effective identification, intervention and prevention of elder abuse.[68]

Since 1990s, according to Diagnostic and Treatment Guidelines on Elder Abuse, it is known fact that healthcare settings have a pivotal role for identifying potential elder abuse victims, as a unique time for them to leave their home and contact someone except their caregivers.[38] In regard to the role of each health care professional namely paramedics, physicians, nurses, radiologists, technicians, social workers were presented with specific roles and responsibilities.[69] Assessment by healthcare professionals especially for acute situations like physical injuries represents an opportunity to directly detect abuse victims in emergency department. [70] Also in home care settings; emergency department and home health aid staffs were in front lines to detect potential victims in their own environments especially for isolated elders. [70,71]

On the other hand, primary health care settings were presented with a special attention to prevent elder abuse through their repetitive contact with elders. As being in a trust relationship with the elder and their family and knowledge about their general health conditions; primary care physicians have a unique place. By routine assessment of suspected elders, family physicians conducts an special opportunity to identify, intervene and prevent abuse.[2,38]

2.3.1. Diagnosis and Clinical Findings

Identifying elder abuse has challenging through distinguishing between clinical features of ageing and signs of abuse.[72,73] Therefore, a careful attention for potential abuse indicators should be considered for each elder in the healthcare settings. It is recommended to check out risk factors and signs of abuse. Besides that, it is also recommended to observe elder-caregiver interaction for any stressed relationship. It is recommended to take a detailed medical history from both elders and the caregivers to identify possible discrepancies. Although assessment strategies can vary according to type of elder abuse it is recommended to make a comprehensive geriatric examination of patients including physical, cognitive and emotional situations. Also it is recommended to make additional laboratory tests and imaging if it is needed. [74,75]

Table 3. Signs of Elder Abuse According to Types[37,38,76]

	Signs:
Physical Abuse:	• Unexplained signs of injuries, bruises, burns, wound, sprains and fractures at different stages of healing • Lacerations to mouth, lips, gums, eyes or ears • Unexplained loss of hair and missing teeth • Falls, including broken eyeglasses or frames • Medication overdose or chemical restraints • Being seen by different physicians and medical centers
Sexual Abuse:	• Trauma like bruising or bleeding, pain or itching in the genital areas • Injury to face, neck, chest, abdomen, thighs or buttocks • Human bite signs • Unexplained STD or incontinence • Sexually transmitted disease • Recoiling from being touched, anxiety, fear, or post-traumatic stress disorder • Fear of bathing or toileting • Difficulty in walking or sitting • Changes in sleep patterns, sleep disturbances or nightmares • Anxiety when near the alleged perpetrator
Psychological/ Emotional Abuse:	• Sudden changes of emotions like fear, shame, feelings of helplessness • Sudden changes of behaviors like passivity or anger • Social isolation, changes in levels of self-esteem • Signs of infantile behavior • Stress, Depression, anxiety • Confusion, agitation, unexplained paranoia • Disrupted appetite or sleeping patterns • Ambivalent feelings toward caregivers or family members

Financial Abuse:	• Unusual activity in bank accounts • Unexplained disappearance of belongings • Inability of a person to access bank accounts or statements, recent addition of a signature on a bank account • Unexplained or sudden inability to pay bills • Lack of funds to essentials like food or clothing • Disparity between living conditions and financial situations • Confused about or unaware about their financial situations
Neglect:	• Malnutrition or dehydration, unexplained weight loss or eating habits • Pallor, sunken eyes, cheeks • Poor personal hygiene • Inappropriate or unusual clothing • Medicines not purchased or administered • Absence of appropriate medical aids like dentures, glasses, hearing aids • Appropriately cared injuries, pressure sores • Lack of safety precautions • Abandoned or left alone for long periods

According to European council of legal medicine (ECLM) guideline there were also some principles exist to keep in mind during the examination of potential elder abuse cases. First of all, it is declared that informed consent should be taken and the examination should be recorded in an objective manner to use as evidence if it is needed. It is also recommended that the examination should be done in private and safe environment separate from family members and caregivers. The language used should be well planned to not annoy them and clear enough to understand. Enough time to think and reply should be given. Lastly, a routine screen was recommended and it is concluded that multidisciplinary evaluation might be needed in complicated cases.[75]

2.3.2. Barriers to Identification and Reporting

Elder abuse has been identified as common but under reported. Although, it was cost effective to prevent than to face with serious consequences; it is estimated that only a fraction of cases can be identified and reported. An investigation into the reasons why reporting rate are so low 2 main reasons were identified.[77]

As a first line, victims were usually tended to hide and not report it. According to a recent study which were investigates barriers to reporting elder abuse, 28 semi-structured interview were made with victims and 4 main barriers were concluded by the victims as; not to damage family bonds, fear of negative consequences for themselves like abandoning, fear of negative consequences for abusers, shame and embarrassment of their experiences and self-blame for the abuse.[78] In a similar study in Iran barriers of help seeking were categorized into three namely; personal attitude toward abuse including thoughts of their own fault, family matter, atonement for their sins and fear of left alone; thought of the inefficiency of support systems or being unaware; and being dependent to others.[79] According to a study in Turkey, it is found that although elders were aware of abuse they were accepted it and tend to be not report especially when the perpetrator was a family member.[80]

On the other hand, elder abuse usually goes unidentified and unreported by healthcare professionals. It is reported that only %33.7 of health and social care professionals had identified elder abuse last year. But, only half of them were reported to authorities.[81] According to a study in İzmir, it is concluded that emergency health care providers in Turkey were unaware of the elder abuse for each detect and report it. 13.65% of emergency health professional pronounced that they never detect any elder abuse case. Also they state that it is hard to ask questions and take act without harming elders and families. [82]Although a huge capability of identifying and intervening; elder abuse was usually missed in healthcare settings. According to a research in US, even the emergency healthcare providers aware of missed cases they did not conduct routine examination. [83] It is concluded that, health professionals also face barriers to report abuse such as lack of enough knowledge and training, lack of standardized protocol to identify and response, additional time and responsibility and lack of easy standardized screening instruments. [78,81,84]

2.4. Screening Instruments

It is a challenge to screen elders because there is no consensus on present benefits and harms of screening elder abuse.[85] American Medical Association (AMA) recommends a routine screening of general elder population for elder abuse.[35,86] It is concluded that periodic assessment for elder abuse risk factors and signs of abuse are crucial for early identification and prevention. It recommended that annually 1 or 2 routine assessment with a standardized short instrument could support the monitoring the changes and gives opportunity to prevent and detect it.[86]

According to a recent review conducted on the screening instruments it is concluded that there is still no gold standard screening instrument exists, all screening tolls have some strengths and shortcamings.[87,88] In line with the health professionals recommendations, it is concluded that the ideal screening tool should be clear enough to identify cases, easy to use in busy work conditions, include referral pathways and consider cultural and individual differs of elders.[88]

A numerous screening tools have been developed to screen elder abuse. Although fundamental function of any instrument is identifying abuse they differ significantly according to their contents, purposes, administration time and settings, intendent responders and psychometric properties. Accordingly, numerous screening instruments exist and recommended to use for different conditions.[12,87,89,90]

There were 5 screening instruments validated in Turkish;

- Hwalek–Sengstock Elder Abuse Screening Test (H-S ‘‘East’’) was developed by Neale et al in 1986, which was validated for to use in risk populations by social work practices includes 3 domains in 15 “yes/no” items which can be used as self-report or by assistance [14,91]
- Vulnerability to Abuse Screening Scale (VASS) is a self-report instrument includes 12 dichotomous items developed by Schofield et al. in 2002, aims to identify older women at risk of elder abuse which was adapted to Turkish by Aşiret et al.[17]
- Geriatric Mistreatment Scale developed in 2013 to assess the perpetrator and the frequency of elder abuse which includes 22 items.[18]

- Elder Self-Neglect Scale, which was validated by Özmete et al in 2018 was developed to identify self-neglect of elders which includes 60 items on 4 construct factors.[16]

2.4.1. Elder Abuse Suspicion Index (EASI)

Elder Abuse Suspicion Index (EASI), a six-item screening instrument has been in the literature since 2008. It was developed by Yaffe et al. to raise primary care physicians' suspicion of elder abuse and to increase awareness on the subject on both elders and physicians. It is structured to use by family physicians in clinical settings on cognitively intact elders. It was designed for initial screening instrument as if in case of necessity to refer the victims to more comprehensive investigation or relevant authorities. [19,21] Therefore it is not designed to necessarily generate psychometric properties consistent with an outstanding screening tool.

It consists of 6 items; including five direct questions answered by elders to assess if they victimized in last 12 months respectively dependence, neglect, emotional-psychological abuse, financial abuse, physical-sexual abuse and one more question to ask physicians' observation to assess signs of abuse like physical as cuts, bruises, poor hygiene, and inappropriate clothing and behavioral like poor eye contact or withdrawn nature.[10,19,22]

This 6-item version of EASI was developed by 4 focus groups in different specialties like physicians, social workers, nurses. A consensus version had been demonstrated by 31 individuals for 5 items. Then according to recommendations of participants, sixth item were included to instrument which includes some signs of abuse to increase physicians' suspicion by observing elder to respond it. Then, it was administered to 953 elders by 104 family physicians. For assessing validity of EASI, it was compared with a gold standard social work assessment which includes 67 items and takes approximately an hour to administer. Then it was a demonstrated as a valid and reliable instrument to suspect elder abuse according to correlation found between instruments was 0.44 sensitivity and 0.77 specificity.[19]

After that, content validity of the EASI was affirmed in 7 countries within a project with WHO the life Course and Ageing Division which aims to develop universal a valid and reliable instrument to use for routine screening by primary healthcare setting

to facilitate identification and prevention elder abuse worldwide in different geographical and cultural settings. [22]

In 2012 it was adapted to self-administered version which was planned to use by elders while waiting room in the healthcare setting. It includes modified versions of first five items in the original EASI with the except of the 6th item which was not suitable for self-report version.[92] Later, in 2019, it has been demonstrated of its long-term care version which includes 3 more items in response to residential settings.[21] Also there were more than 10 linguistic versions for different countries.

According to a review of EA screening instruments, EASI was identified as a culturally transferable, easy to use, quick administration and can be used for exclude abuse by high specificity rates. [89] According to a recent review on screening instruments of elder abuse, it is concluded that the involvement of some of the elder abuse indicators in the questionnaire and administering by the family physicians were some of the advantages of screening by EASI.[88] In its 2013 systematic review for recommendations on elder abuse screening, the US Preventive Services Task Force included only the Elder Abuse Suspicion Index(EASI).[93]

3. MATERIALS and METHODS

3.1. Study Design and Purpose

This research is a methodological study aims to determine the validity and reliability of the Turkish version of Elder Abuse Suspicion Index (EASI).

3.2. Ethical Aspects of the Study

The study protocol was approved by the Yeditepe University Clinical Research Ethics Committee (Date:20.08.2020, No:1276) (Appendix 1). Permission was obtained from Istanbul Provincial Directorate of Health's article 15916306-604.01.01 (Appendix 2). Written permission was obtained from the competent producer, developer of the original EASI through e-mail (Appendix 3). The study conducted in in accordance with the Declaration of Helsinki. Accordingly, each individual was informed about the content of the study and the rights they have in advanced to the data collection. Then, written consents were obtained for volunteered participation (Appendix 4).

3.3. Duration and Location

The study was conducted between the dates of June - October 2021 at Üsküdar Bahçelievler Aile Sağlığı Merkezi.

3.4. Study Sample and Sample Size

Individuals volunteered to participate the study who had visited their family physicians for seeking healthcare over the age of 65 were included. Elders with;

- inability to speak and understand Turkish,
- deafness or blindness,
- diagnosed with Alzheimer's disease and other dementias,
- the elders having less than 24 SMMT

were excluded from the study.

Sample size was determined through the recommended method used for validity and reliability studies as 5 -10 times of the items in the scale.[94,95] According to that, target sample size was calculated as at least 75 subjects since there are 6 items in EASI.

3.5. Data Collection Process

After the routine clinical examination, elder were informed about their rights and invited to be volunteer to research by the family physician. After the informed consent taken (Appendix 4), family physician conducted Standardized Mini Mental State Examination for educated or uneducated (SMMTE/SMMSE-E) screening instrument to assess if the elder can be included the study by having enough cognitive level as being 24 and more SMMTE score.

If the inclusion criterias' were met, family physician administered Elder Abuse Suspicion Index© (EASI). These interviews were carried out privately and by face-to-face contact with the elder in a comfortable atmosphere which was take approximately 10 minutes to complete.

After that, volunteered elder referred the researcher by the family physician who was outside the room in a separate place. Then, Socio-demographic Information and Abuse Related Variables Form and Hwalek–Sengstock Elder Abuse Screening Test (H-S/EAST) were administered by the individuals themselves or with the help of the researcher according to literacy and elders prefer.

3.6. Data Collection Tools

3.6.1. Socio-demographic Information and Abuse Related Variables Form

This form prepared by researcher in order to gather information in 3 main areas including;

- Socio-demographic characteristics (age, gender, marital status, education level, labor status, occupation and family characteristics, number of children, self-report on income status, etc.)

- Health status (having chronic diseases, use of medications, use of health aids, smoking and alcohol habits, social security or insurance etc.)
- Abuse related variables (dependency to someone, type of housing, living arrangements, having own room, whom with live, relationship with adult child, whom were the main caregiver, caregiver characteristics etc.)

This form includes 29 items and was administered as self-report or by the help of the researcher. (Appendix 5)

3.6.2. Standardized Mini Mental State Examination for educated and uneducated (SMMTE/ SMMSE-E)

This tool developed by Folstein et al. in 1975 which was brief, standardized and widely used tool for determining cognitive status. It is composed of 11 items in five headings. It consists of questions regarding orientation, registration, attention and calculation, recall and language. Both of them were validated to Turkish and a score of 24 and above indicates normal cognition level (Appendix 6).[96–98]

3.6.3. Hwalek–Sengstock Elder Abuse Screening Test (H-S/EAST)

This tool was developed in 1986 by Neale et al. for service providers to identify elder abuse cases. It is a self-report screening instrument includes 15 dichotomous items on 3 dimensions regarding “direct abuse” (Items 4, 9, 10, 11, and 15), “characteristics of vulnerability” (Items 1, 3, 6) and “potentially abusive situation” (Items 2, 5, 7, 8, 12, 13, and 14). The scores range from 0 to 15 and higher scores show higher possibility of abuse while a score of 3 or higher indicative of abuse. It was validated to Turkish (Appendix 7).[14,35,91,99]

3.6.4. Elder Abuse Suspicion Index©(EASI)

Elder Abuse Suspicion Index (EASI), a six-item screening instrument has been in the literature since 2008. It consists of 6 items; one or more yes answer of the last 5 directly asked questions (except the first questions which measurers only the risk)

correlates with suspicion of elder abuse.[21] It is a valid and reliable instrument due to the demonstrated sensitivity of 0.47 and specificity of 0.75 according to the correlation of EASI with a gold standard elder abuse assessment method applied by social workers.[12,19,89] Detailed properties of the EASI were given in the literature review.

3.7. Translation and Intercultural Adaptation Process

Intercultural adaptation of a measurement instrument gain importance hence increasing number of multinational research'. It gives opportunity to comparability throughout internationally and adapt an already existing tool is found easier to develop a new tool. Beside that translation of an instrument internationally needs standardization. It is concluded that, cross-cultural adaptation process should not be just linguistic translation of the instrument but also cultural adaptation was needed. Throughout, guidelines were exists to ensure the adaptation of an instrument.[100,101] According to a commonly used guideline it is concluded that the process should be started with linguistic translation, respectively forward translation and backward translation. And after that cultural adaptation should be ensured by taking experts' opinions.[102]

In our study, translation and intercultural adaptation process was completed in several stages according to recommended methods for adaptation studies in cooperation with the developer of the scale.[102]

3.8. Statistical Analysis

In this research, "Statistical Package for Social Sciences" (SPSS) Version 25.0 was used for statistical analysis. Kolmogorov-Smirnov and Shapiro Wilk's tests were benefited for the investigating normal distribution of variables.

Descriptive statistics were calculated for the characteristics of the sample: frequency and percentages for categorical data and mean, standard deviation and range for continuous variables.

For examining differences between groups, non-parametric tests were used due to the distribution of variables was not normal. To compere 2 variables Mann Whitney U test was used. For examining correlation between 2 groups Spearmen Correlation and Phi coefficient was used. The relationship between groups was determined by the Chi-Square test. For all analyses a p value less than 0.05 were accepted as statistically significant.

Validity and Reliability Analysis

The measurement should be valid and reliable to be used. Methods for identifying validity and reliability of the measurements were changed according to properties of the measurement methods.[103]

Validity refers to degree of the tool to measures to one wants to measure. It is examined by assessing if the tool identifies and encompasses the concepts it should be cover. In adaptation studies it is recommended to assess the language, content, construct, criterion, convergent, concurrent-divergent validities according to translated tools features and research methods. Language validity was used to translate the scale in one and other language properly. Content validity refers to make the scale fit in the translated culture. Criterion, convergent and concurrent validity was usually assessed by correlation coefficients like Pearson's or Spearman rho's.[104]

Behind that reliability refers to stability of the measurement when applied different times, conditions and observers. To determine reliability test-retest, internal consistency and parallel forms were recommended to use. [103,105,106]

For screening instrument other 2 qualities were need to be identified was sensitivity and the specificity. Sensitivity was defined as the measurements ability to correctly identify cases, whereas specificity was the ability to identify non-cases.

In our study, to produce language validity; translation and back translation method was used according to Beaton's protocol. Content validity of the scale was determined by Davis technique by calculating Contend Validity Index which was acceptable at 0.80 and above. For examining Convergent Validity of the EASI the correlation between H-S/EAST and EASI were checked through Phi Correlation which was used for 2 dichotonomious variables.

Through the structure of the measurement as being index (which there were no correlation between the items and the total score was calculated by sum) the internal consistency was ensured by the providing the validity of the scale.[103] On the other hand sensitivity and specificity was determined through the examining the difference of outcomes between equivalent tools which were applied individuals under the same conditions. For examining the differences between test outcomes McNemer test was used. Also, Mann-Whitney U test was used to compere if the was differences between EASI decisions and H-S/EAST total and subdivision scores.

4. RESULTS

4.1. Descriptive Statistics

The study was conducted in Üsküdar Bahçelievler Aile Sağlığı Merkezi between June and October 2021. At the end of the data collection period, although 90 individuals had been volunteered to study, 15 of them were excluded because of the exclusion criteria's like under the score of 24 in SMMTE. A total of 75 volunteered elder were applied the study procedure.

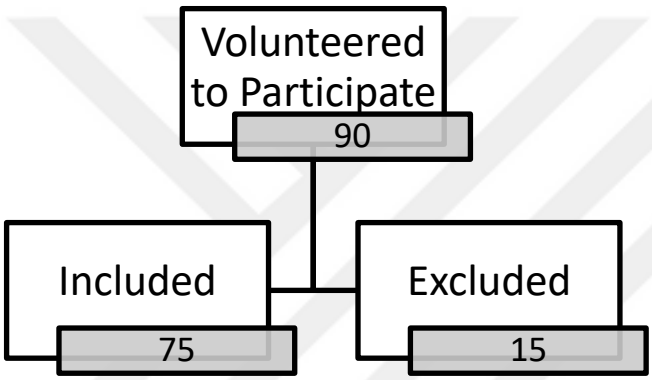


Figure 1. Excluded and Included Volunteers

4.1.1. Sociodemographic Characteristics of Participants

The mean age for the individuals was 70.44±4.20 years: 49.3% of them were between 65 and 69 years old, 34.7% were between 70 and 74 years old and 16% were older than age 75. Frothy nine percent (49.3%) of the respondents were women. In distribution of marital status, it was found the majority of the participants were married (69.3%), 24.0% were widowed and 6.7% were divorced. While 8.0% of the individuals did not receive any education, 48.0% were graduated from primary, 14.7% were high school and 25.3% were university and higher. Majority of them were retired 69.3% and 5.3% of them reported not having a social security. Sociodemographic characteristics of participants were presented in Table 4.

Table 4. Sociodemographic Characteristics of Elders

		Frequency	Percent
AGE	65-69	37	49,3
	70-74	26	34,7
	75 and older	12	16,0
GENDER	Women	37	49,3
	Men	38	50,7
MARİTAL STATUS	Married	52	69,3
	Divorced	5	6,7
	Widowed	18	24,0
EDUCATİON STATUS	Illiterate	6	8,0
	Literate	3	4,0
	Primary	36	48,0
	High-School	11	14,7
	University and Higher	19	25,3
LABOR STATUS	Working	3	4,0
	Non-Working	20	26,7
	Retired	52	69,3
OCCUPATİON	Housewife	21	28,0
	Official	10	13,3
	Private Sector	18	24,0
	Engineer	4	5,3
	Teacher	4	5,3
	Others	18	24,0
SOCIAL SECURITY	None	4	5,3
	Emekli Sandığı	25	33,3
	Social Security	36	48,0
	BAĞKUR	8	10,7
	Private Insurance	1	1,3
	Yaşlılık Aylığı	1	1,3

4.1.2. Health Status of Study Participants

82.7 % of the individuals were having a diagnosed chronic disease and 82.7% were using prescribed medication. Only minority of them were using health aids 17.3% (8.2% hearing aid, 4.1% prosthesis, 4.1% walking aid, 2.7% others) and 16.0% of them received psychological support.

According to alcohol using habits, 13.3% of them were using. While 50.7% of them were reported that they did not ever smoke, 40.0% of them were quit smoking and 6.7% of them were reported as still smoker. Health status of study participants were presented in Table 5.

4.1.3. Family Characteristics of Study Participants

Table 6, 7 and 8 were presented for family characteristics of participants. 58.7% of them reported having as a nuclear family and the average number of children was 2.57±1.153 and ranged from 1 to 5. Perceived family relationship was mainly very good 50.7%. Only 9.3% of them reported not to having own room.

The average person living in the home except to individual were calculated 1.44±1.18 ranging 0 to 4. The perceived economic status according to income-expenses comparison was reported as good (30.7%), medium (53.3%) and bad (14.7%).

It is also stated that 17% of them were living alone, others stated that were living with partner or someone else. Majority of the elders reported that they did not have primary caregiver (54%).

Only 1.3% of them were reported that their caregiver having substance dependence, 8.0% of them were having psychological disease, 17.3% of them for economic dependence to elder and 2.7% of them were having a violence history.

Table 5. Health Statues of the Elders

		N	%		N	%
CHRONİC DİSEASE	YES	62	82.7	Diabetes	23	31
				Hypertension	37	51
				Heart Disease	16	22
				Others	35	48
	NO	11	14.7			
MEDİCATİON	YES	62	82.7	Diabetes	22	30
				Hypertension	37	51
				Heart Disease	11	15
				Others	31	42
	NO	11	14.7			
HEALTH AİDS	YES	13	17.3	Hearing Aid	6	8
				Prosthesis	3	4
				Walking Aid	3	4
				Others	3	4
	NO	60	80.0			
PSYCHOLOGİCAL SUPPORT	YES	12	16.0			
	NO	61	81,3			
SMOKİNG HABBITS	STILL SMOKER	5	6.7			
	QUIT	30	40			
	NEVER USED	38	50.7			
ALCOHOL HABBITS	YES	10	13.3			
	NO	63	86.3			
	TOTAL	73	97.3			

Table 6. Family Structures of the Elders

		Frequency	Percent
FAMILY STRUCTURE	Nuclear	44	58.7
	Extended Family	22	29.3
	Broken Home	9	12.0
NUMBER OF CHILD	0	3	4
	1	7	9.3
	2	29	38.7
	3	20	26.7
	4	12	16
	5	4	5.3
PERCEIVED CONTACT RATE	Always	43	57.3
	Often	21	28.0
	Sometimes	9	12.0
PERCEIVED FAMILY RELATIONSHIP	Very Good	37	49.3
	Good	30	40
	Average	8	10.7
OWN ROOM	Yes	68	90.7
	No	7	9.3
LIVING HOME OWNERSHIP	Individual	39	52.7
	Partner	15	20.3
	Immediate Family	9	12
	Rent	12	16.0
PERCEIVED ECONOMIC STATUS	Good	23	30.7
	Medium	40	53.3
	Bad	11	14.7

Table 7. Living Arrangements and Primary Caregivers of Participants

		Responses	
		N	Percent
WHOME WİTH LİVE	Alone	13	17
	Partner	49	65
	Daughter	15	20
	Son	19	25
	Daughter-in-low	5	7
	Grandchild	7	9
	Others	2	3
Total		75	100
PRIMARY CAREGIVER	None	41	54
	Partner	17	23
	Daughter	9	12
	Son	12	16
	Daughter-in-low	4	5
	Grandson	1	1
	Others	1	1
Total		75	100

Table 8. Characteristics of Caregivers of Participants

		N	%
Substance Dependence	Yes	1	1.3
	No	31	41.3
Psychological Disease	Yes	6	8
	No	26	34.7
Economic Dependence to Elder	Yes	13	17.3
	No	19	25.3
Violence history	Yes	2	2.7
	No	30	40
Total		32	41.1

4.1.4. Distribution of the Standardized Mini Mental State Examination for Educated or Uneducated (SMMTE/SMMTE-E) of the Participants

Table 9 shows descriptive statistics of the SMMTE scores and subdivision scores for both educated and uneducated. According to results, scores were ranged between 24 and 28 for total. Score of SMMTE for total (n=75) calculated as 26.31±1.14, 25.86±0.90 for educated (n=68) and 26.35±1.16 for uneducated (n=7).

Table 9. Descriptive Statistics Table for Subscale Scores of SMMT/SMMT-E

	SMMT					
	Uneducated (n=7)		**Educated (n=68)**		**Total (n=75)**	
	Mean±SD	Min-Max	Mean±SD	Min-Max	Mean±SD	Min-Max
Total	26.35±1.16	24-28	25.86±0.90	25-27	26.31±1.14	24-28
Orientation	9.97±0.17	9-10	9.71±0.49	9-10	9.95±0.23	9-10
Registration	3.00±0.00	3-3	3.00±0.00	3-3	3.00±0.00	3-3
Attention and Calculation	2.22±0.83	0-3	3.00±0.00	3-3	2.29±0.82	0-3
Recall	2.88±0.37	3-3	2.00±0.82	1-3	2.80±0.49	1-3
Language	8.22±0.64	7-9	8.14±0.38	8-9	8.21±0.62	7-9

4.1.5. The descriptive Statistics of H-S/EAST

The descriptive Statistics of H-S/EAST were given in Table 10 according to subdivisions. Direct Abuse score of the H-S/EAST was 0.28 ± 0.605. Vulnerability score of the H-S/EAST was 0.83±0.724. Potential Abuse score of the H-S/EAST was 0.77±1.021. Total score of H-S/EAST was 1.93±1.639.

Table 10. Descriptive Statistics of H-S/EAST

Descriptive Statistics

	N	Min	Max	Mean	SD
Direct Abuse score	75	0	2	0.28	0.605
Vulnerability Score	75	0	3	0.83	0.724
Potential Abuse Score	75	0	5	0.77	1.021
Total Score	75	0	9	1.93	1.639
Valid N (leastwise)	75				

4.1.6. The descriptive Statistics of EASI

The descriptive Statistics of EASI were given in Table 11. It was shown that 85.3% of the participants answered no for the first question which was asked to assess if the individual has a risk for other questions. It was seen that 22.7% of them were answered yes for psychological abuse, 5.3% for financial abuse and 2.7% for physical or sexual abuse. Also, it is calculated only 1 elder was suspected by the family physician.

Table 11. Descriptive Statistics of EASI

		N	%
Q1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	No	64	85.3%
	Yes	3	4.0%
	Did Not Answer	8	10.7%
Q2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with?	No	74	98.7%
	Yes	0	0.0%
	Did Not Answer	1	1.3%
Q3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	No	53	70.7%
	Yes	17	22.7%
	Did Not Answer	5	6.7%
Q4. Has anyone tried to force you to sign papers or to use your money against your will?	No	68	90.7%
	Yes	4	5.3%
	Did Not Answer	3	4.0%
Q5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	No	72	96.0%
	Yes	2	2.7%
	Did Not Answer	1	1.3%
Q6. Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 month?	No	73	97.3%
	Yes	1	1.3%
	Not Sure	1	1.3%

4.2. Validity and Reliability Analysis of the EASI

4.2.1. Language Validity

Translation process was completed in several stages according to Beaton's guideline for adaptation studies in cooperation with the developer of the scale.[102] The flowchart about the translation process was shown in Figure 2.

First of all, to precede the Turkish version of EASI, a written permission was obtained from the Mark Yaffe the competent producer of the original scale through e-mail (Appendix 2).

After that, in the first place, one professional translator and other two translators who are both advanced in English and medical professionals independently completed the forward translation from English to Turkish. Then, these 3 translations were gathered together, and a consensus version had been prepared by the researchers. Then, back translation process was completed by a professional translator who was unaware of the original version of the scale.

Later, the back translated version was compared with the original scale and sent back to the Dr. Yaffe. Then, some arrangements were made in several stages regarding his directions.

After that, for the cultural adaptation; five academicians specialized especially on elder health and fluent in both languages were asked to evaluate each item of the Turkish version of EASI and scored each of them if it is not applicable, partially applicable, applicable or completely applicable related to cultural aspects and linguistic properties (Expert panel). In this way, some modifications were made according to their suggestions.

Finally, an academician of Turkish Language and Literature department in Yeditepe University evaluated the final version of the scale regarding Turkish linguist.

Eventually, the Turkish version of EASI was shared on the official website of the EASI, like other 16 language versions, to provide accessibility. The Turkish version of the EASI is also shown in the (Appendix 9)

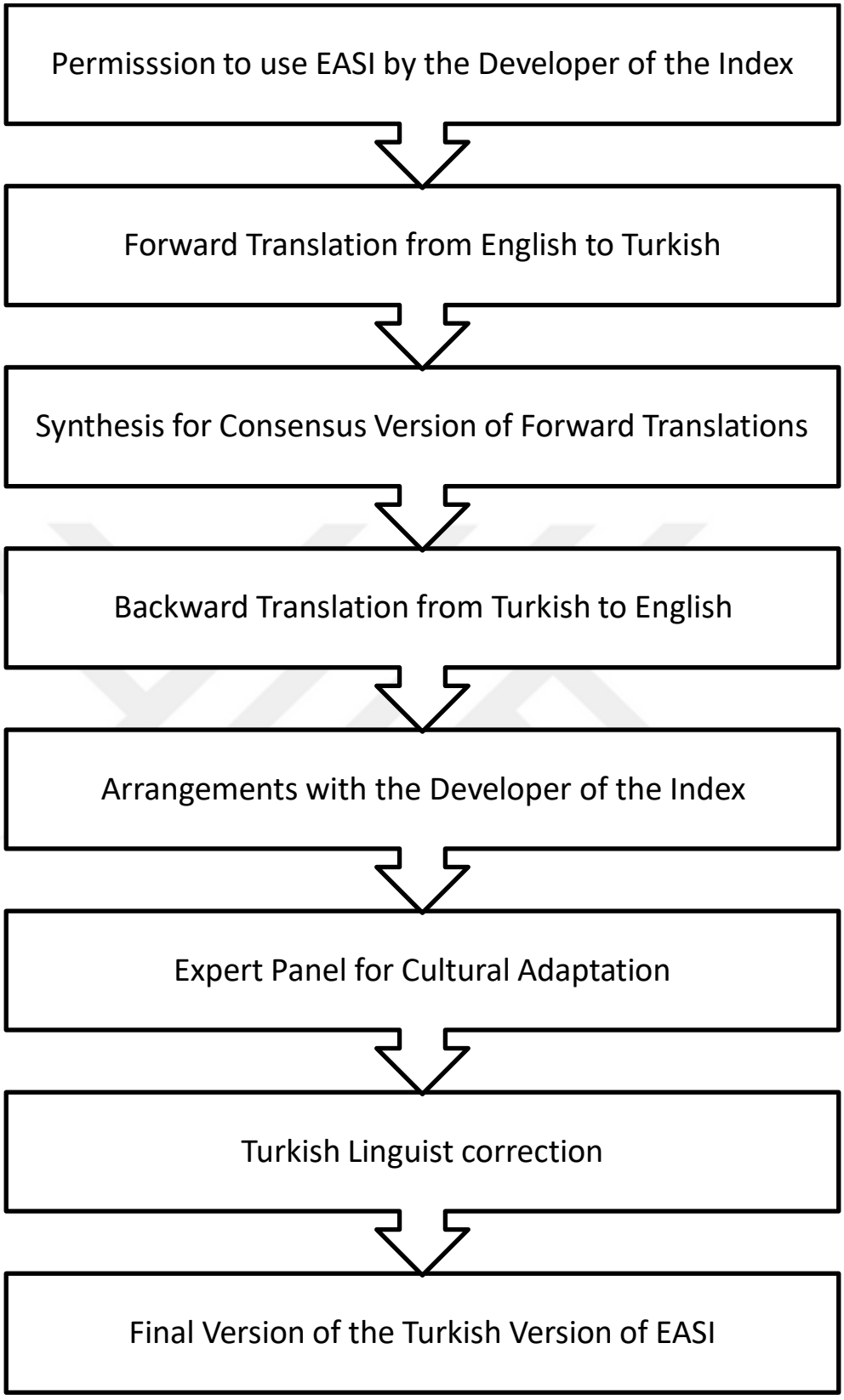


Figure 2. Flowchart of Turkish Translation of Elder Abuse Suspicion Index (EASI)

4.2.2. Content Validity

Through the 5 experts' scoring items, distribution of the scores and calculated Contend Validity Index for each item and the total were shown in the Table 12. Content Validity Index was calculated 0.967 for total and for items between 0.8 -1.0.

Table 12. Experts Scores and Content Validity Index of EASI

Items	Completely Applicable	Applicable	Partially Applicable	Not Applicable	CVI
Q1.	1	3	1	0	0.8
Q2.	2	3	0	0	1.0
Q3.	2	3	0	0	1.0
Q4.	3	2	0	0	1.0
Q5.	4	1	0	0	1.0
Q6.	3	2	0	0	1.0
				CVI	0.967

4.2.3. Convergent Validity

Convergent validity of the EASI was determined according to Phi correlation between EASI and H-S/EAST. There was a positive, moderate and statistically significant correlation between the EASI and H-S/EAST decisions on suspicion of elder abuse ($r=0.313$, $p<0.01$).

Also, it is found that EASI decision of suspicion of abused or not; correlated significantly with total score of the H-S/EAST ($r=0.407$, $p=0.000$). In addition, it is also found that direct abuse and potential abuse subdivisions of H-S/EAST were significantly correlated ($P<0.01$). Correlation between scales was shown in the Table 13.

Table 13. Correlations between EASI and H-S/EAST

		r	p
H-S/EAST, Abused/Non-Abused	Phi	0.313**	0.007
H-S/EAST, Direct Abuse score	Rho	0.297**	0.010
H-S/EAST, Vulnerability Score	Rho	0.168	0.151
H-S/EAST, Potential Abuse Score	Rho	0.351**	0.002
H-S/EAST, Total Score	Rho	0.407**	0.000
N		75	

**Correlation is significant at the 0.01

4.2.4. Reliability Analysis

The difference between H-S/EAST sub dimension and total scores and EASI decision of suspicion of abused or not were examined and showed in Table 14.

- There was a statistically significant difference between the total scores H-S/EAST in terms of identified suspicion of abuse and not individuals according to EASI ($p<0.01$). The ranks of the suspected abused elders were significantly higher than the ranks of the non-abused elders.
- Also, it was found statistically significant difference between direct abuse and potential abuse sub dimension scores of the H-S/EAST and the suspected abused elders according to EASI.

- However, there was no statistically significant difference between vulnerability score of H-S/EAST and the suspected abused elders according to EASI.

Table 14. Differences between H-S EAST Sub dimension and Total Scores in terms of Suspicion of Elder Abuse According to EASI

		N	Rank	U	p
H-S/EAST, Direct Abuse score	No abuse risk	55	35,30	401.50	0.011*
	Yes abuse risk	20	45,43		
	Total	75			
H-S/EAST, Vulnerability Score	No abuse risk	55	36,00	440.00	0.149
	Yes abuse risk	20	43,50		
	Total	75			
H-S/EAST, Potential Abuse Score	No abuse risk	55	33,81	319.50	0.003*
	Yes abuse risk	20	49,53		
	Total	75			
H-S/EAST, Total Score	No abuse risk	55	32,87	268.00	0.000*
	Yes abuse risk	20	52,10		
	Total	75			

U= Mann-Whitney U Test p<0.05

To assess the difference between H-S/EAST and EASI outcomes Mcnemar test were used for 2 dependent samples for suspicion of abused and not situations. It was found that the null hypotheses were retained p=0.096>0.05 means there were no statistically significant difference between 2 test. Result was shown in Table 15.

Table 15. Difference between H-S/EAST and EASI outcomes

Difference between H-S/EAST and EASI Outcomes	
n	75
p	0.096*

*McNemar Test were used in the analysis

4.3. Correlation between EASI and Sociodemographic Variables of Elders

The correlation between demographic variables and suspected abused/not-abused situations was examined in the Table 16. There was no correlation found between suspected abused and nonabused abused elders and gender, marital status, age categories and educational status.

Table 16. Correlation between suspected abused/non abused Situations according to EASI and Gender, Marital Status, Age, Education Status

		r	p
Gender (Women, Men)	Phi	0.068	0.554
Marital Status (Married, Non-Married)	Phi	-0.009	0.940
Age (65-69, 70-74,75 and over)	Cramer's V	0.071	0.828
Education Status (Illiterate and Literate, Primary School, High-school and over)	Cramer's V	0.209	0.195
N		75	

Correlation between health characteristics of elders and EA can not be computed which were shown in the Table 17.

Table 17. Ccorrelation between Health Characteristics of Participants and Elder Abuse

			Elder Abuse Risk			Phi	p
			No	Yes	Total		
Chronic Disease	YES	N	44	18	62	-0.087	n.c
		%	71,0%	29,0%	100,0%		
	No	N	9	2	11		
		%	81,8%	18,2%	100,0%		
	Total	N	53	20	73		
		%	72,6%	27,4%	100,0%		
Medication	YES	N	44	18	62	-0.087	n.c
		%	71,0%	29,0%	100,0%		
	No	N	9	2	11		
		%	81,8%	18,2%	100,0%		
		N	53	20	73		
		%	72,6%	27,4%	100,0%		
Health Aid	YES	N	10	3	13	0.045	n.c
		%	76.9%	23.1%	100.0%		
	No	N	43	17	60		
		%	71.7%	28.3%	100.0%		
	Total	N	53	20	73		
		%	72.6%	27.4%	100,0%		
Psychological Support	YES	N	7	5	12	-0.142	n.c
		%	58,3%	41,7%	100,0%		
	No	N	46	15	61		
		%	75,4%	24,6%	100,0%		
		N	53	20	73		
		%	72,6%	27,4%	100,0%		

n.c: Not Computed, (>20% expected count less than 5)

Table 18 and 19 were shown for to assess the association between family structure of elders and elder abuse. There was only a positive, moderate and statistically significant correlation between perceived family relationship and EA. Also, it is found there was a statistically significant difference between suspected abuse and not elders and number of child (U:373.50, $p<0.05$). Ranks of suspected abused cases were higher ranks than non-suspected elders.

Table 18. Difference Between Number of Child and Elder Abuse

	Abuse Risk	N	Rank	**U**	**p**
Number of Child	No abuse risk	55	34.79	373.50	0.027*
	Yes abuse risk	20	46.83		
	Total	75			

Table 19. Family Structure and Elder Abuse

	Phi	p
Family Structure (Nuclear, Extended Family, Broken Home)	0.141	0.473
Perceived Contact Rate (Always, Often, Sometimes)	0.176	0.321
Perceived Family Relationship (Very Good, Good, Average)	0.356	0.009*
Having Own Room (Yes, No)	-0.090	n.c
Living Home Ownership (Individual, Partner, Immediate Family, Rent)	0.90	n.c
Perceived Economic Status (Good, Medium, Bad)	0.092	0.731
N	75	

n.c: Not Computed, (>20% expected count less than 5)

The correlation between characteristics of caregivers of participants and elder abuse was examined in the Table 20.

Table 20. Ccorrelation between Characteristics of Caregivers of Participants and Elder Abuse

			Elder Abuse Risk				
			No	**Yes**	**Total**	**Phi**	**p**
Substance Dependence	YES	N	1	0	1	0.139	n.c
		%	100.0%	0.0%	100.0%		
	No	N	19	12	31		
		%	61.3%	38.7%	100.0%		
	Total	N	20	12	32		
		%	62.5%	37.5%	100.0%		
Psychological Disease	YES	N	1	5	6	-0.455	n.c
		%	16.7%	83.3%	100.0%		
	No	N	19	7	26		
		%	73.1%	26.9%	100.0%		
		N		20	12		
		%	62.5%	37.5%	100.0%		
Economic Dependence to Elder	YES	N	6	7	13	-0.279	n.c
		%	46.2%	53.8%	100.0%		
	No	N	14	5	19		
		%	73.7%	26.3%	100.0%		
	Total	N	20	12	32		
		%	62.5%	37.5%	100.0%		
Violence history	YES	N	0	2	2	-0.333	n.c
		%	0.0%	100.0%	100.0%		
	No	N	20	10	30		
		%	66.7%	33.3%	100.0%		
		N	20	12	32		
		%	62.5%	37.5%	100.0%		

n.c: Not Computed, (>20% expected count less than 5)

5. DISCUSSION and CONCLUSION

Elder abuse is now recognized as a serious and worsening public health problem needs to be identified and prevented globally.[4] On the other hand, it is also really identified and reported even in healthcare settings where were excepted as an ideal setting for identification for being an opportunity for elders to be in contact with someone else other than perpetrators.[38] Behind that, although screening for abuse was debate, it is concluded by the authorities as it has more benefits than harms. It has been shown that screening with a qualified tool provides an opportunity to early identification and prevention of elder abuse. EASI tool was developed for that purpose namely to raise awareness of both physicians and elders about the elder abuse for early identification and prevention and to refer authorities for definite identification if it is suspected.[19] It was a valid and reliable index which has been already adapted and used in many languages like Spanish, German, Arabic, etc. This scale has been recommended by authorities and a referred as short and easy to use instrument for suspicion of potential cases.[22] Therefore, even we know, there is no literature presenting the Turkish version of the EASI to the best of our knowledge. As a result, this study aims to determine validity and reliability of the Turkish version of the EASI to use by family physicians in the primary healthcare settings.

Adaptation of an already existing instrument was referred as time consuming for researchers and provides comparability of the research throughout different cultures. Behind that, adaptation of a measurement instrument was challenging because of the differences between cultures and languages. It should be translated and adapted to a new instrument not just by linguistically but also culturally. Also, it should be re-examined for psychometric properties to be ensure its validity and reliability to the translated culture.[102,104]

Likewise, English and Turkish are different language properties and there are numerous cultural differences between them. Although EASI was defined as a culturally modifiable instrument, a well-constructed adaptation was needed to use in different cultures. Throughout we used to translation and back translation method to initially construct the language validity of the questionnaire. The Beaton's guidance was

used as a protocol.[102] After the permissions were taken, translation was completed in several stages as explained in Figure 2.

Throughout the translation process, there were some discrepancies in each stage. While some of them were related to linguistic properties of languages like sentence structure or comprehensibility and clarity of the words used in our culture. To be ensuring, each word and term was examined in depth and final version was arranged with the expert's opinions and the developer's guidance. We choose the expressions that most closely resemble the wording in the original version of EASI and also try to provide clarity of the expressions for both elders and physicians. Eventually, the Turkish version of EASI was shared on the official website by the developers of the EASI, like other 16 language versions, to provide accessibility. The Turkish version of the EASI is also shown in the Appendix 9.

It is also recommended to test the psychometric properties of the adapted instruments according to their properties. For examining content validity of the EASI we used Davis Technique. Like is recommended we asked 5 academicians' opinion to assess if the translation was proper for our language and culture and to score each item if it is not applicable, partially applicable, applicable or completely applicable. According to their scoring of each item like showed in the Table 4.9 we calculated Content Validity Index for each item of the index and the total. It was calculated that 0.967 for total and between 0.8 and 1.0 for the items. So that Content Validity of the Turkish Version of EASI was confirmed, as it was acceptable at 0.8 and over.[107]

For examining Convergent Validity of the EASI we examined the correlation between EASI and H-S/EAST by Phi correlation. It was calculated that, there was a positive, moderate and statistically significant correlation between the EASI and H-S/EAST decisions on suspicion of elder abuse ($r=0.313$, $p<0.01$). Also, it was found low to moderate correlation between subdivision scores of H-S/EASTS for direct abuse, potential abuse and total score like shown in the Table 13. On the other hand, there were no correlation found between vulnerability subdivision score of H-S/EAST and EASI. As EASI and H-S/EAST were used for screening elder abuse; the correlation between their decisions of suspected abuse or not abused situations were used as an indicator of validity of the EASI. The proposed assessment tool can be an instrumental tool to suspect potential elder abuse cases.

Because of the indexes were not asses same concepts; the reliability of the indexes were ensured by its validity.[103] On the other hand, we test the reliability of the scale by a parallel form used for if the decisions of the EASI and H-S/EAST give same results when they were used respectively. As it was shown in the Table 15, there was no difference between the scales to be suspected of abuse. Also is shown in the table 14, there were significantly higher ranks for suspected abuse victims according to EASI and the subdivision of direct abuse and potential abuse subdivisions of H-S/EAST.

The original version of EASI was developed by Yaffe et al in 2008. 958 cognitively intact elders were included the study and 3 weeks later they were also evaluated by a gold standard social worker assessment which takes nearly an hour. According to study it was demonstrated that EASI was a valid and reliable instrument to suspect elder abuse according to correlation between instruments was 0.44 sensitivity and 0.77 specificity. According to Spanish adaptation study of EASI, which was completed within the project of "Global Response to Abuse and Neglect of the elderly: Building Primary Health Care Services capacity to deal with a worldwide problem"; Spanish version was found sensitivity of 51%, and specificity of 95%.[108] Likewise, The Irish version of EASI, 716 elders were included and the suspected elders were referred to further investment by the safeguarding services. Although it was found %11 of them were suspected and referred to safeguarding services only %24.1 of them were except and investigated further. It was concluded that the Irish version of EASI demonstrates at least 70% positive predictive value. [109] In our study we found sensitivity of 58.33%, specify 79.37%. So that, the observed sensitivity and specificity was comparable to previous reports from studies.

When we looked at the descriptive statistics of the instruments, 26.7% of the elders screened by EASI were suspected to be abused. On the other hand, 16% of them were found suspected according to H-S/EAST. According to literature the prevalence rates in Turkey varies between 14.2% to 70.9%.[56] According to a recent cross sectional study in Turkey, 13.6% of community dwelling elders were exposed any kind of abuse last year.[8]

Beside that, items of the EASI which were evaluated the risk of abuse, neglect, psychological abuse, financial abuse, physical-sexual abuse, and the signs of abuse respectively. Percentage of psychological abuse was higher as 22.7% than others

respectively financial for 5.5%, physical and sexual for 2.7% and neglect for 0.0%. This result confirms the literature related with the most common form of the abuse was psychological. Also it is confirmed by literature review prevalence can be changed by study population and research methods.[47] Beside that through it was not a cross sectional study we didn't expected to give definite results related with the actual ratios.

When we looked at the correlation between abuse and sociodemographic variables, there were no association found between suspected abused elders and age categories, gender, marital status and education levels. Although it was seen that some of them were correlated with EA in Turkey, it is confirmed that they were just potential risk factors for EA.[1,4,56] In a recent study Turkey, there were no correlation found between age and gender and EA. Likewise we didn't found any correlation between them.[110]

5.1.Limitations and Recommendations

We have some limitations in our study. First of all, although sample size of the participants was enough for adaptation studies, it is recommended to increase the study population to assess further. It is also recommended to use more detailed assessment techniques to compere sensitivity and specificity of the instrument.

One of the limitations of our study was conducted in cognitively well-conditioned community dwelling elders because of the instrument was only suitable for them. Accordingly, it can be concluded that as an at-risk population as being cognitive problems or living in non-community settings were not included to study. Also, it is recommended to be adapting for cognitive problem elders and for institutional settings which were more risked populations.

Also, in our study there was only center and only physician was included for research. Therefore, more centers and more physicians should be included in future research which would also include more individuals and covers entire Turkey. Likewise, it is recommended to validation for other versions of EASI like to use by different professionality's like APS, task forces or other health professionals.

Our study was conducted during the Covid-19 pandemic which might affect the responses of participants, so that it is recommended to study the validation of the instrument in more normal conditions.

5.2.Conclusion

Elder abuse will expected to increase in worldwide and it can be preventable by early identification like screening at risk population. Although there are some tools used in Turkey, it is concluded that there was a need of valid and reliable screening instrument for used for elder abuse screening in Turkey. Therefore, in this thesis were conducted research to identify validity and reliability of the Turkish version of the EASI.

The mean finding of the study was acceptable validity and reliability demonstrated by the Turkish version of the EASI. Therefore, it can be used in the Turkish population by family physicians of elders in the primary health care settings to screen elder abuse and to increase awareness.

Through, Turkey has a mandatory reporting of elder abuse it should be increased the awareness of the elders and physicians. Therefore, more screening and awareness campaigns should be done for elder abuse in healthcare and community settings.

6.REFERENCES

1. World Health Organization. Regional Office for Europe. *European report on preventing elder maltreatment.* Copenhagen : WHO Regional Office for Europe;(2011). https://apps.who.int/iris/handle/10665/107293

2. WHO. *The Toronto Declaration on the Global Prevention of Elder Abuse.* Geneva, World Health Organization, 2002. Accessed 9 May 2011.http://www.who.int/ageing/projects/elder_abuse/en/ index.html, accessed 9 May 2011.

3. Wang XM, Brisbin S, Loo T, MD SS. Elder abuse: an approach to identification, assessment and intervention. *Cmaj*. 2015;187(8):575-582. doi:10.1503/cmaj.141329/-/DC1

4. Pillemer K, Burnes D, Riffin C, Lachs MS. Elder Abuse: Global Situation, Risk Factors, and Prevention Strategies. *Gerontologist*. 2016;56(S2):S194-S205. doi:10.1093/geront/gnw004

5. World Health Organization. *Global status report on violence prevention 2014.* Geneva: World Health Organization; 2014.

6. Yunus RM, Hairi NN, Choo WY. Consequences of Elder Abuse and Neglect: A Systematic Review of Observational Studies. *Trauma Violence Abuse*. 2019;20(2):197-213. doi:10.1177/1524838017692798

7. Yon Y, Mikton CR, Gassoumis ZD, Wilber KH. Elder abuse prevalence in community settings: a systematic review and meta-analysis. *Lancet Glob Health*. 2017;5(2):e147-e156. doi:10.1016/S2214-109X(17)30006-2

8. Kulakçı Altıntas H, Korkmaz Aslan G. Prevalence of elder abuse among community-dwelling older adults in Turkey and its associated factors. *Psychogeriatrics*. 2020;20(1):3-10. doi:10.1111/psyg.12446

9. Republic of Turkey Ministery of Turkey. Turkey health aging action plan and implementation program 2015–2020. Ankara: Anıl Publication;2015. http://staging.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/turkey/turkey_health_aging_action_plan_and_implementation_program_2015-2020.pdf.

10. Yaffe MJ, Tazkarji B. Understanding elder abuse in family practice. *Can Fam Physician*. 2012;58(12):1336-e698.

11. İzbırak G. Birinci basamakta yaşlı istismarının önemi. İzbırak G, editör. *Birinci Basamakta Yaşlı Sağlığı*. 1. Baskı. Ankara: Türkiye Klinikleri; 2019. p.33-8.

12. Cohen M. Screening tools for the identification of elder abuse. *J Clin Outcomes Manag*. 2011;18(6):261-270.

13. Fadıloğlu Ç, Şenuzun Aykar F. Yaşlıda İstismar ve İhmale Yaklaşım. *Ege Tıp Derg*. 2012;51(Ek Sayı):69-77. doi:10.19161/etd.70627

14. Özçakar N, Toprak Ergönen A, Kartal M, Baydur H. Adaptation, reliability, and validity study of the Hwalek-SengstockElder Abuse Screening Test (H-S/EAST): a Turkish version. *Turk J Med Sci*. 2017;47(6):1894-1902. Published 2017 Dec 19. doi:10.3906/sag-1606-166

15. Özmete E. Hwalek- Sengstock Yaşlı İstismarı Tarama Testi : Türkçeye uyarlama çalışması. *Anadolu Psikiyatr Derg*. 2016;17(1):45-52. doi:10.5455/apd.200727

16. Özmete,E., Duru,S., ve Yıldırım,H. (2018). Yaşlılarda Kendini İhmal Ölçeği: Türkçeye uyarlama çalışması. *Anadolu Psikiyatri Dergisi. 19*(Ek Sayı.2), 87-95. doi:10.5455/apd.300262

17. Aşiret GD, Bağcivan G, Özcan M, Eröksüz B, Akbayrak N, Akdemir N. Cross-cultural adaptation and psychometric assessment of the Turkish version of the Vulnerability to Abuse Screening Scale. *Turkish J Med Sci.* 2017;47:1223-1228. doi:10.3906/sag-1609-11

18. Daşbaş S, Koçoğlu Tanyer D, Feyzal Kesen N. The Geriatric Mistreatment Scale: The Validity and Reliability of its Turkish Adaptation. *Turkish J Geriatr*. 2019;22(1):91-100. doi:10.31086/tjgeri.2019150578

19. Yaffe MJ, Wolfson C, Lithwick M, et al. Development and validation of a tool to improve physician identification of elder abuse: the Elder Abuse Suspicion Index (EASI). J Elder Abuse Negl 2008;20:276–300.

20. Schofield M.J. Screening for Elder Abuse: Tools and Effectiveness. In: Dong X, ed. *Elder Abuse*. Springer, Cham; 2017:161-199. doi:10.1007/978-3-319-47504-2

21. Ballard SA, Yaffe MJ, August L, Cetin-Sahin D, Wilchesky M. Adapting the Elder Abuse Suspicion Index© for Use in Long-Term Care: A Mixed-Methods Approach. *J Appl Gerontol*. 2019;38(10):1472-1491. doi:10.1177/0733464817732443

22. World Health Organisation. *A global response to elder abuse and neglect: building primary health care capacity to deal with the problem worldwide: main report.* Geneva: World Health Organization; 2008. Available: http://whqlibdoc.who.int/publications/2008/9789241563581_eng.pdf (accessed 2021).

23. United Nations. *World Population Prospects 2019: Highlights*. United Nations; 2019. https://www.un.org/development/desa/publications/world-population-prospects-2019-highlights.html

24. Turkish Statistical Institute. Ages by statistics, 2020. Published May 18, 2021. Accessed: May 15,2021. https://data.tuik.gov.tr/Bulten/Index?p=Istatistiklerle-Yaslilar-2020-37227. (in Turkish).

25. World Health Organization. *World report on ageing and health.* World Health Organization; Geneva: 2015. Accesed May 19, 2021. https://apps.who.int/iris/handle/10665/186463

26. World Health Organization. *Global strategy and action plan on ageing and health*. Geneva: World Health Organization; 2017.Accesed May 19, 2021. https://www.who.int/ageing/WHO-GSAP-2017.pdf. ISBN: 9789241513500

27. United Nations. *Transforming Our World: The 2030 Agenda for Sustainable Development*. 2015. Accesed May 19, 2021.https://sustainabledevelopment.un.org/post2015/transformingourworld/publication

28. World Health Organization. *Decade of Healthy Ageing*:2021-2030. Updated 2020. Accesed 15 May,2021. https://www.who.int/initiatives/decade-of-healthy-ageing

29. Krug EG, Mercy JA, Dahlberg LL, Zwi AB. The world report on violence and health. *Lancet*. 2002;360(9339):1083-1088. doi:10.1016/S0140-6736(02)11133-0

30. Kalache A, Gatti A. Active ageing: a policy framework. *Adv Gerontol*. 2003;11:7-18.

31. Ertin H, Özkaya H. Etik Açıdan Yaşlıya Kötü Muamele: İstismar ve Toronto Bildirgesi. *Turkiye Klin J Med Ethics Law Hist-Special Top*. 2016;2(2):77-84.

32. Yon Y, Ramiro-Gonzalez M, Mikton CR, Huber M, Sethi D. The prevalence of elder abuse in institutional settings: a systematic review and meta-analysis. *Eur J Public Health*. 2019;29(1):58-67. doi:10.1093/eurpub/cky093

33. Yon Y. Systematic Review and Meta- Analysis of Elder Abuse Prevalence Studies. Dissertation. University of Southern California; 2017.

34. Hall, JE, Karch, DL, Crosby, AE. *Elder Abuse Surveillance: Uniform Definitions and Recommended Core Data Elements For Use In Elder Abuse Surveillance, Version 1.0*. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2016.

35. *National Research Council (US) Panel to Review Risk and Prevalence of Elder Abuse and Neglect, Bonnie RJ, Wallace RB, eds. Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America. Washington (DC): National Academies Press (US); 2003.*36. World Health Organization. *Missing Voices: Views of Older Persons on Elder Abuse*.; 2002.

37. Department of Family and Community Services. *Preventing and Responding to Abuse of Older People (Elder Abuse): NSW Interagency Policy*. June 2020.Accesed May15, 2021. https://facs-web.squiz.cloud/__data/assets/pdf_file/0003/591024/NSW-Interagency-Policy-Abuse-of-Older-People.pdf

38. Aravanis SC, Adelman RD, Breckman R, et al. Diagnostic and treatment guidelines on elder abuse and neglect. *Arch Fam Med*. 1993;2(4):371-388. doi:10.1001/archfami.2.4.371

39. Jackson SL. All Elder Abuse Perpetrators Are Not Alike: The Heterogeneity of Elder Abuse Perpetrators and Implications for Intervention. *Int J Offender Ther Comp Criminol*. 2016;60(3):265-285. doi:10.1177/0306624X14554063

40. Teaster PB, Dugar TA, Mendiondo MS, Abner EL, Cecil KA, Otto JM. *The 2004 survey of state Adult Protective Services: Abuse of adults 60 years of age and older*. Washington, D.C.: National Center on Elder Abuse; 2006. doi:10.4135/9781452286143.n380

41. Lachs MS, Pillemer KA. Elder Abuse. *N Engl J Med*. 2015;373(20):1947-1956. doi:10.1056/NEJMra1404688

42. Touza C, Prado C. Prevention of elder abuse in long-term care facilities. *Educational Gerontology*. 2019;45(8):530-546. doi:10.1080/03601277.2019.1667555

43. Myhre J, Saga S, Malmedal W, Ostaszkiewicz J, Nakrem S. Elder abuse and neglect: an overlooked patient safety issue. A focus group study of nursing home leaders' perceptions of elder abuse and neglect. BMC Health Serv Res. 2020;20(1):199. Published 2020 Mar 12. doi:10.1186/s12913-020-5047-4

44. Post L, Page C, Conner T, Prokhorov A, Fang Y, Biroscak BJ. Elder Abuse in Long-Term Care: Types, Patterns, and Risk Factors. *Research on Aging.* 2010;32(3):323-348. doi:10.1177/0164027509357705

45. Lachs MS, Teresi JA, Ramirez M, et al. The Prevalence of Resident-to-Resident Elder Mistreatment in Nursing Homes. *Ann Intern Med*. 2016;165(4):229-236. doi:10.7326/M15-1209

46. Buzgová R, Ivanová K. Elder abuse and mistreatment in residential settings. *Nurs Ethics*. 2009;16(1):110-126. doi:10.1177/0969733008097996

47. Dong X. Elder abuse: research, practice, and health policy. The 2012 GSA Maxwell Pollack award lecture. *Gerontologist*. 2014;54(2):153-162. doi:10.1093/geront/gnt139

48. Mohd Mydin FH, Othman S, Choo WY, et al. Clinical recognition of elder maltreatment and intention to report among primary care doctors. *J Elder Abuse Negl*. 2020;32(1):72-83. doi:10.1080/08946566.2020.1731640

49. Acierno R, Hernandez MA, Amstadter AB, et al. Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: the National Elder Mistreatment Study. *Am J Public Health*. 2010;100(2):292-297. doi:10.2105/AJPH.2009.163089

50. Lindert J, de Luna J, Torres-Gonzales F, et al. Abuse and neglect of older persons in seven cities in seven countries in Europe: a cross-sectional community study. *Int J Public Health*. 2013;58(1):121-132. doi:10.1007/s00038-012-0388-3

51. Ho CS, Wong SY, Chiu MM, Ho RC. Global Prevalence of Elder Abuse: A Meta-analysis and Meta-regression. *East Asian Arch Psychiatry*. 2017;27(2):43-55.

52. Chen M, Chan KL. Elder Abuse and Neglect in China: Prevalence, Co-occurrence, and Intergenerational Risk Factors [published online ahead of print, 2021 Jan 8]. *J Interpers Violence*. 2021;886260520985501. doi:10.1177/0886260520985501

53. Abdi A, Tarjoman A, Borji M. Prevalence of elder abuse in Iran: a Systematic review and meta-analysis. *Asian J Psychiatr*. 2019;39:120-127. doi:10.1016/j.ajp.2018.12.005

54. Kotzé C. Elder Abuse-The Current State of Research in South Africa. *Front Public Health*. 2018;6:358. Published 2018 Dec 4. doi:10.3389/fpubh.2018.00358

55. Kissal A, Beşer A. Elder abuse and neglect in a population offering care by a primary health care center in Izmir, Turkey. *Soc Work Health Care*. 2011;50(2):158-175. doi:10.1080/00981389.2010.527570

56. Kalaycı I., Ozkul M. The Elderly as Social Victims of Modernization: Abuse and Neglect of the Elderly in Turkey. In: Shankardass M. ed.*International Handbook of Elder Abuse and Mistreatment*. Springer, Singapore;2020: 349-370. https://doi.org/10.1007/978-981-13-8610-7_20

57. Dasbas S, Isikhan V. Elder Abuse in Turkey and Associated Risk Factors. *J Soc Serv Res*. 2019;45(5):739-749. doi:10.1080/01488376.2018.1511883

58. Şen F, Meriç M. Determination of abuse and depression in the elderly. *J Elder Abuse Negl*. 2020;32(1):60-71. doi:10.1080/08946566.2019.1691697

59. Aslan H, Erci B. The incidence and influencing factors of elder abuse and neglect. *J Public Health.2020;28:*525-533. doi:10.1007/s10389-019-01071-7

60. Yunus RM, Hairi NN, Choo WY. Consequences of Elder Abuse and Neglect: A Systematic Review of Observational Studies. *Trauma Violence Abuse*. 2019;20(2):197-213. doi:10.1177/1524838017692798

61. Dong X, Simon M, Mendes de Leon C, et al. Elder self-neglect and abuse and mortality risk in a community-dwelling population. *JAMA*. 2009;302(5):517-526. doi:10.1001/jama.2009.1109

62. Dong X, Simon MA. Elder abuse as a risk factor for hospitalization in older persons. *JAMA Intern Med*. 2013;173(10):911-917. doi:10.1001/jamainternmed.2013.238

63. Mercier É, Nadeau A, Brousseau AA, et al. Elder Abuse in the Out-of-Hospital and Emergency Department Settings: A Scoping Review. Ann Emerg Med. 2020;75(2):181-191. doi:10.1016/j.annemergmed.2019.12.011

64. Dong X, Simon MA. Association between reported elder abuse and rates of admission to skilled nursing facilities: findings from a longitudinal population-based cohort study. *Gerontology*. 2013;59(5):464-472. doi:10.1159/000351338

65. Forum on Global Violence Prevention; Board on Global Health; Institute of Medicine; National Research Council. *Elder Abuse and Its Prevention: Workshop Summary*. Washington (DC): National Academies Press (US); March 18, 2014.

66. Baker PR, Francis DP, Hairi NN, Othman S, Choo WY. Interventions for preventing abuse in the elderly. *Cochrane Database Syst Rev*. 2016;2016(8):CD010321. Published 2016 Aug 16. doi:10.1002/14651858.CD010321.pub2

67. Cimino-Fiallos N, Rosen T. Elder Abuse-A Guide to Diagnosis and Management in the Emergency Department. *Emerg Med Clin North Am*. 2021;39(2):405-417. doi:10.1016/j.emc.2021.01.009

68. Du Mont J, Kosa D, Macdonald S, Elliot S, Yaffe M. Determining Possible Professionals and Respective Roles and Responsibilities for a Model Comprehensive Elder Abuse Intervention: A Delphi Consensus Survey. *PLoS One*. 2015;10(12):e0140760. Published 2015 Dec 2. doi:10.1371/journal.pone.0140760

69. Du Mont J, Kosa D, Yang R, Solomon S, Macdonald S. Determining the effectiveness of an Elder Abuse Nurse Examiner Curriculum: A pilot study. *Nurse Educ Today*. 2017;55:71-76. doi:10.1016/j.nedt.2017.05.002

70. Rosen T, Hargarten S, Flomenbaum NE, Platts-Mills TF. Identifying Elder Abuse in the Emergency Department: Toward a Multidisciplinary Team-Based Approach. *Ann Emerg Med*. 2016;68(3):378-382. doi:10.1016/j.annemergmed.2016.01.037

71. Reingle Gonzalez JM, Cannell MB, Jetelina KK, Radpour S. Barriers in detecting elder abuse among emergency medical technicians. *BMC Emerg Med*. 2016;16(1):36. Published 2016 Sep 2. doi:10.1186/s12873-016-0100-7

72. Mohd Mydin FH, Othman S, Choo WY, et al. Clinical recognition of elder maltreatment and intention to report among primary care doctors. *J Elder Abuse Negl*. 2020;32(1):72-83. doi:10.1080/08946566.2020.1731640

73. Mohd Mydin FH, Othman S. Elder Abuse and Neglect Intervention in the Clinical Setting: Perceptions and Barriers Faced by Primary Care Physicians in Malaysia. *J Interpers Violence*. 2020;35(23-24):6041-6066. doi:10.1177/0886260517726411

74. Rosen T, Stern ME, Elman A, Mulcare MR. Identifying and Initiating Intervention for Elder Abuse and Neglect in the Emergency Department. *Clin Geriatr Med*. 2018;34(3):435-451. doi:10.1016/j.cger.2018.04.007

75. Keller E, Santos C, Cusack D, et al. European council of legal medicine (ECLM) guidelines for the examination of suspected elder abuse. *Int J Legal Med*. 2019;133(1):317-322. doi:10.1007/s00414-018-1880-y

76. Glasgow K, Fanslow J. *Family Violence Intervention Guidelines : Elder Abuse and Neglect*. Wellington: Ministry of Health; 2006. Accesed:May 15, 202. https://www.health.govt.nz/system/files/documents/publications/family-violence-guideliens-elder-abuse-neglect.pdf

77. Fraga Dominguez S, Storey JE, Glorney E. Help-Seeking Behavior in Victims of Elder Abuse: A Systematic Review. *Trauma Violence Abuse*. 2021;22(3):466-480. doi:10.1177/1524838019860616

78. Dow B, Gahan L, Gaffy E, Joosten M, Vrantsidis F, Jarred M.Barriers to Disclosing Elder Abuse and Taking Action in Australia. *J Fam Violence.2020;35:* 853–86. https://doi.org/10.1007/s10896-019-00084-w

79. Adib M, Esmaeili M, Zakerimoghadam M, Nayeri ND. Barriers to help-seeking for elder abuse: A qualitative study of older adults. *Geriatr Nurs*. 2019;40(6):565-571. doi:10.1016/j.gerinurse.2019.04.003

80. Kalayci I, Yazici SÖ, Özkul M, Küpeli A. Perceptions of the elderly on elderly abuse. *Turkish Journal of Geriatrics.* 2016;19(4):232-237.

81. Cooper C, Selwood A, Livingston G. Knowledge, detection, and reporting of abuse by health and social care professionals: a systematic review. Am J Geriatr Psychiatry 2009; 17: 826–38.

82. Mandiracioglu A, Govsa F, Celikli S, Yildirim GO. Emergency health care personnel's knowledge and experience of elder abuse in Izmir. *Arch Gerontol Geriatr*. 2006;43(2):267-276. doi:10.1016/j.archger.2005.10.013

83. Rosen T, Stern ME, Mulcare MR, et al. Emergency department provider perspectives on elder abuse and development of a novel ED-based multidisciplinary intervention team. *Emerg Med J*. 2018;35(10):600-607. doi:10.1136/emermed-2017-207303

84. Schmeidel AN, Daly JM, Rosenbaum ME, Schmuch GA, Jogerst GJ. Health care professionals' perspectives on barriers to elder abuse detection and reporting in primary care settings. *J Elder Abuse Negl*. 2012;24(1):17-36. doi:10.1080/08946566.2011.608044

85. *Research to Practice: Elder Abuse Screening Tools for Healthcare Professionals.* National Center on Elder Abuse; 2016.Accesed May15,2021. http://eldermistreatment.usc.edu/wp-content/uploads/2016/10/Elder-Abuse-Screening-Tools-for-Healthcare-Professionals.pdf

86. Burnett J, Achenbaum WA, Murphy KP. Prevention and early identification of elder abuse. *Clin Geriatr Med.* 2014;30(4):743-759. doi:10.1016/j.cger.2014.08.013

87. Van Royen K, Van Royen P, De Donder L, Gobbens RJ. Elder Abuse Assessment Tools and Interventions for use in the Home Environment: a Scoping Review. *Clin Interv Aging*. 2020;15:1793-1807. Published 2020 Sep 28. doi:10.2147/CIA.S261877

88. Brijnath B, Gahan L, Gaffy E, Dow B. "Build Rapport, Otherwise No Screening Tools in the World Are Going to Help": Frontline Service Providers' Views on Current Screening Tools for Elder Abuse. *Gerontologist*. 2020;60(3):472-482. doi:10.1093/geront/gny166

89. Gallione C, Dal Molin A, Cristina FVB, Ferns H, Mattioli M, Suardi B. Screening tools for identification of elder abuse: a systematic review. *J Clin Nurs*. 2017;26(15-16):2154-2176. doi:10.1111/jocn.13721

90. Rosen T, Platts-Mills TF, Fulmer T. Screening for elder mistreatment in emergency departments: current progress and recommendations for next steps. *J Elder Abuse Negl*. 2020;32(3):295-315. doi:10.1080/08946566.2020.1768997

91. Özmete E, Megahead HA. Screening for Elder Abuse Among Turkish Older People: Validity of the Hwalek–Sengstock Elder Abuse Screening Test (H-S "East"). *Research on Social Work Practice*. 2017;27(3):387-398. doi:10.1177/1049731516654573

92. Yaffe MJ, Weiss D, Lithwick M. Seniors' self-administration of the Elder Abuse Suspicion Index (EASI): a feasibility study. *J Elder Abuse Negl*. 2012;24(4):277-292. doi:10.1080/08946566.2011.652930

93. Moyer VA; U.S. Preventive Services Task Force. Screening for intimate partner violence and abuse of elderly and vulnerable adults: U.S. preventive services task force recommendation statement. *Ann Intern Med*. 2013;158(6):478-486. doi:10.7326/0003-4819-158-6-201303190-00588

94. YaşlioğLu MM. Sosyal bilimlerde faktör analizi ve geçerlilik: Keşfedici ve doğrulayıcı faktör analizlerinin kullanılması. *İstanbul Üniversitesi İşletme Fakültesi Dergis*i. 2017;46:74-85.

95. Esin M.N. Veri Toplama Yöntem ve Araçları & Veri Toplama Araçlarının Güvenirlik ve Geçerliği. In: editor Erdoğan S, Nahcivan N, Esin MN, eds. *Hemşirelikte araştırma: süreç, uygulama ve kritik.* Nobel Tıp Kitabevleri, İstanbul; 2014:193-232.

96. Folstein MF, Folstein SE, McHugh PR. "Mini-mental state". A practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res*. 1975;12(3):189-198. doi:10.1016/0022-3956(75)90026-6

97. Güngen C, Ertan T, Eker E, Yaşar R, Engin F. Standardize Mini Mental Test'in Türk toplumunda hafif demans tanısında geçerlik ve güvenilirliği [Reliability and validity of the standardized Mini Mental State Examination in the diagnosis of mild dementia in Turkish population]. *Turk Psikiyatri Derg*. 2002;13(4):273-281.

98. Babacan-Yıldız G, Ur-Özçelik E, Kolukısa M. et al. Eğitimsizler için modifiye edilen mini mental testin (MMSE-E) Türk toplumunda alzheimer hastalığı tanısında geçerlik ve güvenilirlik çalışması. *Türk Psikiyatri Dergisi*. 2016;27(1):41-46.

99. Neale AV, Hwalek MA, Scott RO, Sengstock MC, Stahl C. Validation of the Hwalek-Sengstock Elder Abuse Screening Test. *Journal of Applied Gerontology*. 1991;10(4):406-418. doi:10.1177/073346489101000403

100. Çapık C, Gözüm S, Aksayan S. Intercultural scale adaptation stages, language and culture adaptation: Updated guideline. *Florence Nightingale Hemşirelik Derg*. 2018;26(3):199-210. doi:10.26650/fnjn397481

101. International Test Commission. ITC guidelines for translating and adapting tests (Second edition). *International Journal of Testing.* 2018;18(2):101-134. doi:10.1080 /15305058.2017.1398166

102. Beaton DE, Bombardier C, Guillemin F, Ferraz MB. Guidelines for the process of cross-cultural adaptation of self-report measures. *Spine (Phila Pa 1976)*. 2000;25(24):3186-3191. doi:10.1097/00007632-200012150-00014

103. Şencan H. *Sosyal ve Davranışsal Ölçümlerde Güvenilirlik ve Geçerlilik*. 1. Baskı. Seçkin Yayıncılık; 2005.

104. Yasir ASM. Cross Cultural Adaptation & Psychometric Validation of Instruments: Step-wise Description. *Int J Psychiatry*. 2016;1(1):6-9. doi:10.33140/ijp/01/01/00001

105. Heale R, Twycross A. Validity and reliability in quantitative studies. *Evid Based Nurs*. 2015;18(3):66-67. doi:10.1136/eb-2015-102129

106. Acemoğlu H, Aktürk Z. Reliability and validity in medical research. *Dicle Tıp Dergisi*. 2012;39(2):316-319. doi:10.5798/diclemedj.0921.2012.02.0150

107. Jesus LMT, Valente AR. Cross-cultural adaptation of health assessment instruments. April ,2016. Accesed: May 13, 2021. http:// sweet.ua.pt/lmtj/lmtj/JesusValente2016.pdf.

108. Pérez-Rojo G, Izal M, Sancho MT; Grupo de Investigación Trátame Bien. Adaptación lingüística y cultural de dos instrumentos para la detección de sospecha de maltrato hacia las personas mayores [Linguistic and cultural adaptation of two tools for the detecting suspected elder abuse]. *Rev Esp Geriatr Gerontol*. 2010;45(4):213-218. doi:10.1016/j.regg.2010.03.001

109. Phelan A, Downes C, Fealy G, O'Donnell D. The elder abuse suspicion index: Results of a pilot study. *Temida*. 2018;21(3):325-344. doi:10.2298/TEM1803325P

110. Şahin H, Erkal S. An evaluation of abuse and neglect in elderly with the Hwalek-Sengstock elder abuse screening test. *Turk Geriatr Derg*. 2018;21(1):16-24. doi:10.31086/tjgeri.2018137961

6. APPENDICES

APPENDIX 1: Ethical Approval

T.C. YEDİTEPE ÜNİVERSİTESİ

Sayı : 37068608-6100-15- 1944 **20/08/2020**
Konu: Klinik Araştırmalar
Etik Kurul Başvurusu hk.

İlgili Makama (Sevde Karakuş)

Yeditepe Üniversitesi Tıp Fakültesi Aile Hekimliği Tıp Eğitimi Ana Bilim Dalı Başkanı Doç. Dr. Güldal İzbırak'ın sorumlu araştırmacı olduğu **"Yaşlı İstismarı Şüphe İndeksi Türkçe Versiyonunun Geçerlilik ve Güvenilirlik Çalışması"** isimli araştırma projesine ait Klinik Araştırmalar Etik Kurulu (KAEK) Başvuru Dosyası **(1936)** kayıtlı Numaralı KAEK Başvuru Dosyası , Yeditepe Üniversitesi Klinik Araştırmalar Etik Kurulu tarafından **19.08.2020** tarihli toplantıda incelenmiştir.

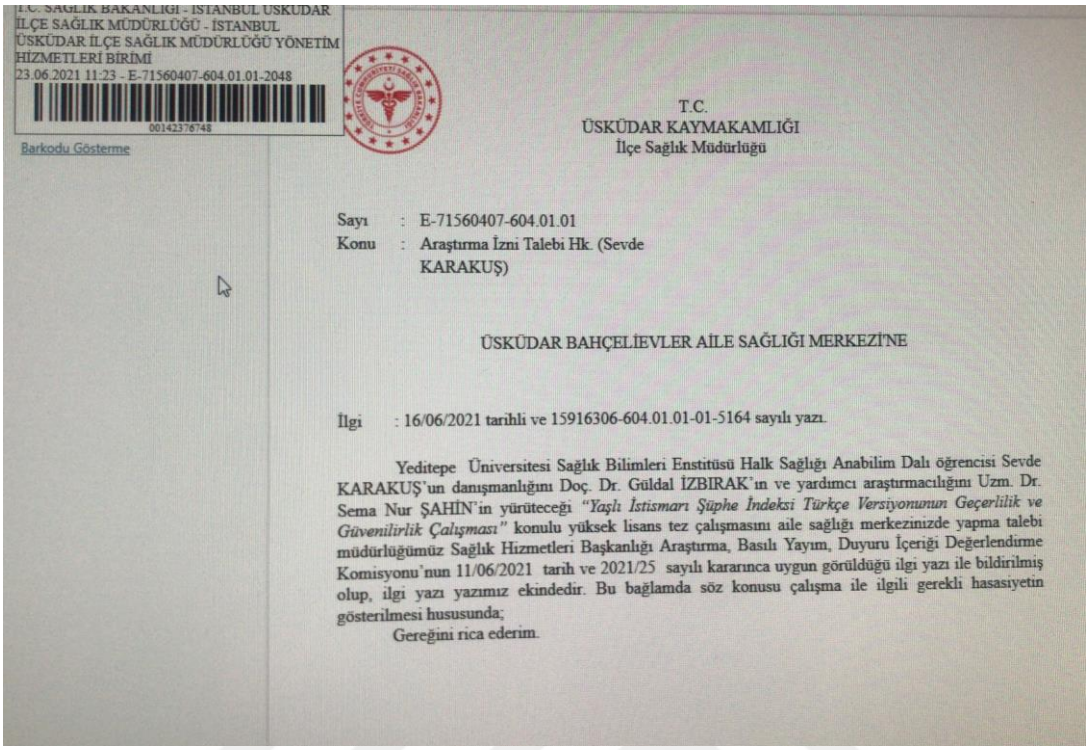
Kurul tarafından yapılan inceleme sonucu,yukarıdaki isim belirtilen çalışmanın yapılmasının etik ve bilimsel açıdan uygun olduğuna karar verilmiştir. **(KAEK Karar No:1276)**

Prof. Dr. Turgay Çelik

Yeditepe Üniversitesi
Klinik Araştırmalar Etik Kurul Başkanı

Yeditepe Üniversitesi 26 Ağustos Yerleşimi, İnönü Mahallesi Kayışdağı Caddesi 34755 Ataşehir / İstanbul
T. 0216 578 00 00 www.yeditepe.edu.tr F. 0216 578 02 99

APPENDIX 2:Permission from Ministry of Health



T.C. SAĞLIK BAKANLIĞI - İSTANBUL ÜSKÜDAR İLÇE SAĞLIK MÜDÜRLÜĞÜ - İSTANBUL ÜSKÜDAR İLÇE SAĞLIK MÜDÜRLÜĞÜ YÖNETİM HİZMETLERİ BİRİMİ
23.06.2021 11:23 - E-71560407-604.01.01-2048
00142376748
Barkodu Gösterme

T.C.
ÜSKÜDAR KAYMAKAMLIĞI
İlçe Sağlık Müdürlüğü

Sayı : E-71560407-604.01.01
Konu : Araştırma İzni Talebi Hk. (Sevde KARAKUŞ)

ÜSKÜDAR BAHÇELİEVLER AİLE SAĞLIĞI MERKEZİ'NE

İlgi : 16/06/2021 tarihli ve 15916306-604.01.01-01-5164 sayılı yazı.

Yeditepe Üniversitesi Sağlık Bilimleri Enstitüsü Halk Sağlığı Anabilim Dalı öğrencisi Sevde KARAKUŞ'un danışmanlığını Doç. Dr. Güldal İZBIRAK'ın ve yardımcı araştırmacılığını Uzm. Dr. Sema Nur ŞAHİN'in yürüteceği *"Yaşlı İstismarı Şüphe İndeksi Türkçe Versiyonunun Geçerlilik ve Güvenilirlik Çalışması"* konulu yüksek lisans tez çalışmasını aile sağlığı merkezinizde yapma talebi müdürlüğümüz Sağlık Hizmetleri Başkanlığı Araştırma, Basılı Yayım, Duyuru İçeriği Değerlendirme Komisyonu'nun 11/06/2021 tarih ve 2021/25 sayılı kararınca uygun görüldüğü ilgi yazı ile bildirilmiş olup, ilgı yazı yazımız ekindedir. Bu bağlamda söz konusu çalışma ile ilgili gerekli hasasiyetin gösterilmesi hususunda;

Gereğini rica ederim.

APPENDIX 3: Permission Letter for Translation of EASI®

Kimden: Mark Yaffe, Dr. <mark.yaffe@mcgill.ca>
Gönderme Tarihi: 7 Mart 2019 Perşembe 04:07
Kime: Guldal Izbirak
Bilgi: 'Sevde karakuş'; sevde.karakus@std.yeditepe.edu.tr; guldalizbirak@hotmail.com
Konu: Re: Permission for the use EASI

I am totally fine with your plans.
Best of luck.
Mark

Mark J. Yaffe, MD,CM, MCISc., CCFP, FCFP
Professor, Department of Family Medicine
McGill University and St. Mary's Hospital Center
Integrated University Centre for Health and Social Services of West Island of Montreal
3830 Lacombe Avenue
Montreal, Quebec, Canada, H3T 1M5
http://www.mcgill.ca/familymed/mark-yaffe

From: Güldal İzbirak <gizbirak@yeditepe.edu.tr>
Sent: March 6, 2019 7:56 AM
To: Mark Yaffe, Dr.
Cc: 'Sevde karakuş'; sevde.karakus@std.yeditepe.edu.tr; guldalizbirak@hotmail.com
Subject: RE: Permission for the use EASI

Dear Professor Yaffe,

We are very pleased with your answer and excited about the collaboration with you and your team. We accept your requests about the study and want to express again what our purpose exactly is, thus there won't be a misunderstanding about the study process. As I mentioned before we are planning to assess the validity and reliability of Turkish version of EASI after fulfilling the requirements about the translation process. Additionally, after our student Sevde Karakuş finishes her thesis, we want to publish an international article regarding her thesis. She graduated at Yeditepe University Faculty of Health Sciences, Department of Physiotherapy and Rehabilitation and still an active student in our Health Sciences Institute Public Health MSc Program on dissertation stage. We understand of your message that your permission extends all of our requests and if so, we will make our action plan after you give your confirmation.
We wait for your answer.
Best wishes,

Güldal İzbırak, MD
Assoc Prof of FamMed
Vice Dean
Head of the Department of MedEd

Adres :Yeditepe Üni
İnönü
E-mail :
Phone
Mobile
Fax : 0(21

From: Mark Yaffe, Dr. [mailto:mark.yaffe@mcgill.ca]
Sent: Friday, March 01, 2019 4:48 AM
To: Guldal Izbirak <gizbirak@yeditepe.edu.tr>
Cc: 'Sevde karakuş' <sevdekarakus@gmail.com>; sevde.karakus@std.yeditepe.edu.tr; guldalizbirak@hotmail.com
Subject: Re: Permission for the use EASI

Dear Professor Izbirak,
Thank you for your interest in the EASI. The proposed work of you and your colleagues will be a welcome addition to the growing international literature on elder abuse and we are pleased to extend permission for you to use the EASI as described.

There are a few standard requests that we ask for its use:

1. Please list the names of the EASI's 3 authors at the bottom of the tool, including my name as the corresponding author.

2. The copyright symbol should be clearly indicated whenever the full name of the tool or the EASI© acronym is used.
3. At the bottom of the tool reproduction the following reference should be included in order to respect the journal's rights:

   Yaffe MJ, Wolfson C, Weiss D, Lithwick M. *Development and validation of a tool to assist physicians' identification of elder abuse: The Elder Abuse Suspicion Index (EASI ©)*. Journal of Elder Abuse and Neglect, 2008; 20 (3): 276-300.

4. At the bottom of the tool reproduction the EASI© website URL should be displayed so that users have detailed information about the strengths and limitations of the tool, as well as access to 15 linguistic versions of the tool: www.mcgill.ca/familymed/research/projects/elder

5. The EASI © questions must be reproduced in the order found in the published version, since changing the order may alter psychometric properties.

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8. Reproductions in whole or in part of the EASI may not be used in any promotional material.

9. Reproduction of any of the existing 16 translations of the EASI© requires our approval as well as that of the principle authors of the translated versions, whose names appear at the bottom of each linguistic version. As well, new translations or modifications of existing linguistics would require a specific new request.

10. I am available to work with those who wish to create a new linguistic version, using recognized translation procedures. Step 1: translation into Turkish by a recognized translator; Step 2: back-translation into English by a second person; Step 3: sending me that English version to ensure fidelity to the original one. Once a translation has been approved, we ask permission to add it the EASI website for the benefit of others. Since the names of the authors of the new linguistic version are included on their work, along with their affiliations and email addresses, it showcases

their interest in elder abuse. This process further makes the new linguistic version available to others.

Sincerely,
Mark

Mark J. Yaffe, MDCM, MCISc, CCFP, FCFP
Professor, Department of Family Medicine
McGill University and St. Mary's Hospital Center
Integrated University Centre for Health and Social Services of West Island of Montreal
3830 Lacombe Avenue
Montreal, Quebec, Canada, H3T 1M5
http://www.mcgill.ca/familymed/mark-yaffe

From: Güldal İzbirak <gizbirak@yeditepe.edu.tr>
Sent: February 25, 2019 8:46 AM
To: Mark Yaffe, Dr.
Cc: 'Sevde karakuş'; sevde.karakus@std.yeditepe.edu.tr; guldalizbirak@hotmail.com
Subject: Permission for the use EASI

Dear Professor Yaffe,
As a group of researchers in our university we are planning to assess the validity and reliability of Turkish version of EASI and use it to reveal the suspected cases in our population. In this context, our purpose is to improve the awareness of elder adults regarding elder abuse and promote them to share information about probable abuse with health professionals in primary care settings.
We would be appreciate if you give us the permission to use this scale in our study.
Best regards,

Güldal İzbırak, MD
Assoc Prof of FamMed
Vice Dean
Head of the Department of MedEd

Adres :
E-mail :
Phone :
Mobile :
Fax :

"This message (including any attachments) contains confidential information and is intended only for the individual named. If you are not the named adressee or not related to the content of this message, you should not read, disseminate, distribute, copy, reproduce or modify this mail. Please notify the sender immediately if you have received this e-mail by mistake and delete this e-mail from your system. E-mail transmisson can not be guaranteed to be secure or error-free as the mail may arrive late or incomplete or the information could be intercepted, corrupted, lost, destroyed, amended or contain viruses. Yeditepe University therefore does not accept liability for any errors, omissions in the contents of this message, the loss of integrity or confidentially of information, or the transmission, reception and storage of use of such in any way whatsoever, which arise as a result of e-mail transmission. Any opinions expressed in this message are those of the author and may not necessarily reflect the opinions of Yeditepe University.

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APPENDIX 4: Informed Consent Form

YAŞLI İSTİSMARI ŞÜPHE İNDEKSİ TÜRKÇE VERSİYONUNUN GEÇERLİLİK VE GÜVENİLİRLİK ÇALIŞMASI

BİLGİLENDİRİLMİŞ GÖNÜLLÜ OLUR FORMU

Sayın Katılımcı

Bu çalışma; yaşlı istismarının ortaya çıkarılması ve bu konudaki farkındalığın arttırılması için geliştirilmiş olan "Yaşlı İstismarı Şüphe İndeksi"'nin, Türk toplumunda kullanılmaya uygun hale getirilmesi amacı ile yapılmaktadır. Bu çalışma bir araştırmadır.

Çalışma, aile hekiminiz ve sonrasında bireysel ya da araştırmacı yardımı ile dolduracağınız 4 adet değerlendirme ölçeğinden (yaşlı istismarını değerlendiren "Yaşlı İstismarı Şüphe İndeksi (EASI)" ve "Hwalek-Sengstock Yaşlı İstismarı Tarama Testi (H-S/EAST)", kişisel bilgilerinizi içeren "Sosyo-demografik ve İstismarla İlişkili Bilgi Formu", ve kognitif durum değerlendiren " Standardize Mini Mental Test (SMMT)-eğitimli ve eğitimsizler için ") oluşmakta ve yaklaşık 15-20 dakika sürmektedir. Çalışmaya sizden başka 74 gönüllünün katılması hedeflenmektedir.

Çalışmaya katılım gönüllülük esasına dayanmaktadır. Çalışmaya katılmama veya katıldıktan sonra istediğiniz bir zamanda çalışmayı bırakma hakkına sahipsiniz. Çalışmadan ayrılmanız halinde, tedavinizle ilgili bir aksama olmayacaktır. Gerek görüldüğünde araştırmacı tarafından çalışma kapsamından çıkartılabilirsiniz. Bu çalışma ile elde edilecek bilgiler araştırma amaçlı olup çalışma verileri bir yayın haline getirilip raporlansa bile kişisel bilgileriniz gizli tutulacaktır.

Sizden beklenen, kimsenin baskısı altında kalmadan, bütün soruları size en uygun gelecek şekilde içtenlikle cevaplamanızdır.

Araştırmamıza katıldığınız için teşekkür ederiz.

Yeditepe Üniversitesi
Yüksek Lisans Öğrencisi
Fzt. Sevde KARAKUŞ

Kişisel haklarım, araştırma konusu ve amacı konusunda yazılı ve sözlü olarak bilgilendirildim. Bu çalışmaya hiçbir baskı ve zorlama olmaksızın kendi rızam ile katılmayı kabul ediyorum.

Gönüllünün;

Adı, Soyadı:
Adresi:
Telefon No:
Tarih:
İmza:

Bilgilendirmeyi yapan hekim;

Adı, Soyadı:
Adresi:
Tarih:
İmza:

APPENDIX 5: Socio-demographic Information and Abuse Related Variables Form

Tarih:.....
Gönüllü Kodu:.....

Sosyo-Demografik ve İstismarla İlişkili Bilgi Formu

1) Doğum tarihiniz(gün/ay/yıl): ..... Yaş:....

2) Cinsiyetiniz:
   a) Kadın
   b) Erkek

3) Medeni Durumunuz nedir?
   a) Evli
   b) Bekar
   c) Boşanmış
   d) Dul

4) Eğitim düzeyiniz nedir?
   a) Okur-yazar değil
   b) Okur-yazar
   c) İlköğretim
   d) Lise
   e) Üniversite ve üstü

5) Çalışma Durumunuz nedir?
   a) Çalışıyor
   b) Çalışmıyor
   c) Emekli

6) Mesleğiniz nedir? ...

7) Sosyal güvenceniz nedir?
   a) Yok
   b) Emekli Sandığı
   c) SSK
   d) Bağ-kur
   e) Yeşil Kart
   f) Özel sigorta
   g) Yaşlılık Aylığı

8) Doktor tarafından tanısı konulmuş kronik bir hastalığınız (Diyabet, Hipertansiyon, kalp ve damar hastalığı, vb.) var mı?
   a) Evet. İse; .....
   b) Hayır

9) Düzenli kullandığınız ilaç var mı?
   a) Evet. İse; .....
   b) Hayır

10) İşitme cihazı, protez, baston gibi yardımcı cihaz kullanıyor musunuz?
   a) Evet. İse; .....
   b) Hayır

11) Psikolojik destek görüyor musunuz ya da gördünüz mü?
   a) Evet
   b) Hayır

12) Sigara kullanıyor musunuz?
   a) Evet, düzenli bir şekilde günde en az 1 sigara kullanıyorum. İse;
      1) Günde kaç sigara kullanıyorsunuz? .....sigara/gün
      2) Ne kadar süredir sigara kullanıyorsunuz? .....ay/yıl
      3) Sigarayı her gün kullanmaya başladığınızda kaç yaşındaydınız? .....
   b) Evet, arada kullanıyorum.
   c) Bıraktım .... ay ..... yıl önce. İse;
      1) Günde kaç sigara kullanıyordunuz? .....sigara/gün
      2) Ne kadar süre sigara kullandınız? .....ay/yıl
      3) Düzenli sigara kullanmaya başladığınızda kaç yaşındaydınız?.....
   d) Hayır, hiç kullanmadım.

13) Alkol kullanıyor musunuz?
   a) Evet, ise ne kadar sıklıkla kullanıyorsunuz?
      1) Hergün
      2) Haftada 1-2 gün
      3) Ayda 1-2 gün
   b) Hayır

1) Aile tipiniz nedir?
   a) Çekirdek

b) Geniş
c) Parçalanmış

2) Kaç tane çocuğunuz var? ....

3) Çocuklarınızla ne sıklıkla görüşüyorsunuz?
   a) Her zaman
   b) Sık sık
   c) Bazen
   d) Nadiren
   e) Hiç

4) Aile ilişkilerinizi nasıl değerlendiriyorsunuz?
   a) Çok iyi
   b) İyi
   c) Orta
   d) Kötü
   e) Çok kötü

5) Şu an kiminle birlikte yaşıyorsunuz?

   a) Yalnız
   b) Eşimle
   c) Bakıcı ile
   d) Kızım
   e) Oğlum
   f) Üvey Evlat
   g) Gelinim
   h) Damadım
   i) Yakın akrabalarım
   j) Diğer

6) Yaşadığınız evde size ait özel bir oda var mı?
   a) Evet
   a) Hayır

7) Evde sizden başka kaç kişi kalıyor?...

8) Ne zamandır yakınlarınızla birlikte kalıyorsunuz?...

9) Yakınlarınızın yanında kendi isteğinizle mi kalıyorsunuz?
   a) Çoğunlukla
   b) Sıklıkla
   c) Bazen
   d) Nadiren
   e) Hiç

10) Birincil bakım veren kişi kim ya da kimler?
   a) Yok
   b) Eşi
   c) Bakıcı
   d) Kızı
   e) Oğlu
   f) Yakın akrabaları
   g) Diğer

11) Size bakım veren kişi ya da kişilerin alkol ya da madde bağımlılığı var mı?
   a) Evet
   b) Hayır

12) Size bakım veren kişi ya da kişilerin psikolojik hastalığı var mı?
   a) Evet
   b) Hayır

13) Size bakım veren kişi ya da kişilerin, size ekonomik olarak bağımlılığı var mı?
   a) Evet
   b) Hayır

14) Size bakım veren kişi ya da kişilerin şiddet geçmişi var mı?
   a) Evet
   b) Hayır

15) Şu an yaşadığınız evin mülkiyeti kime ait?

a) Kendimin
b) Eşimin
c) Oğlumun
d) Kızımın
e) Gelinimin
f) Damadımın
g) Kira
h) Diğer ...

16) Gelir durumunu nasıl değerlendiriyorsunuz?
a) İyi (Gelir giderden fazla)
b) Orta (Gelir gidere eşit)
c) Kötü (Gelir Giderden az)

APPENDIX 6: Standardized Mini Mental State Examination for educated and uneducated (SMMTE/ SMMSE-E)

STANDARDİZE MİNİ MENTAL TEST (SMMT-E)

Ad Soyad : Tarih: Yaş:
Eğitim(yıl): Cinsiyet: Aktif El:
Toplam Puan:

Oryantasyon(toplam puan 10)

Hangi yıl içindeyiz?_____ ( )
Hangi mevsimdeyiz?_____ ( )
Hangi aydayız?_____ ( )
Hangi gündeyiz?_____ ( )
Şu anda sabah mı, öğlen mi, akşam mı?_____ ( )

Hangi ülkede yaşıyoruz?_____ ( )
Şu an hangi şehirde bulunmaktasınız?_____ ( )
Şu an bulunduğunuz semt neresidir?_____ ( )
Şu anda bulunduğunuz bina neresidir?_____ ( )
Şu an bu binada kaçıncı kattasınız? _____ ( )
(her bir madde için 1 puan verilir)_____ ( )

Kayıt hafızası (Toplam puan3)
Size birazdan söyleyeceğim üç ismi dikkatlice dinleyip, ben bitirdikten sonra tekrarlayın.(masa, bayrak, elbise)
(20sn süre tanınır, her doğru isim için 1 puan verilir.)
_____ ( )

Dikkat ve hesap yapma (Toplam puan 3)
Haftanın günlerini geriye doğru sayar mısınız? Örneğin PAZAR' dan önce CUMARTESİ gelir. Devam edin.
(deneyin toplam 5 gün sırasıyla doğru sayması gerekir. Her doğru gün için 1 puan verilir.)
_____ ( )

Hatırlatma (Toplam puan 3)
Yukarıda tekrar ettiğiniz kelimeleri hatırlıyor musunuz? Hatırladıklarınızı söyleyin. (masa, bayrak, elbise)
(her doğru isim için 1 puan verilir.)
_____ ( )

Lisan (Toplam puan 9)

a) Bu gördüğünüz nesnelerin isimleri nelerdir. 8saat, kalem)
(20 sn süre tanınır, her doğru isim için 1 puan verilir, toplam 2 puan.)
_____ ( )

b) Şimdi size söyleyeceğim cümleyi dikkatle dinleyin, ben bitirdikten sonra tekrar edin.
" **Eğer ve fakat istemiyorum**" (10 sn süre tanınır, doğru ve tam cümle için 1 puan verilir)
_____ ( )

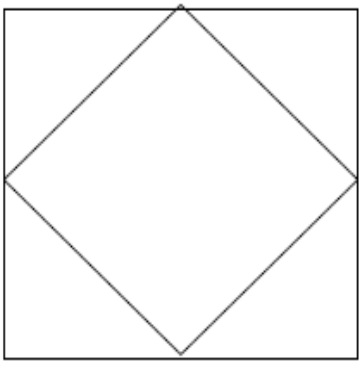
c) Şimdi sizden bir şey yapmanızı isteyeceğim, beni dikkatle dinleyin ve söylediğimi yapın.
" **Masada duran kağıdı sağ/sol elinizle alın, iki elinizle ikiye katlayın ve yere bırakın lütfen**"
(30 sn süre tanınır, her doğru işlem için 1 puan verilir, toplam puan 3)
_____ ( )

d) Şimdi yüzüme bakın ve yaptığımın aynısını yapın. **(Gözlerinizi kapatın)** (Doğru işlem için 1 puan verilir) ( )

e) Şimdi evinizle ilgili bir şey söyleyin. (30 sn süre tanınır, kenar sayısı tam şekil için 1 puan verilir. ( )

f) Size göstereceğim şeklin aynısını çizin. * (1 dk. Süre tanınır, kenar sayısı tam şekil için 1 puan verilir. ( )

***Lütfen arka sayfadaki şekli gösteriniz.**



STANDARDİZE MİNİ MENTAL TEST (SMMT)

Ad Soyad : Tarih: Yaş:
Eğitim(yıl): Meslek: Aktif El:
Toplam Puan:

YÖNELİM (toplam puan 10)

Hangi yıl içindeyiz?_____ ( )
Hangi mevsimdeyiz?_____ ( )
Hangi aydayız?_____ ( )
Bu gün ayın kaçı?_____ ( )
Hangi gündeyiz? _____ ( )

Hangi ülkede yaşıyoruz?_____ ( )
Şu an hangi şehirde bulunmaktasınız?_____ ( )
Şu an bulunduğunuz semt neresidir?_____ ( )
Şu anda bulunduğunuz bina neresidir?_____ ( )
Şu an bu binada kaçıncı kattasınız? _____ ( )
(her bir madde için 1 puan verilir)_____ ( )

KAYIT HAFIZASI (Toplam puan 3)

Size birazdan söyleyeceğim üç ismi dikkatlice dinleyip, ben bitirdikten sonra tekrarlayın.
(masa, bayrak, elbise) (20sn süre tanınır, her doğru isim için 1 puan verilir.)_____ ( )

DİKKAT VE HESAP YAPMA (Toplam puan 3)

100'den geriye doğru 7 çıkartarak gidin. Dur deyinceye kadar devam edin.
(100,93,86,79,72,65) (Her doğru işlem 1 puan)_____ ( )

HATIRLATMA (Toplam puan 3)

Yukarıda tekrar ettiğiniz kelimeleri hatırlıyor musunuz? Hatırladıklarınızı söyleyin.
(masa, bayrak, elbise) (her doğru isim için 1 puan verilir.)_____ ( )

LİSAN (Toplam puan 9)

a) Bu gördüğünüz nesnelerin isimleri nelerdir. (saat, kalem)
(20 sn süre tanınır, her doğru isim için 1 puan verilir, toplam 2 puan.)_____ ( )

b) Şimdi size söyleyeceğim cümleyi dikkatle dinleyin, ben bitirdikten sonra tekrar edin. " **Eğer ve fakat istemiyorum**"
(10 sn süre tanınır, doğru ve tam cümle için 1 puan verilir)_____ ( )

c) Şimdi sizden bir şey yapmanızı isteyeceğim, beni dikkatle dinleyin ve söylediğimi yapın.
" **Masada duran kağıdı sağ/sol elinizle alın, iki elinizle ikiye katlayın ve yere bırakın lütfen**"
(30 sn süre tanınır, her doğru işlem için 1 puan verilir, toplam puan 3)_____ ( )

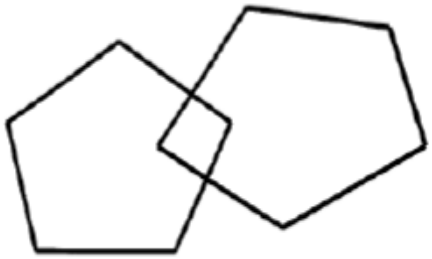
d) Şimdi size bir cümle vereceğim. Okuyun ve yazıda söylenen şeyi yapın.
"**Gözlerinizi kapatın**" **(arka sayfada)** (1 puan) _____ ( )

e) Şimdi vereceğim kağıda aklınıza gelen anlamlı bir cümleyi yazın.(1 puan). _____ ( )

f) Size göstereceğim şeklin aynısını çizin. * (arka sayfada) (1 puan) _____ ( )

***Lütfen arka sayfadaki şekli gösteriniz.**

Gözlerinizi kapatın



STANDARDİZE MİNİ MENTAL TEST UYGULAMA KLAVUZU

BAŞLANGIÇ

1. Doğru kişinin test edildiğinden emin olmak üzere, kişinin isim ve soyadı sorulur.
2. Görme ve işitme için yardımcı cihazı varsa test esnasında bunların kullanılması sağlanılır.
3. Testin uygulanacağı kişilere, bazı sorular sorulacağı söylenerek bilgilendirilir ve testin yapılması için izin alınır.
4. Sorular, anlaşılmadığı veya cevap vermeye teşebbüs edilmediği görüldüğünde, en fazla üç kez tekrar edilir ve yine cevap alınamazsa sözel veya fiziksel hiç bir ipucu vermeden sonraki soruya geçilir.
5. Test uygulanırken, bazı sorularda kullanılmak üzere, bir yüzünde büyük harflerle ve rahat okunabilecek biçimde yazılmış "GÖZLERİNİZİ KAPATIN" yazısı diğer yüzünde dört yanlı bir figür oluşturacak biçim de iç içe geçmiş iki beşgenin çizgili olduğu bir kağıt bulundurulmalıdır.

UYGULAMA

1. SMMT "Size bazı sorular sormak ve çözmeniz için bazı problemler göstermek istiyorum, lütfen elinizden gelen en iyi cevabı vermeye çalışın" sorusu ile başlar.
2. Her bir sorunun klinik tecrübeye dayanan ve kolay anlaşılır kendi özel talimatı vardır.
3. Soruların soruluş şekli görüşmeciye bırakılmamış olup, önceden belirlenmiştir. Soruların tamamen belirle nen şekliyle sorulması gereklidir.
4. Soruların yanlarında cevapların yazılabileceği ve puanlandırılabileceği boşluklar bırakılmıştır. Böylelikle toplam puan test bittikten sonra sağlanabilir.
5. Zaman sınırlaması verilen sorularda, görüşmeci talimat bitiminden itibaren süre tutar. Hızlı cevaplama telaşına kapılmayı önlemek için testin uygulandığı kişiye süre tutulduğu bildirilmez. Müsaade edilen süre aşıldığında, görüşmeci "Teşekkürler, bu kadarı yeterli" diyerek bir sonraki soruya geçer. Zaman sınırlaması, değişkenliği azaltmak, güvenilirliği arttırmak, hastanın yetersiz kaldığı sorular karşısında katastrofik reaksiyonlar geliştirmesini önleyerek sükunetini muhafaza etmek için konulmuştur. Zor bir soru üzerinde çalışıldığında; örneğin beş kenarlı figürlerin kopyasında, zaman dolduğu halde işlem sürmekteyse tamamlanması beklenilir.

YÖNELİM

1. Hangi günde bulunulduğu sorulduğunda, bulunulan günün bir gün öncesi ve bir gün sonrası doğru kabul edilir. Ay sorulduğunda ayın son günü ise yeni ay ve yeni ayın ilk günü ise eski ay doğru kabul edilir. Mevsimlerde hava şartlarına göre görüşmeci cevabın doğruluğunu değerlendirmelidir.
2. Bulunulan ülke, şehir, semt, bina ve kat sorulur.

KAYIT HAFIZASI

1. Görüşmeci hastadan 1 sn ara ile söyleyeceği 3 kelimeyi tekrar etmesini ister. 20 sn süre verilir, her doğru kelimeye 1 puan verilir, sıra ile tekrarı gerekmez.
2. Cevap verildikten sonra puanlandırılır. Yanlış veya eksik cevap verilmişse en fazla beş kez olmak üzere kelimeler tekrarlanıp testteki hatırlama bölümü için öğrenilmesi sağlanılır.

DİKKAT ve HESAP

100'den geriye doğru 7 çıkartılarak sayılır. Her bir doğru çıkarma işlemi için 1 puan verilir. Yanlış yapılan işlemde puan düşüldükten sonra hastaya doğru rakam söylenerek devam edilmesi istenir.

HATIRLAMA

Kayıt hafızası bölümündeki üç kelimenin (masa, bayrak, elbise) hatırlanması istenir. Sıra önemsenmez.

LİSAN TESTLERİ

1. Kalem ve saat gösterilerek ne olduğu sorulur. Cevap için 10 sn verilir. (Toplam puan 2)
2. Yandaki cümlenin tekrarı istenir: "Eğer ve fakat istemiyorum" 10 sn süre verilerek kelimesi kelimesine tekrara puan verilir. Cümleyi uygun biçimde telaffuz etmek için dikkat göstermek gerekir. Zira yaşlılarda görülen yüksek frekanslardaki işitme kayıplarında cümlenin anlaşılması zor olabilir. Doğru cevap 1 puandır. (Toplam puan 1) .
3. Hastanın birazdan söylenecek 3 basamaklı işlemi uygulaması istenir. Öncelikle hastanın dominant olarak kullandığı elini öğrenmek gerekir. Hastaya "Masada duran kağıdı sol/sağ (nondominant) elinizle alın, iki elinizle ikiye katlayın ve kağıdı yere bırakın lütfen" cümlesi söylenerek 30 sn süre ve her bir doğru işlem için 1 puan verilir. Bu işlem öncesinde (talimat okunmadan) kağıdın hasta tarafından alınmasına izin verilmez. Görüşmeci kâğıdı hastanın uzanamayacağı bir mesafede ve kendi vücuduna göre orta hatta tutmalı, talimat verildikten sonra kağıdı hastanın ulaşabileceği alana doğru itmelidir.
4. Bir kağıda büyük harflerle ve puntolarla rahatça okunabilecek şekilde yazılmış cümle okunarak ne yazıyorsa onu yapması istenir. (Toplam puan 1)
5. Hastaya bir kâğıt ve kalem vererek tam bir cümle yazması istenir. 30 saniye süre tanınır. Anlam içeren doğru bir cümle için 1 puan verilir (özne, yüklem, nesne bulunmalıdır).
6. Hastaya bir kâğıt, kalem ve silgi verilerek şekli gösterilen birbiri içine geçmiş iki beşgeni kopya etmesi istenir. 1 dakika süre tanınır. Beşgenlerin kenar sayılarının tam olmasına dikkat edilir. (Toplam 1 puan)

APPENDIX 7: Hwalek-Senstock Elder Abuse Screening Test (H-S/EAST)

Hwalek-Sengstock Yaşlı İstismarı Tarama Testi (H-S "YAŞİST")

1. Sizinle vakit geçiren, sizi alışverişe ya da doktora götüren birisi var mı? ☐ Evet ☐ Hayır
2. Birisinin bakımına, geçimini sağlamasına yardımcı oluyor musunuz? ☐ Evet ☐ Hayır
3. Çoğunlukla üzgün ya da yalnız mısınız? ☐ Evet ☐ Hayır
4. Yaşamınızla ilgili, örneğin nasıl ve nerede yaşayacağınız gibi konularda kim karar verir? ☐ Kendim ☐ Başkası
5. Ailenizde herhangi bir kişiden rahatsız oluyor musunuz? ☐ Evet ☐ Hayır
6. İlaçlarınızı kendi başınıza alabiliyor ve kendinizi gezdirebiliyor musunuz? ☐ Evet ☐ Hayır
7. Etrafta istenmediğinizi hissediyor musunuz? ☐ Evet ☐ Hayır
8. Ailenizde çok içki içen birisi var mı? ☐ Evet ☐ Hayır
9. Ailenizden birisi sizi yatakta kalmaya zorluyor ya da siz öyle düşünmeseniz bile size hasta olduğunuzu söylüyor mu? ☐ Evet ☐ Hayır
10.Birisi sizi istemediğiniz şeyleri yapmaya zorladı mı? ☐ Evet ☐ Hayır
11.Birisi izniniz olmadan size ait olan şeyleri aldı mı? ☐ Evet ☐ Hayır
12.Ailenizdeki kişilerin çoğuna güveniyor musunuz? ☐ Evet ☐ Hayır
13.Birisi size kendisine çok sorun çıkarttığınızı söylüyor mu? ☐ Evet ☐ Hayır
14.Evde özel yaşamınıza (mahremiyetinize) yeterince özen gösteriliyor mu? ☐ Evet ☐ Hayır
15.Son zamanlarda size yakın birisi sizi incitmeye ya da zarar vermeye çalıştı mı? ☐ Evet ☐ Hayır

Kimden: Nilgün Özçakar <nilgunozcakar@gmail.com>
Gönderme Tarihi: 4 Şubat 2020 Salı 17:16
Kime: Guldal Izbirak
Konu: Re: EASI Türkçe versiyonu
Ekler: Hwalek-Sangstock-Scale.pdf; YAŞİST TÜRKÇE FORM.pdf

Merhabalar,
Yaşlı sağlığı çalışma alanına gönül verenlerin çoğalması dileklerimle geçerlik güvenirliğini çalıştığımız tarama testini ekte gönderiyorum. Puanlama ve değerlendirmesini orijinal formda belirtildiği gibi yaptık, o form da ekte.
Araştırmanızda kullanmanızdan memnuniyet duyarız. Kaynaklarınız arasında aşağıdaki şekilde atıf olarak göstermenizi rica ediyoruz.

Özçakar, N., Ergönen, A. T., Kartal, M., & Baydur, H. (2017). Adaptation, reliability, and validity study of the Hwalek-Sengstock Elder Abuse Screening Test (HS/EAST): a Turkish version. ***Turkish journal of medical sciences,*** ***47*****(6), 1894-1902.**

Kolay gelsin, iyi çalışmalar.

Prof.Dr.Nilgün Özçakar
Dokuz Eylül Üniversitesi Tıp Fakültesi
Aile Hekimliği Anabilim Dalı

Güldal İzbirak <gizbirak@yeditepe.edu.tr>, 3 Şub 2020 Pzt, 15:05 tarihinde şunu yazdı:

> Sayın Hocam,
>
> Sizinle görüştüğümüz üzere , aşağıda bilgilerini paylaştığım çalışmamızın bu aşamasında, sizden aşağıda linkini verdiğimiz EASI© Türkçe versiyonunun yapı geçerliğine ilişkin, 2017 tarihli "Adaptation, reliability, and validity study of the Hwalek–Sengstock Elder Abuse Screening Test (H-S/EAST): a Turkish version" adlı makaleniz konusu olan ölçek ve skorlama bilgilerini kullanmak istiyoruz. Gerekli izinin tarafınızdan verilmesi ve uygun gördüğünüz taktirde dökümanları tarafımıza iletmenizi talep ediyoruz. Araştırmamıza verdiğiniz katkıdan dolayı teşekkür ederiz.
>
> Saygı ve selamlarımla
>
> https://mcgill.ca/familymed/files/familymed/easi_turkish_jan_2020.pdf

TÜİK İstatistiklerle Yaşlılar 2018, verilerine göre Türkiye'de yaşlı nüfusunun 5 yıl içerisinde %16 oranında artarak yedi milyon kişiyi ulaştığı ve 2018 yılında %8,8'e yükselen toplam nüfusun, yaşlı nüfusa oranının; 2023 yılında %10,2, 2030 yılında %12,9'a ulaşmasının beklendiği ifade edilmişti. Aynı raporda Türkiye geneli beklenen yaşam ortalamasının erkekler için 75,3 yıl ve kadınlar için 80,8 yıla ulaşırken; 65 yaşına ulaşan kişilerin ortalama 17,7 yıl beklenen yaşam süresi olduğu ifade edilmiştir(1).

2002 yılında Dünya Sağlık Örgütü tarafından hazırlanan Toronto Deklarasyonunda yaşlı istismarı; yaşlının güven ilişkisi içerisinde bulunduğu kişi tarafından; yaşlıya zarar veren ya da yaşlıyı sıkıntıya sokan; tekrarlı ya da tekrarsız yapılan davranış ya da gerekli olan davranışın yapılmaması olarak tanımlanmıştır(2).

Ülkemizde yapılan çalışmalarda ise yaygınlık değişmekle beraber toplumun %13'ü ila %27'sinin çeşitli alanlarda (fiziksel, cinsel, duygusal, finansal istismar ya da ihmal) ve çeşitli kişiler tarafından (aile bireyleri, bakım verenler) istismara uğradığı tespit edilmiştir.(3)

Ülkemizde sağlık bakanlığının 2015 yılında yayınladığı, *Türkiye Sağlıklı Yaşlanma Eylem Planı ve Uygulama Programı 2015-2020 Raporun*' da yaşlı istismarın tanınması ve önlenmesi için toplum, ailelere ve kurumlara yönelik önlemlerin alınması, orta vade hedefleri arasında gösterilmiştir. Aynı raporda; sağlık personellerinin, mezuniyet öncesi ve sonrası eğitimlerle yaşlı ihmal ve istismarının tanınmasını, önlenmesini ve bu alanda hizmet sunum kapasitesini arttırmasını hedef ve stratejileri kapsamında göstermiştir(4).

Yaşlılar için kolay ulaşılabilir temas noktası olan birinci basamak sağlık çalışanları; istismar vakalarına erken tanı koyma, müdahale etme ve gerekli kurumlara bildirim açısından ayrıcalıklı bir konuma sahiptir(5). Güvenilir tarama ve değerlendirme araçlarının kullanılması ise farkındalığı arttırmakta ve muhtemel vakaların yakalanmasını kolaylaştırmaktadır(6). Türkiye' de ise yaşlı ihmal ve istismarını değerlendirmek için kullanılan Hwalek-Sengstock Yaşlı İstismarı Tarama Testi(H-S/EAST), Savunmasızlık için İstismar tarama ölçeği(VASS) ve Geriatrik İstismar Ölçeğinin geçerlilik güvenilirlik çalışması yapılmıştır(7-10).

Yaffe ve arkadaşları tarafından 2008 yılında Elder Abuse SuspicionIndex ©EASI (Yaşlı İstismarı Şüphe İndeksi) isimli; yaşlı istismarına tanı konulması sürecinde, birinci basamak sağlık çalışanlarında *şüphe oluşturmak* amacıyla kullanılan; biri bağımlılık, diğer beşi ise istismara yönelik semptom ve bulguları içeren geçerli, kısa, objektif, uygulaması kolay bir ölçek geliştirmiştir.(6,11)

Yaşlı istismar şüphesinin değerlendirilmesi için geliştirilen Elder Abuse Supicion Index ©(EASI) ölçeğinin Türkçe 'ye geçerlilik ve güvenilirlik çalışmasını yapmak için 1 Mart2019 tarihinde e-posta yolu ile izin alındı. Çeviri sürecinde; 1 yeminli tercüman ve 2 ileri düzeyde İngilizce bilen kişi tarafından Türkçe' ye çevrisi yapıldı ve bu çeviriler araştırmacılar tarafından gözden geçirilerek ortak bir çeviri metni oluşturuldu. Daha sonra başka bir yeminli tercüman tarafından geri çevirisi yapıldı ve ölçek sahibinin istekleri doğrultusunda (içeriksel ve şekilsel) düzenlemeler yapıldı. 30 Nisan 2019 tarihinde Mark Yaffe ile işbirliği içerisinde çeviri süreci tamamlandı.

Daha sonra; ölçeğin kapsam geçerliliği ve kültürel eşdeğerliğinin sağlanması için uzman kişilerin görüşlerine başvuruldu. Yeditepe Üniversitesi Fen Edebiyat Fakültesi Türk Dili ve Edebiyatı Bölümü'nden bir akademisyen tarafından da teyit edildi.

1. Türkiye İstatistik Kurumu (TÜİK). İstatistiklerle Yaşlılar, 2018. (Erişim Tarihi 18.03.2019). *Erişim: http://www.tuik.gov.tr/PreHaberBultenleri.do?id=30699*

2. World HealthOrganization. (2002). The Toronto declaration on the global prevention of elder abuse. http://www.who.int/ageing/projects/elder_ abuse/alc_toronto_declaration_en.pdf adresinden 23.10.2017 tarihinde edinilmiştir.

3. Yıldız MİBölüm 20: Yaşlıda ihmal ve istismar. İçinde: Göçe Kutsal Y, Cangöz B, Baydar T, edt. *Geriatrik Bilimle,* Hacettepe Üniversitesi Geriatrik Bilimler Uygulama ve Araştırma Merkezi, Akraka, 2018:359-371.

4. Sağlık Bakanlığı. Türkiye Sağlıklı Yaşlanma Eylem Planı ve Uygulama Programı 2015-2020, Ankara: 2015: Yayın No:960, İSBN 978-975-590-520-4

5. İzbırak G. Birinci basamakta yaşlı istismarının önemi. İzbırak G, editör. Birinci Basamakta Yaşlı Sağlığı. 1. Baskı. Ankara: Türkiye Klinikleri; 2019. p.33-8.

6. Cohen M. Screening tools for the identification of elder abuse. J Clin Outcomes Manag. 2011;18(6):261-270.

7. Özçakar N, Toprak Ergönen A, Kartal M, Baydur H. Adaptation, reliability, and validity study of the hwalek–sengstock elder abuse screening test (H-S/EAST): A Turkish version. *Turkish J Med Sci*. 2017;47(6):1894-1902. doi:10.3906/sag-1606-166

8. Özmete E. Hwalek- Sengstock Yaşlı İstismarı Tarama Testi : Türkçeye uyarlama çalışması The Hwalek-Sengstock Elder Abuse Screening Test : the adaptation study into Turkish. *Anadolu Psikiyatr Derg*. 2016;17(1):45-52. doi:10.5455/apd.200727

9. Aşiret GD, Bağcivan G, Özcan M, Eröksüz B, Akbayrak N, Akdemir N. Cross-cultural adaptation and psychometric assessment of the Turkish version of the Vulnerability to Abuse Screening Scale. *Turkish J Med Sci*. 2017;47:1223-1228. doi:10.3906/sag-1609-11

10. Daşbaş S, Koçoğlu Tanyer D, Feyzal Kesen N. The Geriatric Mistreatment Scale: The Validity and Reliability of its Turkish Adaptation. *Turkish J Geriatr*. 2019;22(1):91-100. doi:10.31086/tjgeri.2019150578

11. Yaffe MJ, Wolfson C Lithwick M, et al. Development and validation of a tool to improve physician identification of elder abuse: the Elder Abuse Suspicion Index (EASI). J Elder Abuse Negl 2008;20:276–300

Doç.Dr.Güldal İzbırak

Dekan Yardımcısı

Aile Hekimliği / Tıp Eğitimi AD

APPENDIX 8: Elder Abuse Suspicion Index© (EASI)

ELDER ABUSE SUSPICION INDEX © (EASI)

EASI Questions Q.1-Q.5 asked of patient; Q.6 answered by doctor *(Within the last 12 months)*			
1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO	Did not answer
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?	YES	NO	Did not answer
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO	Did not answer
4) Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO	Did not answer
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO	Did not answer
6) **Doctor:** Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	YES	NO	Not sure

Mark J. Yaffe, MD McGill University, Montreal, Canada
Maxine Lithwick, MSW CSSS Cavendish, Montreal, Canada
Christina Wolfson, PhD McGill University, Montreal, Canada

APPENDIX 9: Turkish Version of Elder Abuse Suspicion Index © (EASI)

YAŞLI İSTİSMARI ŞÜPHE İNDEKSİ © (EASI)

(Elder Abuse Suspicion Index © (EASI))

EASI Soruları S.1 - S.5 hastaya sorulur; S.6 doktor tarafından cevaplanır. Son 12 ay içerisinde;			
1) Şunlardan herhangi birisi için başkalarına bel bağladığınız oldu mu: yıkanma, giyinme, alışveriş, banka işlemleri veya yemek?	EVET	HAYIR	Yanıt yok
2) Herhangi bir kişi yemek yemenizi, giyinmenizi, ilaç almanızı, gözlük takmanızı, işitme cihazı kullanmanızı, tıbbi bakım almanızı veya istediğiniz kişilerle birlikte olmanızı engelledi mi?	EVET	HAYIR	Yanıt yok
3) Herhangi bir kişi sizinle, kendinizi utanmış veya tehdit edilmiş gibi hissettirecek şekilde konuştuğu için üzüldünüz mü?	EVET	HAYIR	Yanıt yok
4) Herhangi bir kişi sizi, istemediğiniz halde, kâğıt imzalamaya veya paranızı kullanmaya zorlamaya çalıştı mı?	EVET	HAYIR	Yanıt yok
5) Herhangi bir kişi sizi korkuttu mu, istemediğiniz şekilde size dokundu mu veya size fiziksel olarak zarar verdi mi?	EVET	HAYIR	Yanıt yok
6) **Doktor:** Yaşlı istismarı; yetersiz göz teması, içe kapanık mizaç, yetersiz beslenme, hijyen sorunları, kesikler, çürükler, uygun olmayan giyim veya ilaçla tedaviye uyum sorunları gibi bulgularla ilişkili olabilir. Bugün veya son 12 ay içinde bunlardan herhangi birini fark ettiniz mi?	EVET	HAYIR	Emin değil

©Yaffe MJ, Wolfson C, Weiss D, Lithwick M. Development and validation of a tool to assist physicians' identification of elder abuse: The Elder Abuse Suspicion Index (EASI ©). Journal of Elder Abuse and Neglect, 2008; 20 (3): 276-300.

EASI© websitesi URL: www.mcgill.ca/familymed/research/projects/elder

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EASI© Turkish Version;

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