WHOSEFVA

Working with Healthcare Organizations to Support Elderly Female Victims of Abuse

# TRAINING MANUAL

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In cooperation with:

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# FOREWORD

Violence against older persons is a worldwide concern that touches on human rights, gender equality and population ageing. As the number of older people grows, the extent of elder abuse can be expected to grow as well[1]. However, it is widely understood that data on the prevalence of violence against older persons is insufficient and underreported. One reason for this is the lack of training for social and healthcare providers on how to recognize signs of abuse and how to support older victims of domestic violence. Effective national healthcare guidelines and best practices for dealing with violence of older victims are also still inadequately developed. On the other hand, another reason for underreporting can be that victims of violence, especially older women, hesitate to seek support, or are unable to. These silent and 'invisible' victims can lead to the misleading conclusion that violence against older people either does not exist, or exists only slightly. This manual concentrates on the characteristics of violence against older persons. It particularly aims to describe the special situation of older female victims of violence and how to support them to lead a safe and dignified life.

The Pan-European project "Working with Healthcare Organizations to Support Elderly Female Victims of Abuse" (WHOSEFVA) developed an accessible and replicable training programme for social and health care professionals, with emphasis on training the health care sector. The aim of WHOSEFVA is to support healthcare organisations to create standards and procedures from the point of view of victims' safety and legal protection, to increase the capacity of domestic violence organizations to cooperate with healthcare providers and to provide training on supporting older victims. These aims were achieved through carrying out trainings and developing an Online Open Course based upon this training manual. WHOSEFVA aimed to increase the capacity of domestic violence organizations further to advocate for needed healthcare policy changes on the national level.

The WHOSEFVA project highlighted central international documents such as the Charter of Fundamental Rights of the EU, the articles 4, 14, 21, 23 and 25 of the Istanbul Convention and the 2002 Madrid International Plan of Action on Ageing. According to MIPAA, "older women face greater risk of physical and psychological abuse due to discriminatory societal attitudes and the non-realization of the human rights of women" (Issue 3) and recommends training caring professions. MIPAA's Regional Implementation Strategy for the UNECE Region (MIPAA/RIS, 2002) emphasizes that measures should be taken to mainstream gender issues and states that opportunities should be provided for older women to advocate on health issues and encourage their participation in developing programs and to better address the problems which older women identify. WHOSEFVA implemented this strategy by organizing focus groups and interviews with older female victims of violence to understand their experiences, needs, concerns and expectations better. The evaluation and feedback from the Mutual Learning Workshops for social and health care professionals and Focus Groups and interviews of older women were used for the development of this manual based on the summaries made by Maria Rösslhumer, the Austrian Women's Shelter Network. In addition, efficiency and implementation results of the Elder Abuse Suspicion Index© (EASI) in partner countries are introduced.

The 57th Session of the Commission on the Status of Women in 2013 urged for the collection, collation, analysis and dissemination of data by age, sex and action to prevent violence against

[1] World Health Organization 2017. Abuse of older people on the rise – 1 in 6 affected. News Release 14 June 2017. Geneva. http://www.who.int/news-room/detail/14-06-2017-abuse-of-older-people-on-the-rise-1-in-6-affected

older women in healthcare settings. Recommendation (CM/Rec 2014) notes that member states should implement sufficient measures to raise awareness among medical staff, care workers and informal caregivers to detect abuse in all settings, to advise them, which measures to take if they suspect that violence has occurred, and to encourage them to report abuse.

The Consortium of the WHOSEFVA Project consists of eight partners in six European countries:

- Women's Support and Information Centre (Estonia) offers comprehensive assistance for domestic violence victims
- Johan Skytte Institute of Political Studies of University of Tartu (Estonia) conducts research on domestic violence in Estonia
- Kilcooley Women's Centre (Great Britain) offers a comprehensive range of support services for all ages, with a focus on support for elder people
- Union of Women Associations of Heraklion Prefecture (Greece) provides direct help to women-victims of violence and their children with personal interviews, psychological support and provision of legal advisors
- Centre Marta (Latvia) provides support to women in Latvia – non-citizens and migrants, women with low income and unemployed women, female victims of human trafficking and of domestic violence and works for policy and advocacy development
- Austrian Women's Shelter Network (Austria) is a network of autonomous women's shelters
- Women against Violence Europe is a legal entity and formal network composed of European women's NGOs working in the field of combating violence against women and children
- Women's Line Finland (Finland) worked as a partner for one year in the project and the work was continued by VoiVa-Empowering Old Age Cooperative, which is a national non-governmental organization in Finland focusing on prevention of violence against older persons

This manual provides overall training programme on violence against older people, with emphasis on the special situation of violence against older women. The manual deals with terminology used when talking about violence against elderly and provides information on future challenges. Violence against older persons can occur in various environments, including their homes, hospitals, assisted living arrangements and nursing homes. This manual takes a perspective on the issue in domestic settings (meaning violence by family members and trusted people in non-institutional settings) and briefly covers violence occurrence in institutional settings. Violence in home and institutional settings may have different dynamics, causes, and outcomes and thus are best to address separately.

The additional materials created in WHOSEFVA project, which can be used together with this manual, can be found online:

- MOOC (*Massive Online Open Course*) video course: http://whosefva-gbv.eu/mm4-en
- Slides: http://fileserver.wave-network.org/researchreports/TrainingMaterialsFinal.pptx

# INTRODUCTION

## What is the purpose of this training manual?

The purpose of this manual is to support trainers in the areas of social care, health care and victims' support services by providing them with updated knowledge regarding the needs and concerns of older persons who are victims of abuse.

This manual is designed to support trainers to deliver training on the prevention and response to violence against older persons and violence against older women. Trainers should ideally have on-hand experience working with victims of domestic violence, the elderly and/or social and healthcare professionals. This manual provides direct information and points trainers toward additional useful resources.

Violence against older persons is a unique problem that falls between domestic violence services and elderly care, sharing elements of both. This manual aims to synthesize the elements of these two separate fields, which are most relevant for working with elderly victims. The professionals in both fields can benefit by sharing their expertise and knowledge. This was one of the aims of the "Working with Healthcare Organizations to Support Elderly Female Victims of Abuse" (WHOSEFVA) project, within which this manual was created.

## This training manual will:

- Introduce challenges of prevention of violence against older women in Europe
- Explain key terms, concepts and approaches to prevention of violence against older persons and women
- Introduce health care and medical aspects of the identification and examination of violence against older persons
- Build the capacity of domestic violence, social and healthcare professionals to work with older persons and female victims of violence or who are at risk of violence
- Promote the development of quality services from the point of view of the needs of older victims and survivors

## This training manual is divided into eight chapters:

**Chapter 1** provides the background to the issue of violence against older persons by introducing the definitions and terms in the field and the forms of elder abuse.

**Chapter 2** introduces different angles of violence against older persons by describing the challenges of the changing situation of European populations and provides a picture of the prevalence of elder abuse and its explanations through different theoretical perspectives to the issue.

**Chapter 3** aims to show the complex nature of violence against older persons, for example by pointing special characteristics of it and what aging in society might bring to the life of older persons.

**Chapter 4** introduces what is known about risk and protective factors and their central role in prevention of elder abuse. It also describes the pivotal knowledge all professionals should understand about consequences of violence against older persons.

**Chapter 5** highlights issues on working with older victims of violence, with the special attention how to take into account the situation of older women.

**Chapter 6** concentrates on the work of health care professionals by addressing requirements and challenges for identification and intervention of elder abuse and by introducing assessment, examination and working procedures and instruments especially in emergency settings.

**Chapter 7** outlines challenges of professional work in the field of violence against older persons.

**Chapter 8** gives some clues on conducting training with social and health care professionals, for example by introducing the lessons learned through the activities of the WHOSEFVA project.

**Appendix 1** includes a form that can be used for medical examinations of assaulted patients in emergencies

**Appendix 2** describes good practices that have been developed in the Multi-Agency Model for Preventing Elder Abuse in Helsinki city

**Appendix 3** describes the most important International Instruments Regarding Abuse of Older Women

Each chapter begins with a brief list of the topics covered and learning outcomes. Learning outcomes help the trainer to concentrate on the key messages of the training. Notes for the trainer give some detailed information about the training content. Each topic contains several sources for further exploration. The manual aims to give new knowledge and understandings in the field based on research, in-field studies, and knowledge and experiences gained through WHOSEFVA project activities.

## Who is the WHOSEFVA training designed for?

This manual is designed for goal-oriented training of professionals who are working in a wide range of services which older persons use. Special target groups include health care workers e.g. in health centres, hospitals, geriatric services and home care. This manual also provides the learning outcomes of each chapter. It is important that trainers know what they want the professionals to achieve through each session and exercise, and trainers should help professionals connect their past experiences with current practical knowledge. Trainers should help professionals understand the theoretical concepts taught in training and apply them into real-life situations. The motivation to learn will increase when the connection between knowledge introduced in the sessions and real-life situations becomes relevant and clear. Furthermore, trainers should guide and facilitate the learning, and should request that professionals accept an equal responsibility for their own learning.

# CHAPTER 1: WHAT IS VIOLENCE AGAINST OLDER PERSONS?

## Topics Covered

Definitions and terms related to violence against older persons
- Old Age
- Violence against older persons
- Elder abuse

Older persons' own perceptions

Violence against older women

Forms of violence against older persons
- Physical violence
- Psychological violence
- Financial violence
- Sexual violence
- Neglect
- Institutional abuse
- Coercive control
- Sexual harassment and stalking

## Learning outcomes

Participants will:

- ✓ Be able to critically assess terms used to describe violence against older persons
- ✓ Understand various forms of violence against older persons
- ✓ Understand violence against older persons as part of a larger problem of violence against people of all ages
- ✓ Understand the gendered nature of violence against older persons

## Notes for the trainer

- ➢ Professionals engaged in practical work may prefer just a brief introduction of definitions and terms related to violence against older persons
- ➢ It is essential to introduce the forms, signs and consequences of violence. Keep in mind that there is little knowledge and/or research regarding institutional abuse and coercive control as a type of intimate partner violence, as well as sexual harassment and stalking.

# Definitions and terms related to violence against older persons

## Old Age

When training social and healthcare professionals for the WHOSEFVA Project, a common question was how old age and an older person are defined. Although there are commonly used definitions of old age, there is no general agreement on the age at which a person becomes 'old'. Most developed countries in the world have accepted the chronological age of 65 years as a definition of an older person. This is the age at which one can often begin to receive pension benefits. In the developed countries, chronological age plays a central role; however, it is not equivalent to, for example, biological age. The United Nations (UN) generally uses 60+ years to refer to the older population; however, it does not use a standard numerical criterion.[1]

According to the 2012 Special Eurobarometer, in the 27 EU member states the average age at which someone reaches 'old age' is 63.9 years. Opinions on the precise age at which one becomes an older person vary widely between different countries, with a difference of more than a decade between the "oldest" and the "youngest" older person. While respondents in the Netherlands, on average, thought that old age began at the age of 70.4, respondents from Slovakia answered that people became old at the age of 57.7.[2]

There are many dimensions of old age. Chronological age is defined as the number of years since someone was born. Biological age refers to physical changes which 'slow us down' as we enter middle and old age. Psychological age refers to psychological changes, including those related to mental functioning and personality, which occur as we age. Social aging refers to changes in person's roles and relationships, both within their circles of relatives and friends and within formal organizations such as the workplace.[3]

## Violence against older persons and elder abuse

The concept of 'elder abuse' was first described in the United Kingdom (UK) scientific journals in the 1970s and was referred to as 'granny battering'. In 1975, G.R. Burston expressed concern that not just babies and children, but also older people experienced battering: "Perhaps general practitioners in particular, and casualty officers especially, should become as conscious of granny battering as they are now aware of baby-battering."[4]

When describing the phenomenon of violence against older persons, the common term used is 'elder abuse'. There are debates about the field which elder abuse belongs to; in particular, the question is whether elder abuse should be considered a separate field or a type of domestic violence. This is because elder abuse is similar to but also different from other types of domestic violence. Similarities and differences between elder abuse and both child abuse and domestic violence are reflected in the attitudes of researchers as well as in public policies and services.

The term 'elder abuse' describes the phenomenon of violence against older persons in general and is gender-neutral. In many cases the literature that uses this term does not take gender analysis into account or pays no attention to the gender of victims. However, old age alone should not be used to define the type of abuse. For example, if a woman is a victim of intimate partner violence, should she be considered a victim of elder abuse instead just because she is over 65 years old? Older women may have in fact experienced abuse at the hands of their partners throughout their lifetime. At the same time, while victims of violence are faced with similar consequences and exhibit similar characteristics (e.g. fear of retaliation and stigmatization, desire to not leave home or to protect the abuser, emotional distress, difficulties in reporting

abuse), there are profound differences in the types of interventions that are appropriate for and services available to older persons. For instance, women's shelters are often designed and their staff trained to meet the needs of younger victims.[5]

This manual uses the term 'violence against older persons' when describing the phenomenon in general. Sometimes the term 'elder abuse' is used; however, this term may imply ageism, which might lead to viewing abuse of older people as a less serious form of violence in comparison to violence against other age groups. What should be underscored therefore is that violence against older persons is part of a larger problem of violence against people of all ages. Violence can occur at any time during a person's life – it is not a problem for younger people only.

As noted in this manual, signs of various disabilities and a need for assistance in daily activities put older people of both genders at risk of abuse. Therefore, both older men and women can become victims of violence. However, most victims are women, and they face certain specific challenges when dealing with the consequences of violence.[6]

Elder abuse was defined in the 1995 Action on Elder Abuse[7] 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**." This definition has been adopted by the World Health Organisation (WHO)[8] and is the most widely used in the world.

The Irish Working Group on Elder Abuse (2002) emphasized that it is important to think of elder abuse as an umbrella term for a wide range of harm that can affect older people. The working group defined violence against older persons based on the definition used by the Action on Elder Abuse and added a dimension of human rights to it: ''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 or violates their human and civil rights.''

There has been debate over the expression "relationship where there is an expectation of trust". In some countries, for example in Italy, it is argued that such a relationship is not essential to the definition of elder abuse. Abuse can occur within a relationship where there is no expectation of trust and/or when trust is completely absent from a relationship between an offender and a victim. This is especially true of Italy where two of the most common forms of elder abuse are those of fraud and 'bag-snatching' in the post-offices when older people cash their pension checks. In many types of fraud, thieves obtain older people's trust, but they do not establish an effective social relationship with them, only a social contact. For instance, those people who pretend to work as gas company representatives and thereby manage to enter older people's homes and rob them or obtain their money by deception, cannot be said to have a relationship with their victims.[9]

The definition by the US Department of Justice and Department of Health and Human Services (2014) gives a broader view on violence against older persons. According to this definition, elder abuse "includes physical, sexual or psychological abuse, as well as neglect, abandonment, and financial exploitation of an older person by another person or entity, that occurs in any setting (e.g., home, community, or facility), either in a relationship where there is an expectation of trust and/or when an older person is targeted based on age or disability."[10]

## Older persons' own perceptions

Older persons' own perceptions and views are crucial to defining violence and identifying interventions to stop it and mitigate its consequences. According to several studies that examined older people's views on violence, they understand it in a broad context, including its societal dimension. For example, within an international multicultural research project focused on elder

abuse, at least 50 people aged 60 years and over were interviewed in each participating country (including several minority groups in the US, Norway, Japan and Finland). In Finland, those who were interviewed mentioned all forms of violence: physical, psychological, financial and sexual abuse as well as neglect. They also viewed social mistreatment, that is violation (or denial) of their personal rights, as a form of abuse.[11] A similar study was conducted in Ireland where older people participated in eight focus groups. According to the results of this study, older people considered elder abuse a diminishment or withdrawal of personhood, that is a transition of an older person from a person to 'non-person'.[12]

## Violence against older women

This training manual recognizes the gendered nature of violence against older persons. Violence against older women has the same roots as violence against women in general; it is based on gender inequality and harmful and discriminatory gender norms.

While men can experience violence, women are more likely to become its victims, and most perpetrators are men, which applies to the older population as well. Power and control play a central role in violence against women, and in older women's cases this role can be even more decisive with power and control taking diverse forms. Overall, inequality experienced by women intensifies with age, and discrimination on the basis of age and gender can result in situations where women experience neglect and other forms of violence.[13]

According to the WHO (2014 and 2015), violence against older women can be defined as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering… including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life... this can also include financial abuse, exploitation or deprivation of resources, neglect, and abandonment."[14]

Most literature on violence against older persons does not take into consideration the significance of gender. At the same time, feminist research on violence against women rarely pays attention to older women and usually concentrates on younger women or younger women with children. In addition, there is a lack of agreement on the definition of violence against older women, and the data on the issue are inadequate and incomplete. The collection of such data is in turn hindered by the absence of a common definition of old age; different studies have used different 'starting points' of old age (e.g. 40-45, 50-55 and up to 65 or 66 years old). All of these factors contribute to invisibility of older women in the discourse on violence and abuse. Nevertheless, recent research on violence against older people has begun to criticize the use of gender-neutral terms and has brought to the fore gender differences in how violence is experienced by older people. Specific circumstances that older women find themselves in as well as unique challenges they are faced with as victims of violence have also been highlighted.[15]

The invisibility of violence against older women is also reflected in elderly care and services for women who are victims of domestic violence. Elderly care services do not take gender into account, while services for victims of domestic violence are not tailored to the needs of older women. However, this situation is slowly changing. One of the reasons for this may be related to the demographic change within our societies, in particular the feminization of aging, especially in the oldest age group. This poses new challenges to research as well as social, healthcare and domestic violence services.

One key factor that makes it especially important to address violence against older women is the cumulative nature of discrimination that women face: they experience gender inequality throughout their lives and face ageism as they grow older. As a result, older female victims of

violence face triple jeopardy as they belong to three different marginalized groups: they are female, they are of older age and they have experienced, or are likely to experience, abuse.[16]

## Forms of violence against older persons

Violence against older people can be divided into the following categories:

**Physical violence** – infliction of pain or injuries on an older person, use of physical coercion and physical or drug-induced restraint

**Psychological or emotional violence** – infliction of mental anguish on an older person

**Financial or material violence** – illegal or improper exploitation or use of funds and/or resources of an older person

**Sexual violence** – non-consensual sexual contact of any kind with an older person

**Neglect** – refusal or failure to fulfil caregiving obligations[17]

According to the National Study of Elder Abuse and Neglect conducted in Ireland in 2010, one quarter (25%) of older people who participated in the study experienced more than one type of mistreatment, while 14% of them experienced three or more types of mistreatment. Psychological abuse was found to be likely to accompany other forms of abuse. For example, in nearly all reported cases of physical abuse psychological abuse also took place, and the latter was also present in over 40% of cases of financial abuse. In addition, 50% of neglect cases were accompanied by financial and psychological abuse.[18]

In what follows, different forms of violence against older people are described. Each of the following subsections is dedicated to one form of abuse and deals with its signs and consequences as well as strategies to prevent it. It should be noted that some signs can actually point to different forms of abuse an older person is suffering from, and that signs of violence can also be its consequences. In addition, prevention strategies that different forms of violence require overlap, and older people might need several different types of support when they find themselves in an abusive situation.

## Physical violence

Physical violence can be defined as the use of physical force against an older person, which can cause bodily harm, permanent impairment, or physical pain. This may include for example striking an older person with a hand or an object.[19] According to the 2014 FRA survey, the first survey of its kind on violence against women across the 28 EU member states, 2% of interviewed women aged 60-74 years had experienced physical violence by a partner in the 12 months prior to the interview.

**Physical violence can include**:

| | |
|---|---|
| Scratching, biting, slapping | Pushing, kicking |
| Burning | Choking or strangling |
| Throwing things at a person | Force-feeding or denying food |
| Using weapons or other objects to inflict pain | Physical restraining |

In the Prevalence Study of Abuse and Violence against Older Women, which was conducted in 5 EU countries,[20] physical abuse was measured using four indicators: a) someone had restrained a woman in any way; b) someone had hit a woman or otherwise attacked her; c) someone had thrown a hard object at a woman or used a weapon against her; d) someone had given a woman too much medicine in order to control her or make her docile. According to this study, 2.5% of 2,880 respondents had been victims of at least one form of physical abuse. 50.7% of perpetrators were a partner or a spouse, and 16.4% were a daughter and a son (including in-law).[21]

**Signs of and consequences of physical violence include**:

| | |
|---|---|
| Bruises, wounds, abrasions, contusions, hematomas | Physical pain and soreness |
| Broken bones, dislocations of joints, fractures | Swelling, burns |
| Dental problems | Decreased sight or blindness |
| Decreased hearing or deafness | (Permanent) disabilities |
| Brain injuries | Increased risk of premature death |

Safety planning and risk assessment, identification of risk factors and signs of violence via screenings/routine enquiries about elder abuse as well as early intervention contribute to preventing physical violence against older people.

## Psychological violence

This form of violence is also called emotional violence. Psychological violence is systematic non-physical actions which are intended to inflict mental pain, anguish and suffering on an older person.[22] While psychological violence is believed to be the most common form of violence, it is the most difficult form to identify since it might not leave any physical signs. Psychological violence can lead to mental distress, humiliation and fear. According to the FRA survey, 37% of women aged 60-74 years have experienced some form of psychological violence by a partner since the age of 15.

**Forms of psychological violence include:**

| | |
|---|---|
| Emotional manipulation or other cruel behaviour | Verbal intimidation, shouting |
| Denying access to services, religious and/or cultural events | Insults, scolding |
| Forcing a person to participate in and follow religious rules and customs against their will | Humiliation, threats, denigration |
| Non-verbal communication hints, such as facial expressions and body gestures | Controlling behaviour |
| | Abandonment |
| | Harassment, stalking |

The 2014 FRA survey took into account 17 forms of psychological partner violence and grouped them into four categories:[23]

**Controlling behaviour**, such as trying to keep a woman from seeing friends or visiting her family or relatives, insisting on knowing where she is and whom she has spoken to;

**Economic violence**, such as preventing a woman from making decisions about family finances or shopping independently, or forbidding her to work outside the home;

**Abusive behaviour**, such as belittling or humiliating a woman in public or in private, making a woman watch pornographic material against her will, threatening a woman with violence or threatening to hurt someone else a woman cares about;

**Blackmailing** with abuse of children, such as threatening to take the children away from a woman

Power and control dynamics play a key role in how older women experience psychological violence, and perpetrators often take advantage of older persons' vulnerability. Threatening an older person with physical punishment or depriving them of satisfaction of their basic needs may include denying or delaying provision of food, medication or basic care. Preventing an older person from decision-making, falsely accusing them of misdeeds and controlling their freedom can result in isolation and emotional pain. Psychological violence can worsen depression, which an older person may already be suffering from, and aggravate other mental health issues. As a result, psychological violence may have more lasting effects than physical violence.[24, 25]

According to the Prevalence Study of Abuse and Violence against Older Women,[26] emotional abuse was the most common form of violence experienced by older women in all participating countries. Nearly a quarter of older women surveyed in 5 countries (23.8%) reported at least one incident of emotional abuse in the 12 months prior to the survey. The most common forms of psychological abuse reported were shouting or yelling at older women (14.1%), undermining what they did (14%) and doing something to spite them (14%). The most common perpetrators of emotional abuse against older women in all countries were current partners or spouses, children, or other family members.

**Signs of psychological violence include**:

| | |
|---|---|
| Feelings of helplessness, shame, powerlessness | Depression |
| Loss of interest in self or environment | Unusual passivity or anger |
| Lack of eye contact with a practitioner, carer or another person | Confusion, agitation |
| Nervousness around a carer or another person | Isolation |
| Paranoid behaviour or confusion not associated with illness | Withdrawal, apathy |
| Display of signs of trauma, e.g. rocking back and forth | Fearfulness |
| | Reluctance to talk openly |
| | Insomnia/sleep deprivation |

**Psychological violence can lead to:**

| | |
|---|---|
| Long-term trauma symptoms | Depression and anxiety |
| Post-traumatic Stress Disorder (PTSD) | Dementia |
| Increased mortality and suicide risk | Substance abuse |

**Identification of risk factors and behavioural signs of psychological violence exhibited by an older person or in their relationship with carers is a key to (early) intervention and prevention of psychological violence.** This can be done during care meetings with an older person, professionals and other people involved as well as screenings/routine enquiries about elder abuse.

## Financial violence

The most cited definition of financial abuse comes from the WHO (2008): "**the illegal or improper exploitation or use of funds or other resources of the older person**."[27]

**Forms of financial violence include**:

| |
|---|
| Controlling the use of money and property by an older person |
| Theft, use of coercion or fraud to (try to) obtain older person's money or possessions |
| Illegal or improper use of older person's money, property or assets |
| Exploitation of and pressure in connection with wills, property or inheritance |
| Fraud and internet scams |

Older people, especially those with cognitive impairment, often become victims of financial violence, and social exclusion contributes to this. In particular, older people are very likely to suffer from fraud enabled by new technologies (e.g. internet scams and identity theft). Financial violence against older people can also be accompanied by threats and intimidation. Financial exploitation has a destructive effect on older people's lives and can result in fear, lack of trust and acute and chronic anxiety.[28]

**Signs of financial violence**:

| |
|---|
| Individual expresses concern that they do not have enough money to cover their basic needs |
| Individual is confused about funds missing from their accounts |
| Individual reports that furniture, jewellery, credit cards, or other items are missing |
| Numerous unpaid bills or overdue rent that an older person should be able to afford or someone else is expected to pay |
| Lack of amenities, e.g. a TV, or appropriate clothing that an older person should be able to afford |
| A recently signed will, or changes in a will, when an older person is incapable of drafting or signing it |
| Loans or mortgages obtained by an older person |

In the Prevalence Study of Abuse and Violence against Older Women, financial abuse was measured using four indicators: a) an older woman had been taken advantage of financially; b) she had been blackmailed for money or other possessions or property; c) she had not been allowed to make decisions about money or to buy things; d) she had had money, a possession or property stolen. According to the results, 8.8% of older women in all participating countries had experienced at least one form of financial abuse in the 12 months prior to the survey, and financial abuse was the second most prevalent form of abuse (after emotional mistreatment). 33.7% of perpetrators were partners or spouses, 28.7% were daughters or sons (including in-laws), 18.5% were other family members, 14.4% were other people known closely, 5.1% were neighbours and 9% were paid home helps or caregivers.[29] In the FRA survey, financial violence was measured using two indicators: a) having been prevented from making independent decisions about family finances and from shopping; b) having been forbidden to work outside home. Survey results indicated that 12% of women aged 60-74 years had experienced economic violence by a partner since the age of 15.[30]

**Financial violence**:

| |
|---|
| Worsens victim's economic well-being and quality of life |
| Deprives victims of their savings and assets, and thus foundation for their economic independence |
| Creates barriers to leaving an abusive relationship/situation, e.g. lack of access to economic resources can render women financially dependent on abusers, which in turn leads to increased risk of injuries and homicide |
| Creates barriers to leading an independent life even after a woman has left an abusive relationship since she might be in debt or lack resources to rebuild her life |

Identification of risk factors and signs of financial violence during screenings/routine enquiries about elder abuse, including in the healthcare systems, can help prevent financial violence. Discussions with older people and their close relatives about preventing financial violence and creation of safety plans, establishment of clear guidelines for the authorities and people involved as well as dissemination of information among the public (e.g. via awareness-raising campaigns) also plays a key role in the prevention of financial violence. Cases of financial violence against older people should be reported to the authorities, and (early) interventions undertaken if needed.

## Sexual violence

Sexual abuse of an older person occurs when a perpetrator engages in any kind of sexual behaviour towards them, including physical contact of a sexual nature, without their consent. This type of abuse, as part of domestic violence, can be experienced by a woman throughout her whole life, and it includes incestuous acts towards an older person/woman. It should be emphasized that some victims of sexual abuse are unable to give consent due to their health condition, such as cognitive impairment.

Sexual abuse is the least reported type of violence against older persons, and this is due to several reasons. On the one hand, older victims may choose to not report cases of sexual violence; for example, stigma and fear may keep them from doing so. On the other hand, some victims may be unable to report such cases due to their cognitive impairment. In addition, some older persons might not view certain types of behaviours as sexual abuse or deny the fact that sexual abuse has occurred.[31]

Sexual violence against older women is significantly underestimated. Therefore, it has been largely ignored and rarely discussed, with research on sexual violence against older women being relatively scarce. This has resulted in limited understanding of characteristics of this phenomenon and its impacts on victims, as well as a lack of knowledge about how prevalent this issue is. This situation may further reinforce the mistaken belief that only younger women become victims of rape and thus lead to disbelief and/or understatement of sexual violence against older women.[32]

Older victims of rape do not fit society's stereotypes of what a rape victim looks like. Based on ageist attitudes, which see ageing as a process of gradual and continuous loss of value, society tends to view older people as asexual.[33] Older women are believed to not be interested in sex. At the same time, a common misconception is that sexual violence against women is based on male sexual desire; older women, however, are not viewed as sexually desirable. Consequently,

they are not considered sexual subjects and therefore are not seen as potential or typical victims of sexual abuse and rape.[34,35]

Contrary to common beliefs, **sexual violence is committed because of power and control issues rather than being motivated by sexual desires**. Sexual offenders are attracted to vulnerability and use violent sexual acts to establish and/or demonstrate control over vulnerable persons. Perpetrators seek out potential victims whom they perceive as easy to overpower and manipulate and who would be unlikely to report an assault or whose reports would not be deemed credible. Like sexual assaults against younger victims, sexual violence against older people is believed to be motivated by anger and/or desire to control victims.[36,37]

**Older women, who are victims of sexual violence, may have experienced it for a long period of time, particularly in cases where an abuser is a spouse or an intimate partner.** Therefore, to fully understand the effects of sexual violence on older women it is important to take into account its cumulative nature over the course of a woman's life.[38]

**Forms of sexual violence include**:

| | |
|---|---|
| Unwanted sexual contact, e.g. inappropriate touching, sexualized kissing | Sexual assault and battery |
| Forcing an older person to watch sexual acts or pornographic material | Forcing an older person to perform a sexual act |
| Forcing an older person to undress against their will, coerced nudity | Forced intercourse/rape |
| Cleaning or treating older person's genital area roughly or inappropriately | Explicitly sexual photographing |
| | Sexual remarks/suggestions |

Around 130 reports of rape and sexual assault of older persons are submitted annually to the police in the UK. Between 1 January 2009 and 31 December 2013, the UK police recorded 655 rape and sexual assault cases where victims were 60 or more years old at the time the offence was committed. Sexual violence against older people turned out to be as gendered as against younger age groups: the vast majority of victims were women, while men were victims in only 7% of cases.[39]

In the Prevalence Study of Abuse and Violence against Older Women, sexual abuse was measured using four categories:[40] a) a woman had been talked to in a sexual way that had made her feel uncomfortable; b) she had been forced to watch pornography against her will; c) she had been touched in a sexual way against her will; d) she had been forced, or someone attempted to force her, into sexual intercourse/relations. According to the study results, 3.1% of older women had experienced sexual abuse. 55.4% of perpetrators were partners or spouses, and 21.7% of perpetrators were other people closely known by a woman.[41]

The 2014 FRA survey[42] used four questions to measure sexual violence: a) a woman had been forced into sexual intercourse[a] by being held down or hurt in some way; b) someone had attempted to force a woman into sexual intercourse by holding her down or hurting her in some way; c) a woman had been forced to take part in any form of sexual activity against her will or due to her inability to refuse; d) a woman had consented to sexual activity out of fear of what

[a] Oral sex, forced anal or vaginal penetration.

may have happened in case of her refusal. According to the survey results, 1% of women aged 60-74 years had experienced sexual violence and 3% had experienced physical and/or sexual violence by a partner in the 12 months prior to the survey.

130 cases of suspected sexual abuse of older people were investigated by the Protective Services caseworkers and/or supervisors, in consultation with Holly Ramsey-Klawsnik, from 1993 to 2002 in the USA. Out of 130 consultation cases, 77% (N = 100) involved suspected sexual violence within a family; these cases in turn fell into two categories: marital sexual violence and incestuous violence.

**Sexual violence against older persons within their family can be**: long-term domestic violence; recent violence in a long-term marriage; sexual victimization in a new marriage. Incestuous violence can be committed by adult children and other relatives, including quasi-relatives.[43] Like other forms of domestic violence, violence against older persons in the family tends to be primarily a problem of male violence directed against female victims. Common perpetrators are husbands and sons, while typical victims are wives and mothers. In terms of age, spouse perpetrators are usually of older age themselves, and incest offenders are often middle-aged.

An adult child who perpetrates sexual violence against their parent is usually unmarried and has poor social life, is unemployed or under-employed, lives in the home of an elderly parent and is financially supported by the parent. In addition, adult children who become abusers often suffer from mental illnesses or substance abuse. The older and more ill the parent gets, the more vulnerable they become, which is especially true for older woman. Overall, cases of abuse by an adult child are often multifaceted and may include neglect, psychological and physical abuse, financial exploitation as well as sexual abuse in some cases.[44]

In incestuous sexual violence cases, perpetrators tend to be adult sons, while mothers usually become victims. It is rare for incestuous violence to be perpetrated by adult daughters, although the phenomenon does occur. Female perpetrators typically have serious mental health problems, substance abuse problems or both. Another rarely observed phenomenon is incestuous violence perpetrated by other relatives such as sons-in-law, grandchildren, siblings and nephews.[45]

Sexual violence can have a devastating impact on older women causing long-term suffering, such as for example incontinence and pain when urinating because of the injuries. Other consequences include loss of weight, fear of having contracted a sexually transmitted infection, fear of leaving the house and loss of enjoyment from social activities (such as shopping) as well as fear of men.[46]

Experiences of interpersonal violence can have a greater impact on women's health than general trauma experiences, such as floods, hurricanes or earthquakes. **Out of all traumatic experiences sexual assault in adulthood is the most stressful one.** Changes in older people's lives that are related to ageing, e.g. retirement, widowhood, chronic illnesses etc, may have an effect on how older people experience (sexual) violence and cope with its consequences.[47]

**The following can be signs of sexual violence**:

| | |
|---|---|
| Unexplained incontinence (bladder or bowel) | Urinary tract infections |
| Bleeding, bruising, abrasions, infection, tenderness of the ano-genital area, thighs, and breasts | Unexplained venereal disease |
| Difficulty walking or sitting, or pain when toileting | Depression or withdrawal |
| Increased interest in sexual matters | Anxiety or excessive fear around a caregiver |
| Increased sexual or aggressive behaviour | Fear of being touched |
| | Insomnia |

**Consequences of sexual violence may include:**

| | |
|---|---|
| Severe psychological trauma, shame, guilt, self-blame | Fear and unwillingness to live at home |
| Chronic pain, long-term physical and health problems | Depression, anxiety, nervousness |
| Increased use of alcohol and other substances | Distrust of others |
| Suicidal thoughts, attempted or completed suicide | Inability to sleep at night (e.g. having nightmares or flashbacks) |

**Identification of risk factors and signs of sexual violence plays a key role in (early) intervention and violence prevention.** This can be done during screenings/routine enquiries about elder abuse, especially in the healthcare settings. This in turn requires training of professionals, as well as older persons and their families, and the development of specialized services that will take into account older women's needs. Awareness-raising campaigns also contribute to preventing sexual violence against older women.

## Neglect

Neglect can be defined as a **failure by responsible persons to satisfy essential basic needs of an older person** such as medical attention or necessary medication, food, hydration, hygiene and other basic daily activities, safety, clothing etc, which results in serious health and safety risks. **Unintentional** neglect occurs when a carer does not have the skills and/or knowledge necessary for taking care of a dependent person who is unable to satisfy their needs on their own. In such cases, carers may not be aware of the types of support that are available to them, or they might be ill themselves and thus unable to provide care to an older person. Neglect is considered **intentional** (sometimes called active neglect) when an older person is intentionally harmed and/or abandoned, or when others are not allowed to provide adequate care to an older person.

According to the Prevalence Study of Abuse and Violence against Older Women,[48] **different forms of neglect** can take place during the following activities:

| | |
|---|---|
| Washing or bathing, incl. getting in or out of the bath-tub or shower | Preparing meals or eating |
| Shopping for groceries, clothes or other things | Doing routine housework |
| Taking care of older person's medication | Travelling/transportation |
| Getting to and using the toilet | Getting in and out of bed |
| | Dressing or undressing |

In the above mentioned study, rates of neglect were calculated for those women who needed assistance with daily activities, but were refused it. 5.4% of older women in 5 countries included in the study had experienced neglect in the 12 months prior to the survey:

- 3% of older women reported that they had been refused help to do routine housework
- 2.7% of older women (22.4% in Portugal and 1.1% in Finland) had been refused assistance with shopping for groceries, clothes or other things
- 2.4% of women had not received help with travel or transportation
- Other forms of neglect occurred very rarely

**Neglect can take the following forms**:

| | |
|---|---|
| Person is abandoned, left unattended for long periods of time or locked in the house alone | Inadequate food and drink |
| Inadequate or inappropriate use of medication; person is over-sedated in the middle of the day | Isolation; lack of mental, physical, social contacts |
| Person is not provided with necessary aids, e.g. glasses, hearing or walking aids | Clothing inadequate for the season |
| Immobility, person stays in bed almost all the time | Restraints; person is tied up to the chair or bed |

Neglect can lead to depression and emotional suffering as well as infectious illnesses and premature mortality. **Signs of neglect include**:

| | |
|---|---|
| Pain, discomfort, multiple large bedsores | Under- or over-medication |
| Unexplained weight loss, malnutrition, dehydration, constipation | Signs of withdrawal, depression, passivity |
| Poor hygiene, unkempt appearance: an older person is dirty, smells strongly of urine | Absence of required assistive technologies |
| Poor or nervous interactions between an older person and caregivers/family | Lack of concern on the part of caregivers/family |

## Institutional abuse

Recently a shift has occurred in perspectives on elderly care with more emphasis placed on community care as opposed to care in restrictive institutional settings, which might lead to institutional abuse. Many countries lack national data on the prevalence of abuse in institutional settings; local data from smaller-scale studies is more common.[49]

There is no standard definition of institutional abuse. However, it has become common "to draw a distinction between individual acts of abuse in institutions and actual institutional or institutionalised abuse." The term 'institution' covers a wide range of health and social care settings, as well as any setting where service users interact with professionals (outside their own home). This includes hospitals, nursing and care homes, day care (including health and social care), respite care (including health and social care), care provided by the voluntary sector and hospice care.[50]

**Abuse in institutional settings can take the following forms**:

| |
|---|
| **Restraints**[51]<br><br>Controlling behaviour towards older persons, especially in hospitals and nursing facilities<br><br>Forcible confinement<br><br>Mechanical restraint, e.g. Posey vests, wrist and ankle restraints made of leather, plastic or cloth, their excessive, unwarranted or unnecessary use<br><br>Forcing a person to remain in bed or tying them to a bed or chair<br><br>Chemical restraint, i.e. unwarranted use of medication to control a person<br><br>*Inappropriate use of restraints, including mechanical and chemical restraints, within care settings can be an infringement on/denial of person's rights and dignity. Restraints should only be used in very rare exceptional circumstances (for the safety of an older person).*[52] |
| **Physical violence**[53]<br><br>Rough treatment, immobilisation, coercion to do certain things, assault |
| **Psychological abuse**<br><br>Verbal abuse: bossiness, criticism, use of coarse, inappropriate or childish language<br><br>Ignoring the wishes or will of a resident, belittling, ignoring and isolating them, or leaving them alone against their will |
| **Sexual abuse**<br><br>Any kind of sexual contact which a resident does not wish for or which they do not understand, and which they are incapable of consenting to |
| **Neglect of care and assistance duty**<br><br>Poor standards of care, rigid routines and inadequate responses to older people's complex needs |
| **Violation of rights**<br><br>Treatment that shows lack of respect for the dignity of an older person |
| **Financial exploitation and other restrictions** |

Frequency and types of elder abuse that occur in residential settings were investigated in a study conducted in Sweden.[54] The findings indicated that elder abuse involving the staff did occur. 11% of the staff knew about situations of elder abuse and 2% admitted that they themselves had been abusive towards an older resident. Psychological and physical abuse were the most common types of abuse by the staff. In the cases reported within this study, abusers were mostly characterised as hot-tempered, exhausted and burned out. The abused persons were often mentally and/or physically handicapped and usually over 80 years old.

In 2016, Valvira, the Finnish National Supervisory Authority for Welfare and Health, carried out research on cases of abuse in institutional settings, including violations of rights and treatment that lacks respect for the dignity of older persons. Within this study, a survey was conducted in social welfare assisted living units that provide 24-hour residential care. Most of the 7,406 employees who participated in the survey stated that they had witnessed abuse. 25% of respondents had noticed the use of coarse and inappropriate language on a daily, weekly or monthly basis, and 20% had witnessed bossiness, punishment or criticism. The most common offenders were another employee or another resident.[55]

## Coercive control

The Duluth Model of power and control is a tool that is frequently used to understand domestic violence. The Power and Control Wheel (see page 37) illustrates the central role that power and control play in domestic violence; in particular, the wheel demonstrates how power and control that men exercise over women is translated into domestic violence.[56] **Control is exercised via actions intended to manipulate, dominate and regulate person's feelings, thoughts, opinions, behaviours and actions.** It takes advantage of person's devotion and loyalty, intimacy of the relationship and fear caused by violence.[57]

Coercive control can be defined as a pattern of behaviour of an abusive partner that involves the use of physical violence and related tactics, such as isolation, emotional abuse, and/or economic abuse, as a means of maintaining control over all aspects of one's partner's life. As a result, the victim finds themselves entrapped in an unreal world of confusion, contradiction and fear created by the abuser.[58]

The concept of coercive control arose out of the debate about the nature, extent and distribution of domestic violence; in particular, the question was whether domestic violence is primarily rooted in men's control over women or whether it is gender symmetrical, meaning that both men and women can be perpetrators of domestic violence.[59] As a result of this debate, domestic violence has been divided into two main types: situated couple violence and intimate terrorism. **Intimate terrorism** occurs frequently; it is very serious and highly controlling in nature, it can escalate over time and is gendered, that is men are perpetrators of intimate terrorism, while women are victims. **Situated couple violence**, on the contrary, is less frequent, less serious and is not as coercive or controlling in nature as intimate terrorism; it does not escalate and is gender symmetrical.[60]

**Domestic violent crime**[61] is another approach to domestic violence which focuses on the relationship between violence, economy and society rather than on ideas and motives. It deals with violent crimes perpetrated by intimate partners and other family members and is gender asymmetrical. According to this approach, violence escalates over time if victims' resilience is compromised due to the lack of access to structural, especially economic, resources. Unlike the above mentioned approach, domestic violence crime does not make a distinction between more serious gendered and less serious non-gendered forms of violence, and posits that there is potential for violence escalation in any abusive relationship.[62]

Researchers have concluded that the c**oncept of 'domestic violent crime', which does not make a distinction between "serious" and "not so serious" violence and sees all violence as gender asymmetrical, is the best way forward if we are to understand and combat domestic violence.** These factors, as well as the probability of violence escalation when victims do not have access to economic resources, have important implications for policy. In particular, the domestic violent crime concept challenges the relevance of current risk assessment methodologies predicated on the existence of multiple types of violence, only one of which is serious. This is not to deny the existence of coercive control, but to see all violence as coercive and controlling.[63] This view is reflected in the new UK law "Controlling or Coercive Behaviour in an Intimate or Family Relationship" that came into force on 29 December 2015. The aim of the law to codify all provisions dealing with coercive and controlling behaviour (criminal and non-criminal) into a single act.[64]

Coercive control which involves physical violence together with psychological aggression and/or financial violence is directly linked to **intimate partner violence (IPV)** which has received increased attention recently. While so far research has mostly concentrated on younger women, it should be noted that older women can experience IPV in two ways: as long-term violence throughout their lives or as a new experience that occurs later in their lives (e.g. if they enter a new relationship). In any case, exposure to violence in later life has serious health consequences, can contribute to chronic stress and even lead to early mortality of those exposed.[65,66]

The National Elder Mistreatment Study conducted in the US explored the relationship between coercive control tactics used by intimate partners and risk of physical abuse to persons aged 60 years or over. 68% of study participants were women, and the mean age of the sample was 72 years. According to the findings, respondents who experienced emotional coercive control by an intimate partner were approximately 8.5 times more likely to also experience physical abuse than respondents who reported that they had not experienced emotional coercive control. At the same time, this study did not find women to be more likely to experience physical violence than men. This might be in part due to the fact that, as emphasized by the researchers, the operationalisation of coercive control used in the study was narrow in scope compared with the concept of coercive control. **Good health and social support appeared to serve as factors that protect older people from violence.**[67]

## Sexual harassment and stalking

**Sexual harassment is defined as unwelcome sexual advances, requests for sexual favours, and other verbal or physical conduct of a sexual nature.**[68] The 2014 EU–wide FRA survey on violence against women defined sexual harassment as acts that were unwanted by respondents and which respondents deemed to be offensive or intimidating; sexual harassment included physical, verbal and non-verbal forms as well as cyber harassment. In the EU, on average, 38% of women aged 60-74 years had experienced sexual harassment since the age of 15 and 5% had experienced it in the 12 months prior to the survey.[69]

Stalking is unwanted or obsessive attention by an individual or a group towards another person. Stalking behaviour is related to harassment and intimidation and may include following and monitoring a victim. A study by Jasinski and Dietz[70] examined physical abuse and stalking victimization using a survey with a sample of 3622 adults aged 55 years and older[b]; the average age of respondents was 66.4 years, and women comprised more than a half of the sample. Respondents were asked if they had experienced any of the following actions:

- Received unsolicited letters/written correspondence and phone calls

[b] The original sample included 8,000 men and 8,000 women aged 18 years and older.

- Had someone try to communicate with them in other ways against their will
- Found unwanted items left for them to discover
- Had someone show up at places where they had no business
- Had someone stand outside their home, school or workplace
- Been followed or spied on
- Had someone vandalize or destroy their property

Results of the survey demonstrated that **domestic violence and stalking among older people are almost as common as among all age groups**. Women aged 55 years and older were significantly more likely than men to be both stalked and physically abused by a current partner. At the same time, older men were more likely to report victimization by someone other than their current partner. In addition to this, it is important to note that almost one-third of respondents indicated that they had a chronic disease or health condition that was disabling or interfered with their normal lives. Respondents who reported more serious disabilities were also more likely to report that they had been victims of domestic violence or stalking. Also, respondents who were not married were more likely to have experienced domestic violence and stalking. These data suggest that, while intimate partner violence and stalking are believed to be experienced primarily by younger women, they also affect older women and men.[71]

The 2014 FRA survey on violence against women defined stalking as repeated offensive or threatening acts against a respondent perpetrated several times by the same person. The various acts of stalking were divided into three categories: a) offensive or threatening communications; b) following or loitering; c) damage to property. According to the results, 18% of EU women aged 18–74 years had experienced at least one form of stalking, and 5% had done so in the 12 months prior to the survey. Among women aged 60-74 years, 16% had experienced stalking since the age of 15, and 2% had experienced it in the 12 months prior to the survey.[72]

**Common forms of stalking by perpetrators include**:[73]

Following a victim or showing up unexpectedly wherever they are; whether a perpetrator comes into contact with a victim or not is not important, since watching someone repeatedly can be a form of harassment

Sending persistent unwanted gifts, letters/notes/e-mails, texts/messages via social media

Damaging house, car or other property of a victim

Wiretapping victim's phones, monitoring their computer use or social media accounts to learn about them, their family and personal life, their whereabouts

Using technology (e.g. hidden cameras or GPS) to track victim's location and activities

Driving by or loitering outside victim's home, school, or work

Threatening a victim, their family, friends, or pets; a perpetrator may also threaten to reveal information (true or false) that could damage their reputation or relationships

Seeking information about a victim via public records, online search services, private investigators or by going through their garbage/personal property; a perpetrator may also contact victim's friends, family, neighbours or co-workers to gain access to or information about them

Posting personal information or spreading harmful rumours about a victim

Creating or manipulating situations in order to come into contact with a victim, e.g. applying for a job where they work or calling them with personal emergencies to make them feel guilty or sorry

**What can victims do when being stalked**[74]

Stalking can be difficult to prove for several reasons; it may begin with subtle individual incidents which seem harmless or innocent until they escalate, and it may be difficult to obtain 'hard' evidence of stalking. If a victim is in contact with their stalker and they feel safe doing so, then they should send a clear message that they would like to be left alone (however, for safety reasons it is not recommended to confront a stalker alone). Victims should also document all incidents, however small or isolated they may seem; documentation provides evidence and should include dates and places of contact, notes and emails sent by stalkers as well as photos and videos of stalkers or those sent by them to victims. It is also recommended that victims install home security systems and tell others about their experiences. Social media use should be limited and victims' accounts should be private. Finally, victims of stalking should change phone numbers and door locks as well as patterns of behaviour.

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# CHAPTER 2: APPROACHES TO VIOLENCE AGAINST OLDER PERSONS

## Topics Covered

Population ageing and its challenges in the EU

Prevalence of violence against older persons in Europe

Theoretical approaches to violence against older persons
- Caregiver Stress Theory
- Social Learning Theory
- Power and Control Theory
- The Ecological Model Theory
- Generational Intelligence Framework

Human Rights Approach

## Learning outcomes

Participants will:

- ✓ Understand challenges posed by the growing elderly population to social and healthcare system services
- ✓ Become aware of gender perspectives on elder abuse
- ✓ Understand how theoretical knowledge on violence against older persons is linked to interventions and other practical issues in professional work
- ✓ Be able to challenge ones' own attitudes and beliefs about older women and men
- ✓ Feel empathy towards older victims (generational aspect)

## Notes for the trainer

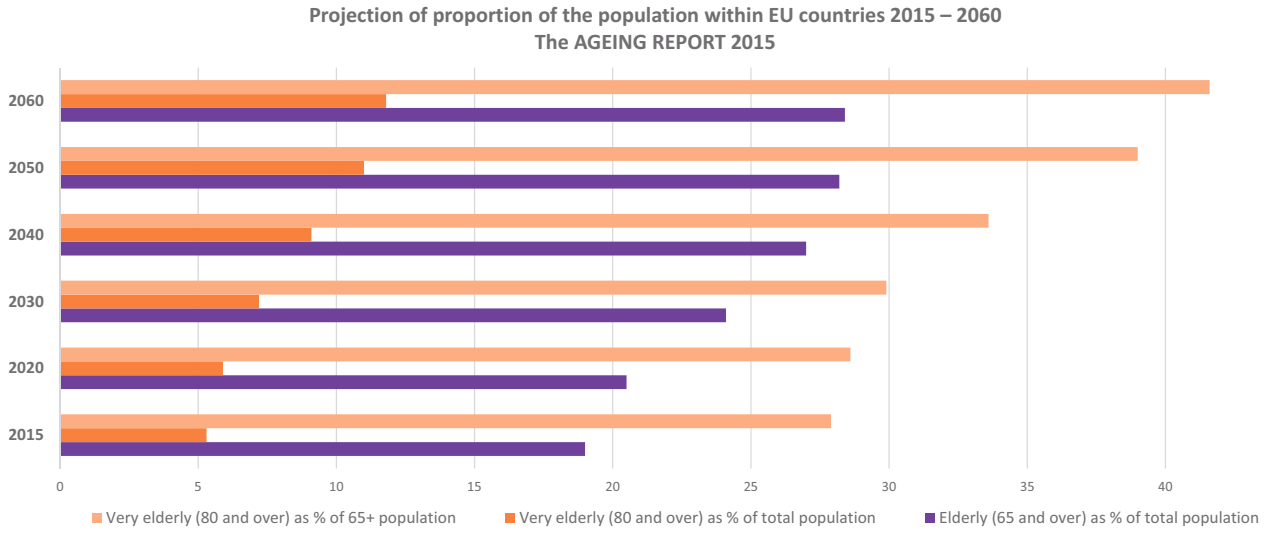
- ➢ Try to find national/local statistics/studies showing the prevalence of violence against older persons in your country/region
- ➢ When talking about perpetrators of violence against older women, it is important to show that, according to literature on the topic, over 50% of perpetrators are spouses/partners, and psychological abuse is the most common form of violence. IPV among older couples is more of a hidden issue, and social and healthcare professionals often assume (based on their practice) that main perpetrators of violence are adult children and the most common form of abuse is financial. This is due to the fact that adult children often have mental and substance abuse problems and therefore the authorities get to interact with them. Also, couples may require fewer social and healthcare services (e.g. home care) than older persons living alone.

# Population ageing in the EU and its challenges

The EU population is becoming progressively older as a result of increasing life expectancy at birth, low fertility rates and entry of the post-second world war baby-boom generation into retirement.[1] It is estimated that in 2020 the amount of people aged 65 years and older will amount to 20.5% of the total population in European countries, and by 2040 it will increase to 27%. The amount of people aged 80 years and older will be 5.9% and 9.1% respectively (see figures 1 & 2).[2]

According to the 2017 Synthesis Report on the Implementation of the Madrid International Plan of Action on Ageing, in Finland, Germany, Italy, and Portugal, more than one fifth of the population was 65 years old and above in 2015, and the proportion is expected to increase by over a quarter by 2030. This will also be the case in Greece, Slovenia and Spain. The proportion of those 80 years old or above is also growing fast: by 2030, this age group is expected to reach an 8% mark in Finland and 9% in Italy.[3]

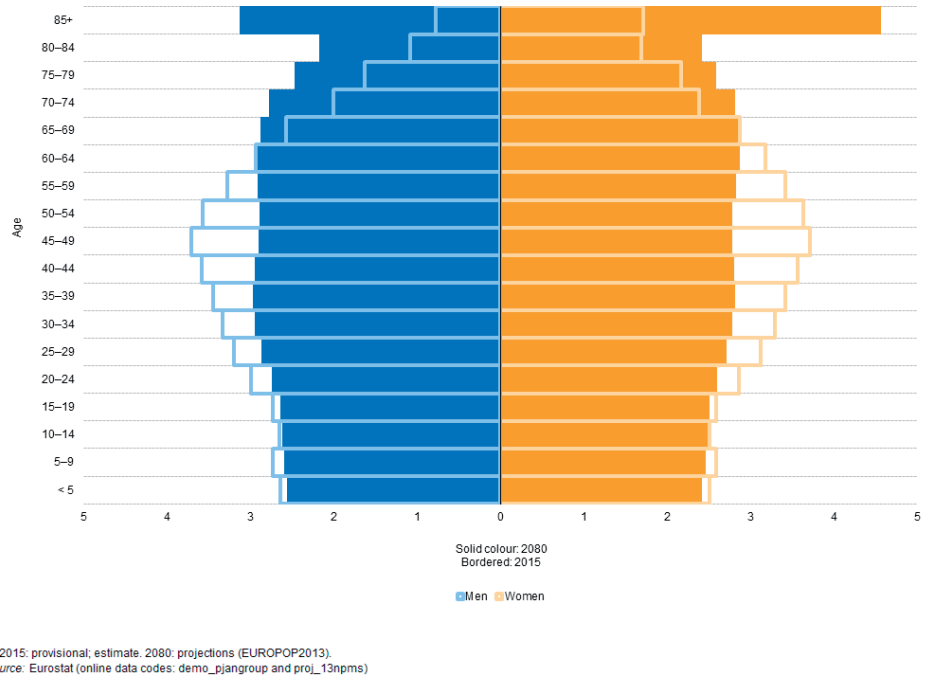
Figures 1 & 2. Projection of proportion of the population within EU countries 2015 – 2060.[4]




| Age group | 2015 | 2020 | 2030 | 2040 | 2050 | 2060 |
|---|---|---|---|---|---|---|
| Children (0-14) as % of total population | 15,6 | 15,6 | 14,9 | 14,6 | 15,0 | 15,0 |
| Population (15-64) as % of total population | 65,4 | 63,9 | 61,1 | 58,4 | 56,9 | 56,6 |
| Elderly (65 and over) as % of total population | 19,0 | 20,5 | 24,1 | 27,0 | 28,2 | 28,4 |
| Very elderly (80 and over) as % of total population | 5,3 | 5,9 | 7,2 | 9,1 | 11,0 | 11,8 |
| **Very elderly (80 and over) as % of 65+ population** | 27,9 | 28,6 | 29,9 | 33,6 | 39,0 | 41,6 |

Advances in medical science and social welfare could ensure that many older people enjoy longer periods free from disability when they reach old age. Diseases can also be avoided or their impacts lessened through better health care strategies. However, people aged 85 years and older may still have poorer health and therefore be more vulnerable to abuse. In this group,

there are more women than men since women tend to live longer.[5] In particular, life expectancy at birth for women in Europe is about 5.5 years longer than for men, which results in "feminization of ageing". Therefore, gender aspect of population ageing should be taken into account by policy-makers (see figure 3).[6]




(*) 2015: provisional; estimate. 2080: projections (EUROPOP2013).
*Source*: Eurostat (online data codes: demo_pjangroup and proj_13npms)

Figure 3. Population pyramids by gender 2015 and 2080.[7]

Women face more challenges associated with ageing than men. In comparison to men, older women are three times more likely to be widowed or to live alone and spend more years and a larger percentage of their lives disabled; women are also nearly twice as likely as men to reside in a nursing home, and are more than twice as likely to live in poverty. Poverty is of particular concern since it increases with age and is especially prevalent among older women of colour and older women who live alone. Most women in old age will live their lives as widows dependent on social security benefits as their primary source of income. Therefore, the older women get, the more vulnerable they become.[8]

**The challenge for violence prevention services is to increase knowledge on how to support older victims of abuse, especially women, and such attitudes as ageism and sexism should be addressed at the societal level.** What is more, there is a lack of understanding of how dementia and cognitive impairment can affect behaviour, particularly lead to aggressive and over-sexual behaviour. Collaboration with local services is needed to resolve these issues, and social and healthcare organizations must be supported in their efforts to address abuse and safety matters. This is especially true since the number of older patients visiting social and healthcare institutions may increase, as well as the number of nursing home placements, and they may have poor health, e.g. physical and cognitive impairments (the number of people with dementia is particularly expected to increase), which in turn will lead to additional expenditures on healthcare systems.[9]

Findings from the cross-national abuse survey Elder Abuse: A Multinational Prevalence Survey – ABUEL,[10] which was carried out in 2009, demonstrated that 26% of people aged 60–84 years living in seven European urban communities had experienced some form of abuse in the 12 months prior to the survey. Violence against older persons has been historically consid-

ered a social issue, but currently it is seen more and more as a population health issue as well. Regardless of the nature or type of abuse, it can lead to physical and mental health problems and decreased quality of life of older persons. The survey showed that respondents who had experienced psychological, sexual or physical abuse or had physical injuries had more frequent contacts with health care providers than non-abused respondents in the last 12 months prior to the survey. The study also revealed that financial abuse was the only form of violence which did not lead to more frequent use of healthcare services. Another analysis of the data revealed that an experience of any type of abuse was statistically associated with using healthcare services.[11]

**The role of healthcare service organizations in the identification of abused older people and people at risk of abuse is crucial.** Recognizing risk factors, applying abuse identification instruments and implementing good practices of medical examination and documenting, e.g. forensic evidence for legal purposes, can help healthcare organizations fulfil this role. In addition, healthcare organizations should implement intervention strategies if needed, conduct safety assessments, share information with victims and families, make referrals to appropriate services and cooperate with different actors within healthcare, social and legal systems.

## Prevalence of violence against older persons in Europe

Information on violence against older women and men in Europe is very limited. The prevalence rates vary from 0.8% to 29.3%; for men the rates are 0.7%-15% and for women they are 0.9%-23.3%.[12] The results often depend on definitions, surveys and sample methods used. However, WHO assumes that current numbers may reflect only a small proportion of incidents, and some experts believe elder abuse is underreported by as much as 80%.[13]

**There is a lack of standardized criteria and legal provisions for measuring violence against older people.** As a result, the actual scale of the problem is unknown, which impedes the development of effective prevention and response measures. There is a need for introducing a new set of universally applicable standards for the protection of older persons against violence, which would contribute to providing a comprehensive response to the problem.[14]

Both women and men can experience abuse and/or neglect in later life, especially when they start to show signs of disability and become dependent on others for help in their daily activities.[15] However, older women face greater risk of physical and psychological abuse due to discriminatory societal attitudes and the lack of realization of women's human rights.[16] In addition, the vast majority of older victims of sexual violence are women.

In the 2007 UK Study of Abuse and Neglect of Older People,[17] over 2,100 people in England, Scotland, Wales and Northern Ireland were surveyed; this included people aged 66 years and over living in private households. Overall, 2.6% of people aged 66 years and older reported that they had experienced mistreatment involving a family member, close friend or care worker over the past year. When in incidents involving neighbours and acquaintances were included, the overall rate increased from 2.6% to 4%. Prevalence rates of different types of mistreatment were the following: neglect (1.1%), financial (0.7%), psychological (0.4%), physical (0.4%) and sexual (0.2%). 6% of those who had experienced mistreatment in the past year prior to the survey reported two different types of mistreatment.

Women were more likely to say that they had experienced mistreatment than men (3.8% of women compared to 1.1% of men). Men aged 85 years and over were more likely to have experienced financial abuse than men in the younger age groups, whereas women aged 85 years and

over were more likely to have been neglected. In addition, people living alone were more likely than those living with others to have experienced financial abuse.

**Prevalence of mistreatment increased with declining health condition.** Levels of mistreatment were higher among older people with: poor self-reported health condition; a limiting long-term illness; lower quality of life; and among those suffering from depression. Overall, mistreatment was more widespread among people who reported feeling lonely in the week before the survey compared to those who had not felt lonely. 51% of incidents of abuse involved a partner/spouse, 49% another family member, 13% a care worker and 5% a close friend.

Prevalence of mistreatment varied depending on marital status and sex. 4.6% of single women reported having experienced mistreatment (0.2% of men); among women living with a partner (married or cohabiting), 4% reported having experienced mistreatment (1.2% of men), while only 1.3% of widowed women did so (1.6% of men). A significant finding was the higher rate of interpersonal abuse (psychological, physical and sexual) reported by women who were separated or divorced: 7.8% reported interpersonal abuse and 15.4% reported any form of mistreatment. This suggests that domestic violence may remain a force in some women's lives even when they no longer live with their abusive partners. When it comes to abusers, in two-thirds of the cases perpetrators lived in the same household as their victims, and in two-fifths of the cases respondents provided care to them. 75% of perpetrators of interpersonal abuse were aged 65-74 years and 80% of them were men.[18]

Violence against older women was also researched in the Prevalence Study of Abuse and Violence against Older Women that involved partners from five EU countries: Finland, Austria, Belgium, Lithuania and Portugal. It was coordinated by the National Institute for Health and Welfare THL (Finland). The survey included women aged 60-97 years who lived in private houses and asked them questions about violence and abuse in the last 12 months. 2,880 women were surveyed in all participating countries during 2010.

Overall, 28.1% of older women had experienced some form of violence. Emotional abuse was the most common form of violence experienced (23.6%) followed by financial abuse (8.8%), violation of rights (6.4%) and neglect (5.4%). Sexual abuse (3.1%) and physical violence (2.5%) were the least reported forms. In most cases, perpetrators of emotional abuse, financial abuse, sexual abuse and violation of rights were women's partners or spouses. Neglect was an exception to this; in most cases of neglected older women were abused by their adult children, children-in-law or a home care worker.[19]

According to the FRA study, on average 19% of surveyed women over 60 years old had experienced partner violence since the age of 15 and 3% in the past 12 months prior to the survey. In terms of non-partner violence, the percentages were 17% and 3% respectively. 66% of women did not report the most serious incidents of partner violence to the police or any other organization.[20]

WHO estimates the prevalence of physical and/or sexual intimate partner violence among ever-partnered women in Europe to be 25.4% and in high income countries 23.2%. The global prevalence of physical and/or sexual intimate partner violence among all ever-partnered women is 30.0%. It should be emphasized that globally violence is widespread already among young women aged 15–19 years. This suggests that violence commonly starts early in women's lives and/or relationships, and then its prevalence progressively rises to reach its peak in the age group of 40–44 year olds.[21]

# Theoretical approaches to violence against older persons

Theories and approaches to violence against older persons influence our understanding of risk factors, prevention and interventions. Theories describe aspects of different phenomena that exist and show how they happen as well as explain why those phenomena happen. Theories dealing with violence against older persons tend to adapt existing theories from other fields, including child abuse, intimate partner violence and domestic violence, rather than develop unique theories. The emphasis of theories presented in this training manual is on interpersonal relationships, although there are also broader sociocultural and multisystemic approaches to violence.

Before presenting theoretical approaches to violence, however, it should be mentioned that violence against older people is a complex phenomenon. It can take multiple forms such as physical, sexual and emotional violence, neglect, and financial exploitation. Perpetrators can be spouses or partners, family members, caregivers, and other persons in positions of trust or authority. The complexity of violence cases means that no single theory can explain all manifestations and situations of violence. Different theories explain different aspects of a complex problem, and theoretical explanations should address not only individual characteristics of older victims and their perpetrators, but also the broader context within which violence occurs.[22]

## Caregiver Stress Theory

This theory is one of the earliest explanations of elder abuse. Research on violence against older persons conducted in the early 1980s suggested that caregiver stress was the primary cause of violence. The Caregiver Stress Theory **focuses on family members caring for an older adult who is impaired in some way**. Without support, the carer can be unable to adequately perform their caregiving responsibilities. The older victim in this theory is typically described as highly dependent on the caregiver, who becomes overwhelmed, frustrated and abusive because of the continuous caretaking demands of the older person.

Researchers in the early 1980s faced significant challenges: they were studying a problem that was rarely discussed and poorly understood. There were no baseline data or common definitions of elder abuse. Sample sizes were often small and results were not frequently generalized. What is more, most studies gathered information from professionals and abusers – not victims themselves. It should be noted however that results derived from abusers' perspectives need to be interpreted with caution since abusers are known to downplay abuse and justify their behaviour. Overall, the Caregiver Stress Theory can lead one to think that stress is an acceptable justification for violence, and it has been concluded that focusing solely on stress can divert attention from other significant contributing or causative factors.[23]

## Social Learning Theory

This theory posits that **violent acts are learned behaviour transferred through the process of modelling** (transgenerational violence), in the sense that violence may be passed down from generation to generation. When children observe violence, they internalize this behaviour and start to perceive it as acceptable. They also learn attitudes towards and roles of men and women in family and society. Therefore, violence in this theory is a result of an individual having learned to use violence in an earlier context to either resolve conflicts or obtain desired outcomes. Violence against an older person thus may be perpetrated by a child who was themselves abused by their parents.[24]

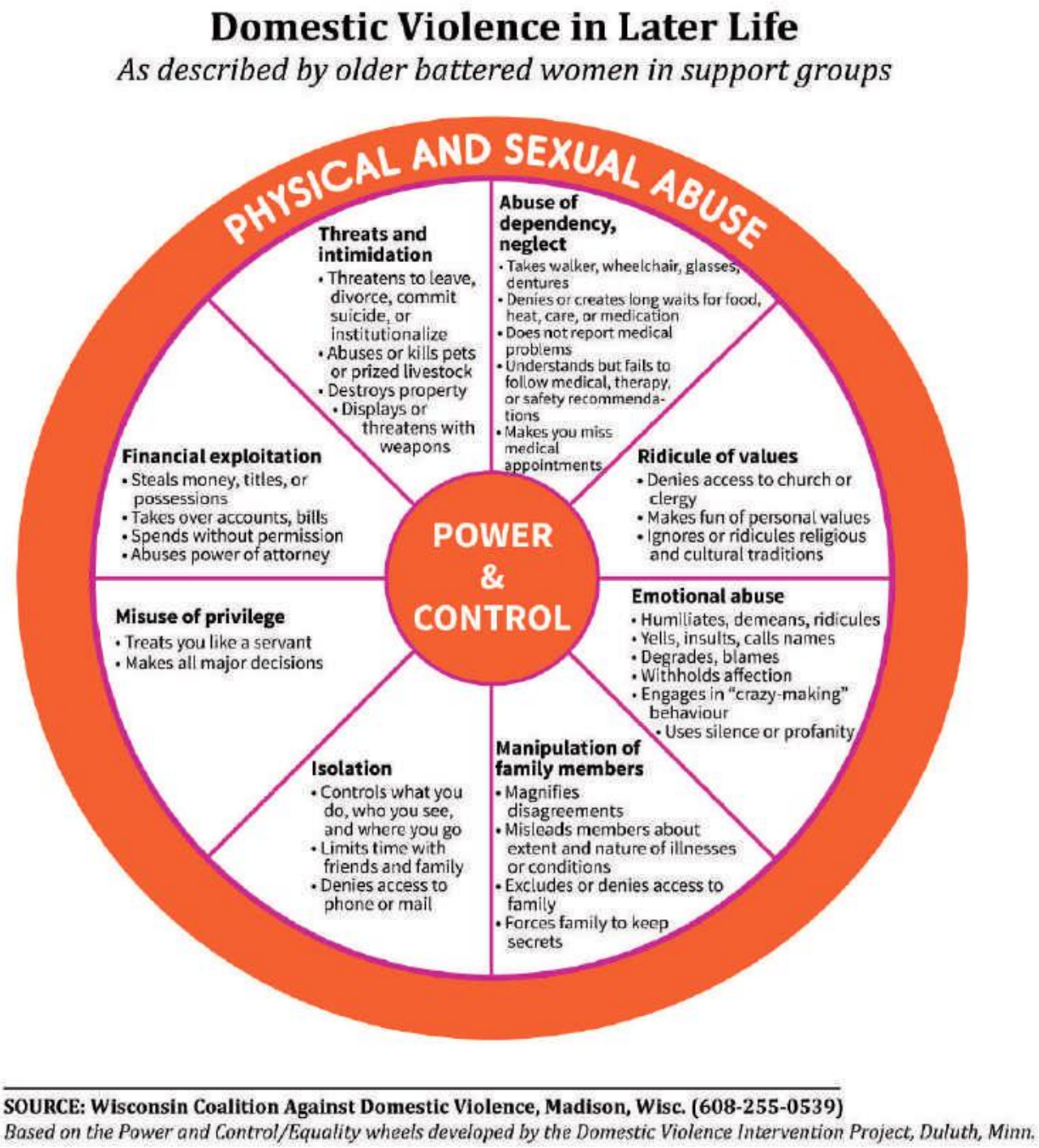



Figure 4. Domestic Violence in Later Life. As described by older battered women in support groups

## Power and Control Theory

In some cases, **elder abuse takes a form of intimate partner violence with dynamics similar to that of the power and control dynamics experienced by younger women who are abused**.[25] As a sociocultural feminist approach, the Power and Control Theory explains violence in a societal and multi-system context, highlighting men's power and control over women. According to this theory, **violence is grounded in the perpetrator's need to gain and maintain control over the victim**. Many abusers harm older persons to meet their own needs, believing that they are entitled to use any means to achieve their goals and that they have a right to control their victims. Also, many abusers hold rigid stereotypes about people over whom they exercise power.[26]

According to the Power and Control Theory, perpetrators use various tactics to gain and retain control over their victims; often they set rules for the living arrangements such as dinner time, what is watched on television, who the victim talks to and where they are allowed to go. Abusers' thinking patterns lead them to believe their needs and wants are more important than those of other people and thus they can use any methods to satisfy those needs; for example, they can steal from a grandparent if they need money or force a spouse to have sex if they desire sexual contact or want to dominate or humiliate their partner.[27]

The Power and Control Wheel illustrates different forms of violence described by older women attending support groups for battered women in the USA. They described physical abuse, sexual violence, isolation, emotional abuse etc, and different tactics used against them by spouses, partners, caregivers, or adult children (See figure 4)[28].

## The Ecological Model Theory

Gender must be taken into account to understand violence and respond to it. In particular, there is a need for broader analysis to acquire a clearer understanding of how economic, social and political status of women and the elderly, as well as the cumulative effect of ageism and sexism, contribute to violence against older persons.[29] The Ecological Model Theory has been increasingly applied to the complexity of violence against older persons since it identifies a large number of factors which can arise at individual, relationship, community and societal levels and lead to violence.

The Ecological Model Theory was first developed by Bronfenbrenner in 1979 to describe child development and well-being. According to Bronfenbrenner, the world of a child consists of five systems of interaction: Micro-, Meso-, Exo-, Macro- and Chronosystem. Each system offers an ever-growing diversity of options and sources of growth. Bronfenbrenner's work has been used primarily to interpret and understand the domain of child and adolescent psycho-social development.

| |
|---|
| **Microsystem** consists of the child's most intimate learning environment (physical, social and psychological). The real power of this initial set of interactions with the family lies in what children experience in terms of developing trust and mutuality with significant people in their lives. Forging caring relationships between a child and parents (as well as other caregivers) contributes to a child's healthy personality. |
| **Mesosystem** contains the community and relations with each other in ever-expanding circles and even more expansive relations. The real power of mesosystems is that they help to connect two or more systems in which a child, parents and family live. |
| **Exosystem** means systems we all live in psychologically and not physically. Exosystems are the contexts we experience indirectly; however, they too have a direct impact on us. This implies that there are different systems of societies which can be empowering or degrading. Exosystem can include, for example, healthcare policy and system and social welfare. |
| **Macrosystem** is a larger system of cultural beliefs, societal values and political trends. |
| **Chronosystem** frames all of the dynamics of families, communities, social systems as well as values, beliefs and traditions, and can be the historical context which changes over time.[30] |

When applied to violence against older persons, the Ecological Theory Model suggests that violence and neglect occur within four systems, namely the micro-, meso-, exo- and macrosystems (see figure 7 on page 58). These systems may overlap however, since risk factors found in one system may also exist in other systems.[31]

- **Microsystem (individual level)** refers to the relationship between older persons and their caregiver and close family
- **Mesosystem (relationship level)** refers to the relationship between older persons and wider community
- **Exosystem (community level)** focuses on interactions between, for example, older persons and elderly care services in the community and society and their impact on older people's well-being
- **Macrosystem (societal level)** refers to beliefs about and attitudes to older persons, for example how valuable they are considered to be in society

Eventually the chronosystem was added to the analysis of elder abuse in 2011 to explore institutional violence against older persons, that is violence happening for example in nursing homes. This system focuses on the impact of time on multiple levels and/or contexts of (potential) abuse (e.g. the effect of the length of residence in a nursing home on the likelihood of abuse occurring).[32]

The Ecological Model Theory is useful for examining violence against older persons because it offers a broader understanding of risk factors, prevention and interventions as it deals with older victims, perpetrators, contexts of caregiving as well as a broader societal context. This theory explores the interplay between individual and contextual factors and views violence as a result of multiple influences on behaviour.[33]

| |
|---|
| **Individual roots of violence** focus on individual characteristics which increase the likelihood of being a victim or a perpetrator of violence. For example, having substance abuse and a history of aggression and violence present risks at the individual level. |
| **Relationship roots of violence** emphasize relations with peers, intimate partners and family members and view quality of the overall relationship as a causal factor. An example is intimate partner violence and violence by a caregiver towards a care recipient. |
| **Community roots of violence** look at community norms related to domestic violence, for example a social norm of family privacy, norms related to male authority over women, traditional gender norms and social isolation in the community, which is viewed as both a cause and a consequence of abuse. |
| **Societal roots of violence** refer to cultural norms which see violence as an acceptable way of resolving conflicts, e.g. norms that support male dominance over women and children.[34] |

## Generational Intelligence Framework

This framework offers an insight into violence against older persons by incorporating both interpersonal relationships and the wider social environment, and regards generational intelligence as a way of understanding violence against older persons. Generational intelligence includes the **ability to reflect on and act based on an understanding of one's own, and other people's, life course as well as family and social history, and place this understanding within social and cultural context**. In this framework, **relationships are viewed as inter-generational space in which perceptions, attitudes and ideas about other generations and age groups are shaped by society and culture**.

To become generationally intelligent, one must become aware of their own generational identity, understand other generational identities and build empathy towards them. Thus, being generationally intelligent means acting in a way which considers generational differences (e.g. in terms of values and needs).[35] According to this framework, the dominant generation cannot see beyond their own priorities and can regard generational differences as threatening. At a societal level, **ageism** takes place when older generation's priorities and needs are viewed as less important than those of dominant age-groups.

Negative social attitudes towards older people might lead to seeing elder abuse as acceptable. Social ageism thus acts as an 'enabler', that is a factor which permits elder abuse as it creates a context or social space where such behaviour is possible or more likely. In the generational intelligence framework, elder abuse is therefore seen as a form of 'damaged' intergenerational relations, due to ageism or dysfunctional organisational environments.[36] This makes generational intelligence important in the caregiving context where it opens up opportunities for examining and promoting positive interactions between younger and older people through for example training professionals.[37]

# Human rights approach

Professionals within the elder abuse field are becoming more and more interested in the human rights perspective on elder abuse and its prevention. The human rights implications of elder abuse are recognized in many countries. These countries acknowledge that to protect older people from poor treatment and cruel practices and to empower them to speak up social policy must move from a needs-based approach to a rights-based one. As a result, **human rights are increasingly becoming the foundation of elder abuse prevention practices**.[38]

In the context of population ageing, which has emerged as a worldwide concern, more attention is being paid to the importance of promoting human rights of older people. Human rights are universal legal guarantees that protect individuals and groups against infringement upon their fundamental freedoms, dignity and entitlements. They have intrinsic value for all human beings and are founded on respect, dignity and worth of every individual. **Violence against older persons is a form of violation of human rights**. In particular, different forms of abuse can violate such individual human rights as the right to privacy, right to autonomy and freedom, right to have access to family and friends. At the same time, violation of personal rights of older people can be seen as a form of abuse in itself. This form of abuse has also been referred to as **social abuse**. The denial of human rights to older persons presents a macro level context of elder abuse.[39,40]

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# CHAPTER 3: COMPLEXITY OF VIOLENCE AGAINST OLDER PERSONS

## Topics Covered

Main types of domestic violence against older persons
Invisibility of older women as victims of violence
Gender perspectives on violence against older persons
Ageism, sexism and violence against older persons
Specific situation of older women as victims of violence
Violence against older persons with dementia

## Learning outcomes

Participants will:

- ✓ Learn about main types of violence against older persons
- ✓ Understand how invisibility of older victims of violence influences their professional life
- ✓ Become aware of gender differences in how older people experience domestic violence
- ✓ Explore the connection between ageism, sexism and violence against older persons
- ✓ Learn about violence against older people with dementia

## Notes for the trainer

- ➢ This chapter introduces many different aspects of violence against older persons; therefore, it is recommended that the trainer chooses topics that are relevant for participants. For example, the connection between dementia and abuse may be of great importance to professionals working in home care.

## Main types of domestic violence against older persons

The term **'violence against older persons' can be applied to victims aged 50 years and older.** This is due to the fact that not much is known about violence against 'younger' older persons. Most research on elder abuse focuses on people who are over 65 years old and/or are frail and dependent on their caregivers. However, there is a lack of knowledge about and research on victims aged 50-62 years since most of them are healthy and many might still be employed; therefore, this group rarely uses social or health care services intended for elderly. In addition, the number of victims aged 50 years and older who access domestic violence services (e.g. hot lines and shelters) is in general rather low. This is partly because many services for domestic violence victims focus on meeting the needs of younger women and their children.[1]

Different **factors** may cause domestic violence against older people. For example, c**ognitive impairment** (dementia processes) can contribute to sexually inappropriate and/or aggressive behaviour. **'Payback' violence and neglect** might occur due to changing roles of family members, for instance when an abusive man becomes physically and psychologically dependent on his wife. These factors together with the distinctive features of older people's situations (e.g. poor health, retirement etc) make violence against older persons a complex phenomenon that requires appropriate responses.

**There are three main types of domestic violence against older persons**[2]:

| |
|---|
| **Domestic violence while growing older**: domestic violence starts (rather) early in life and continues into old age (e.g. long-term intimate partner violence) |
| **Domestic violence in later life**: an older person enters into an abusive relationship later in their life and a perpetrator might be a new spouse/intimate partner |
| **Domestic violence that begins in old age**: a strained relationship, which started earlier in life, escalates into violence as partners age. This type is often linked to retirement/disability. |

## Invisibility of older women as victims of violence

Violence against older women exists on the margins of societal discussion of violence, and neither domestic violence nor elder abuse adequately capture the experiences of older women as victims of violence. On the one hand, there is a lack of gender analysis in the elder abuse field; on the other, **efforts to combat and prevent violence against women lack a 'lifespan' approach to violence and are fixated on 'visible' victims** (i.e. younger women). As a result, older women as victims of violence have become invisible and are usually overlooked. However, although the rates of physical and sexual abuse among older women are lower than among their younger counterparts, non-physical forms of violence (e.g. verbal and emotional violence) do not demonstrate such an inverse relationship with age. Therefore, o**lder women's experiences should not be marginalized and the gendered nature of violence against them should be recognized** to effectively address their victimization.[3]

Although the consequences of violence are profound, **only a small proportion of older victims seek help**. This might be due to, for example, feelings of powerlessness, shame or guilt.[4] Underreporting in turn reinforces the belief that violence against older people is not widespread resulting in a vicious cycle (see also figure 5) in which:[5,6,7]

Professionals tend to believe that domestic violence does not occur amongst older people;

This false assumption leads to a lack of recognition of violence against older people and understanding of its signs;

This in turn may encourage professionals to associate injuries, confusion or depression with age related issues rather than violence;

As a result, professionals do not offer older people opportunities to report violence;

Since older people rarely report violence themselves, they remain invisible as victims;

This vicious cycle is also based on prevalence studies which assume that experienced violence decreases with age and is not a significant problem for older persons.


Figure 5. Invisibility of older persons as victims of violence

## Gender perspectives on violence against older persons

The following are some gender differences pertaining to older people's experiences of violence:

- Older women are more likely to be victims of domestic violence than older men, in part because they usually live longer;
- Domestic violence and/or neglect are often perpetrated by older women's spouses, partners or adult children;
- Older men usually become victims of domestic violence or neglect perpetrated by their adult children or close friends;
- Women are more likely than men to experience violence in younger age, and it may continue throughout their lives; years of violence can have severe effects on victims' health;
- Older men's first experiences of violence or neglect may occur later in their lives once they have developed a disability and started to rely on others for help;
- Older women may have fewer financial resources than older men, and thus may find it harder to leave a violent relationship because of financial dependence.

Violence and neglect affect older people emotionally and physically. Both older women and men may feel shocked, embarrassed, guilty, or ashamed that someone they trust is hurting or taking advantage of them. Some older persons may feel that they must help and protect their spouse or children, even if they are abusive. Also, older people may not think about the consequences or effects of violence on themselves. In intimate partner violence cases, children may discourage their parent from taking action, for example by protecting the other parent or refusing to take sides.[8]

Since violence against older persons has traditionally been considered 'gender neutral', responses to it are focused on personal or interpersonal problem-solving and do not take into account the broader context.[9] **Older women, however, are more likely to live longer than their spouses as well as to live in poverty, be dependent on social welfare and suffer from chronic health problems, disabilities and other limitations in their daily activities. These factors marginalize older women in society, increase their risk of being abused and make it difficult for them to seek support.** Cumulative effects of long-term gender discrimination combined with ageism and a failure of the feminist movement to take older women's interests into account make **older women invisible or subject to negative stereotyping**. In particular, older women have often been excluded from studies of violence against women and have largely been absent from discussions on shelters and hotlines. Therefore, the circumstances and special needs of older women as victims of abuse have been overlooked. As a result, they might lose their right to live their lives free from violence.[10,11]

The fact that violence against older women is in many cases perpetrated by their spouses justifies the use of a gender-based approach, at least in the domestic violence context.[12] **The 'gender lens' uncovers how public policies, programs and practices affect men and women differently.** When inequalities and disadvantages are based on gender, it should be taken into account by decision-makers in order to restore fairness and equality.[13]

While it is commonly assumed that domestic violence is mainly experienced by younger women, it is clear that o**lder women also experience physical, sexual, emotional and financial violence and neglect by their partners and other family members, and that the dynamics of power and control are the same regardless of victims' age**. However, since violence against older women is considered only within the context of 'elder abuse', gender differences are largely ignored. This supports the perception of older persons as sexless, and treats male and female victims of abuse in later life in the same way.[14]

Women can experience violence through their whole lives (see figure 6); however, there is a lack of understanding of such long-term violence, and evidence-based prevention and intervention strategies covering the whole lifespan of women are largely non-existent. While gender analysis of violence against women focuses on male domination and subordination of women, it has been overlooked that subordination might be especially relevant in older women's cases since they are less likely to have adequate pensions and other benefits than older men, leaving older women with fewer resources to ensure their independence.[15]

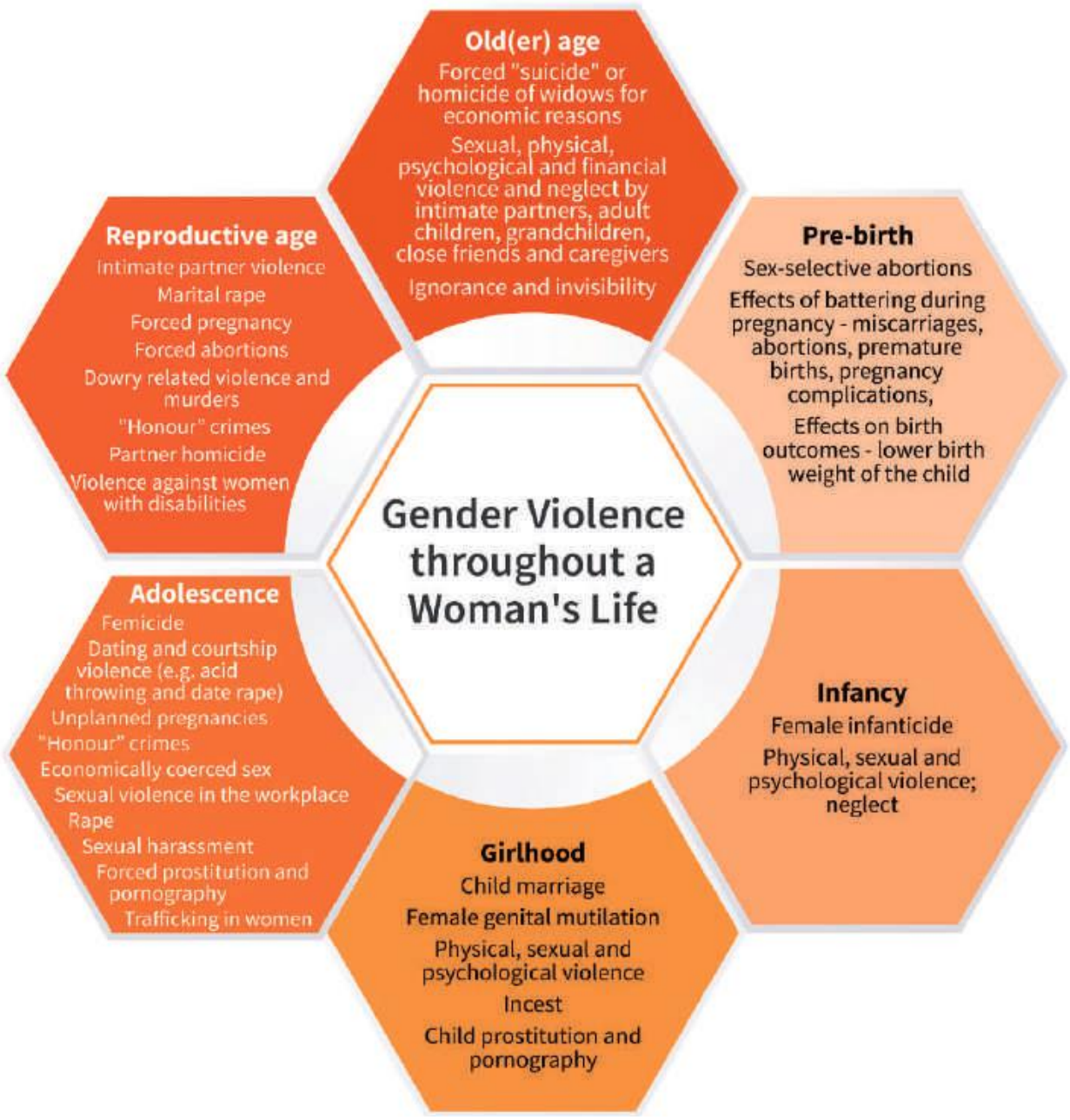


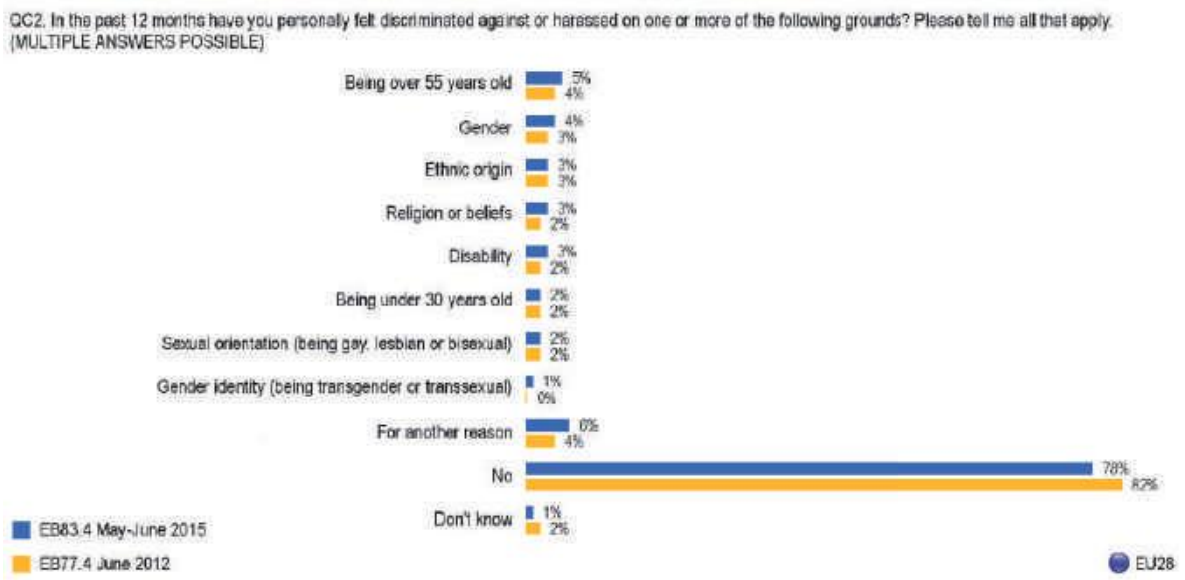

Figure 6: Gender Violence Throughout a Woman's Life[16]

## Ageism, sexism and violence against older persons

Robert Butler, a physician and social scientist, was the first one to define the term '**ageism**' in 1960 as "**a process of systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this with skin colour and gender.**

**Old people are categorized as senile, rigid in thought and manner, old-fashioned in morality and skills. Ageism allows the younger generations to see older people as different from themselves; thus, they subtly cease to identify with their elders as human beings**."[17]

The World Health Organization defines ageism as "the stereotyping and discrimination against individuals or groups on the basis of their age; ageism can take many forms, including prejudicial attitudes, discriminatory practices, or institutional policies and practices that perpetuate stereotypical beliefs."[18] According to the 2015 Special Eurobarometer,[19] one fifth of respondents (21%) reported that, in the 12 months preceding the survey, they had personally felt discriminated against or had been harassed; 5% reported having been discriminated against due to being over 55 years old, and 4% due to their (see the graph below).




**Both men and women experience ageism in the form of stereotyping**. Typically, older men are stereotyped as increasingly feminine, weak and dependent, while older women are viewed as asexual, unhealthy and also dependent. Ageism is reflected in the language used to talk about older men and women, and it denies them their autonomy and dignity and creates barriers to exercising their human rights. As a result, ageism can be seen as a factor that permits violence against older people and can contribute to the denial of the seriousness of this issue. Ageism is therefore central to understanding and confronting violence against older persons.[20,21]

It should be stressed that negative attitudes towards older people are widely present within the health and social care settings where older persons are most vulnerable. **Ageism has been demonstrated to cause cardiovascular stress, lowered levels of self-efficacy and decreased productivity.** What is more, older people's own perspectives on aging can have harmful effects on their health. Research suggests that older people who have negative attitudes towards ageing may live on average 7.5 years less than those with positive attitudes.[22,23]

Older women experience not only ageism but also sexism, and a combination of age and gender discrimination puts older women at higher risk of violence and abuse.[24] The term 'double jeopardy' refers to the fact that women experience more disadvantages than men as they age due to the combination of sexism and ageism.[25] Furthermore, inequality and discrimination experienced by women intensify with age.[26] Feminization of poverty is a key manifestation of this, and invisibility of older women is symbolic of this phenomenon.[27]

## Specific situation of older women as victims of violence

Older women experience violence differently from younger women, which has significant implications for the suitability of existing domestic violence services for their needs. Violence can escalate over time and its effects may become more severe due to increased fragility and vulnerability of older women. The forms of violence women experience can also change with age. For instance, while physical violence may diminish over the years, it can be replaced with more serious psychological abuse and other forms of control and domination, including humiliation and derogation.[28] However, in many cases older women do not see psychological/emotional abuse as violence, or they tend to understate emotional abuse as physical violence they experience decreases.[29] Also, women who experience violence are likely to be victims of several forms of abuse. As a result, i**f an older woman admits to experiencing one form of violence, it is likely that she is or has been a victim of other forms as well**.[30]

Overall, there are several differences in how younger and older women **experience domestic violence**, and these can be divided into **five categories: traditional norms, financial barriers, (dis)ability, lack of knowledge and information, and social networks**.

First of all, many older women were socialized into norms that differ from younger women's norms. In particular, they tend to have more traditional attitudes and values when it comes to gender roles, marriage and family. As a result, many older women share a belief that divorce is a taboo, view family matters as strictly private and are very loyal and committed to their families. Such values prevent older women from discussing family problems with others, including discussing domestic violence.

Secondly, financial difficulties which older women face can keep them in abusive relationships. Many older women were housewives when they were younger. Therefore, when they got a chance to work in later life they lacked skills and experience to seek employment, and were also faced with ageism. As a result, their pensions might be low, and they might not have any savings.

Thirdly, older women are more likely than younger ones to have health issues, which makes them highly dependent on other people, and some health conditions might render older women especially vulnerable. Due to this, it might be difficult for them to leave a violent situation if they receive care from abusive partners. Also, some older women provide care to other family members, e.g. their abusive husbands, and strong care ethics can prevent them from leaving.

Furthermore, older women may have gotten accustomed to living in a situation of long-standing abuse, and they might not realize that this situation is not normal. In addition, they might be unaware of available services and help.

Finally, as women age, their social networks become smaller due to the deaths of their peers, and it might become more difficult to stay in contact with those who are still alive. As a result, abusive spouses may be the only people left in older woman's lives, which contributes to the feeling of isolation.[31]

## Violence against older persons with dementia

Dementia refers to a number of conditions which develop as a result of degenerative changes in the brain, and primarily affect older people. For instance, Alzheimer's disease is the most common form of dementia. Dementia can be characterised by the loss of cognitive, social and behavioural functions, which impacts person's mood and personality as well as their ability to speak, understand, think rationally, communicate, remember and perform basic self-care ac-

tivities such as dressing, eating and bathing. As dementia progresses, an older person requires increased assistance and care due to more profound disabilities.[32]

According to Alzheimer's Disease International, 46.8 million people worldwide lived with some form of dementia in 2015. The regional estimates of dementia prevalence in people aged 60 years and over currently range from 4.6% in Central Europe to 8.7% in North Africa and Middle East; other regional estimates fall between 5.6 and 7.6%.[33]

Population ageing is a crucial factor in understanding the future global distribution of dementia, given that age is the main risk factor; in general, more older people will mean more people at risk of developing dementia. It has been estimated that the number of people with dementia will reach 74.7 million in 2030 and 131.5 million in 2050. The impact of dementia can be understood at three levels: at the individual level, dementia can cause health problems, disability, poor quality of life and reduced life expectancy; at the family and friends' level, it means that they need to provide more care and support to a person with dementia; at the wider societal level, it means higher health and social care costs. While dementia does shorten life expectancy of those affected, the greatest negative impact it has is that on the quality of life of both individuals living with dementia and their family and carers.[34]

Dementia is associated with stigma: an external stigma towards persons with dementia and an internal stigma since affected people feel ashamed of themselves.[35] As a result, many people who have dementia feel marginalised and isolated, and may lose their friends or become misunderstood by their family members.[36] Dementia-related stigma can also make people unwilling to seek diagnosis and/or support once diagnosed. In addition, family members can ignore early signs of dementia because of the fear of stigma since they can also experience its negative effects. External dementia related stigma also exists among health care professionals, which might lead to lower standards of care and distortion of services.[37]

Violence against older persons with dementia is underreported because its detection is often complicated by various biological, pathological, ethical and cultural factors. For example, dementia is associated with a high level of dependence on carers. Thus, older persons may be reluctant to report violence due to their fear of retaliation or losing support. In addition, it might be difficult to distinguish common physical and psychological signs of violence (e.g. withdrawal from communication) from dementia symptoms. Current estimates of prevalence of violence against older people with dementia vary greatly between studies, from 27.9 to 55%.[38] Psychological violence is the most common form of violence against older persons with dementia, with prevalence estimates ranging from 27.9 to 62.3%; physical violence has been estimated to affect from 3.5 to 23.1% of older persons with dementia.[39]

Several studies have reported higher rates of physical abuse of people with dementia than of those without this disorder. For instance, older persons with Alzheimer's disease have been found to be 4.8 times more likely to experience violence than those who do not have it. Disruptive and aggressive behaviour of people with dementia can be a major cause of stress for carers (family members, paid carers or health care service providers), which might lead them to retaliate with violence and result in drinking problems. Carers, who may be old and frail themselves, can also be victims of assault by care recipients with dementia, and violence on the part of carers can make care recipients even more aggressive.[40,41] In addition, depression, anxiety, alcohol abuse, social isolation and poor relationships with victims before the occurrence of dementia are associated with a higher risk of violence and neglect by carers. In long-term care facilities, low levels of job satisfaction and high burnout rates among workers may lead to an increased risk of violence and neglect.[42]

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# CHAPTER 4: RISKS AND CONSEQUENCES OF VIOLENCE AGAINST OLDER PERSONS

## Topics Covered

Ecological Model
- Risk factors for violence against older women and older people with dementia
- Protective factors
- Multifaceted responses

Consequences of violence for older people
- Cognitive and emotional consequences
- Physical health consequences
- Suicidal thoughts/attempts
- Increased mortality risk

Older women and long-term violence
- Violence related stigma
- Complex/Cumulative trauma
- Post-traumatic stress disorder (PTSD)
- Historical/intergenerational trauma

## Learning outcomes

Participants will:

✓ Understand that violence against older persons is a multifaceted problem influenced by socio-cultural, economic, psychological and environmental factors, and therefore it should be confronted on several different levels at once

✓ Become aware of risk factors for violence against older women

✓ Acquire skills necessary to prevent violence against older persons by identifying risk and protective factors for violence

✓ Learn about life-threatening consequences of violence as well as its effects on older women's behaviour

✓ Understand violence related stigma that older persons are faced with as well as how long-term violence affects women

✓ Be able to challenge ones' own beliefs and attitudes towards older women

## Notes for the trainer

➢ It is recommended that the trainer initiates a discussion on specific characteristics of clients/patients that professionals deal with to help them identify possible risk factors

➢ It is important to make connections between preventative measures, responses to violence and risk and protective factors at each level of the Ecological Model

➢ Do not just share knowledge about consequences of violence, but try to create positive and supportive attitudes towards older victims. It might be beneficial to use videos when discussing this topic.[1]

# Ecological Model

**Understanding risk factors for violence against older people and their timely identification are the basis for effective prevention of and response to violence.** Risk factors can be defined as conditions or characteristics that increase the likelihood of an older person becoming a victim of violence and/or their vulnerability to harm.[2] In order to prevent violence against older people in the long run, numerous risk and protective factors as well as several levels of the ecological model must be taken into account.

## Risk factors for elder abuse[3]

Risk factors for violence against older people exist at different levels: individual level (victim or perpetrator), relationship level and broader environment in which older people live. Older persons who exhibit or are exposed to three to four risk factors have been found to be almost four times more likely to experience elder abuse, and those who exhibit or are exposed to five or more risk factors have been demonstrated to be 26 times more likely to experience elder abuse.[4]

**Major risk factors at different levels are the following:**

| **Individual level – older person/victim** |
|---|
| Cognitive impairment, psychiatric illness, psychological and behavioural problems |
| Poor physical health, functional dependence (assistance with daily activities is required) |
| Low income/pension |
| Past experiences of abuse and related trauma |
| Ethnicity |
| **Individual level – perpetrator of violence (incl. risks associated with caregiving)[5,6]** |
| Caregiving burden and/or stress experienced by carers |
| Psychiatric illness or psychological problems, high level of hostility |
| Poor quality of a relationship between a carer and an older person before changes in older person's health |
| Aggression of an older person towards their carer |
| Poor/inadequate preparation of a carer for fulfilling caregiving duties |
| Assumption of caregiving responsibilities at an early age |
| Inadequate coping skills |
| Exposure to abuse as a child |

| Relationship level[7] |
|---|
| Family disharmony, poor or conflictual relationships between family members |
| High levels of financial and/or emotional dependence of a vulnerable older person on their carer or vice versa |
| History of disruptive behaviour by an older person |
| Lack of appropriate assistance to family members, e.g. because they do not seek help |
| **Environment – community and society[8]** |
| Lack of social/formal support: services for older people or carers (e.g. respite care) are limited, inaccessible or unavailable, or there is a lack of information about such services |
| High levels of tolerance and acceptance of aggressive behaviour |
| High levels of decision-making freedom within healthcare and social services and a lack of service provision standards |
| Certain societal views and values, e.g. the belief that people who experience suffering should remain silent |
| Ageism and negative attitudes towards older people |

Certain factors might **increase the likelihood of violence** against older people in the long-term care settings. These factors include **lack of staff and their inadequate training, negative attitudes of staff to older people, aggressive behaviour by residents (e.g. due to dementia), vulnerability and isolation** of older people at large facilities.

As described in the previous chapter, older people with dementia might be particularly vulnerable. Risk factors for violence against these people might vary depending on the stage of dementia, and it is important to identify them in order to prevent abuse. However, **common elder abuse screening tools are not suitable for older persons with dementia** as such tools are based on the assumption that an older person is able to understand and answer questions. Therefore, screening instruments that rely on healthcare professionals' assessment of signs of abuse may yield better results than other methods when direct questioning of an older person with dementia is impossible.[9]

**Risk factors for violence against older persons with dementia include:**

| Individual level – older person/victim who has dementia |
|---|
| Secondary symptoms of dementia: dementia symptoms such as aggression and/or hypersexual behaviour[a] (e.g. sex talk or sexual acts)[10,11] are particularly challenging for caregivers; stress and embarrassment experienced by caregivers as a result of such behaviours may lead them to use violence against older people |

a It has been estimated that 7% to 25% of patients with dementia exhibit inappropriate sexual behaviour. This seem to be more common among men, but the exact male/female ratio is unknown.

**Individual level – perpetrator of violence**

- Poor psychological health, mental health problems (e.g. symptoms of depression), anxiety
- Stress associated with caregiving duties
- Alcohol abuse

**Relationship level**

- Poor relationship between an older person and a caregiver prior to the onset of dementia
- Reciprocity of abuse: in cases where older people exhibit secondary symptoms of dementia they might act violently towards their carers, which starts a vicious cycle of violence that requires immediate intervention

**Environment – community and society**

- Lack of assistance/services/training provided to people who take care of older persons with dementia
- Inappropriate/inconvenient household living arrangements

Previously, the main emphasis was on exploring and addressing risk factors at the individual and/or relationship level. However, **cultural norms and traditions, such as ageism, sexism, discrimination and societal tolerance towards violence, are becoming increasingly recognized as underlying factors that might create conditions favourable to violence**. Older people are often seen as frail, weak, dependent and therefore less worthy of investments and/or care than other groups. The ecological model (see figure 7) is thus very important since it takes into account multiple difficulties that older people face and underscores the multifaceted nature of violence against them by exploring the interplay between different risk factors.[12] However, professionals should also be aware that **in some cases of abuse risk factors might not be apparent or present, while in other cases the existence of multiple risk factors might not result in violence**.[13]

## Risk factors for violence against older women

The Prevalence Study of Abuse and Violence against Older Women explored different risk factors for violence at two levels: micro, i.e. individual, level and meso, i.e. social, level. Risk factors at the individual level included sociodemographic characteristics (e.g. age), socioeconomic status indicators, mental and physical health and coping styles. Risk factors at the social level included relationships (e.g. marital status), place of residence and community integration (e.g. feelings of safety or loneliness, social activities). The obtained data demonstrated that several risk factors at both micro and meso level were associated with the higher likelihood of abuse:

**Micro level**: Abuse was significantly more prevalent among women aged 60-69 years who were married, not fully retired, reported poor physical and mental health and used a disengaged coping style when faced with stressful and difficult situations.

**Meso level**: Abuse was significantly more prevalent among older women who felt more lonely, considered household income management bad, lived in larger households and with a partner.[21]

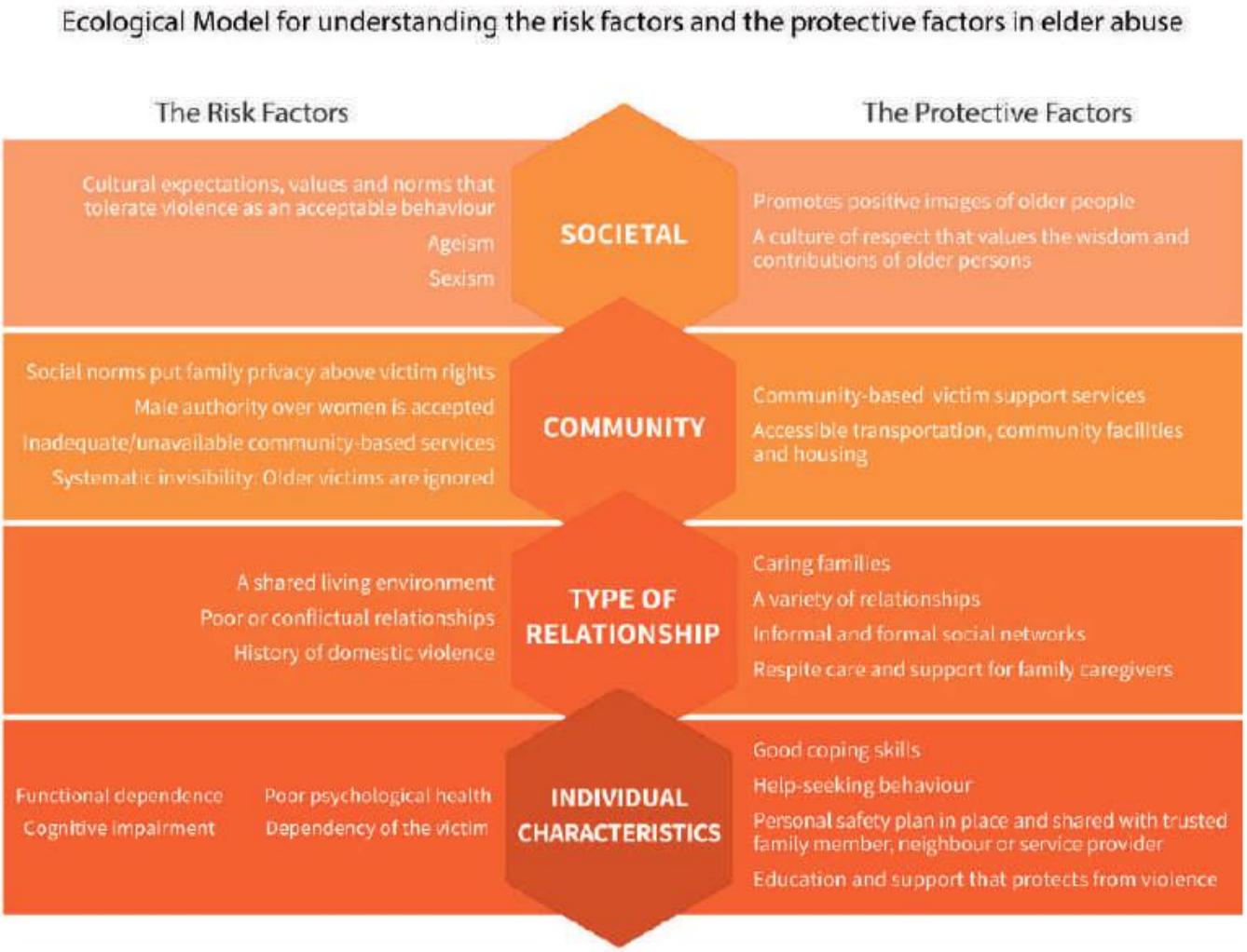


Figure 7. Ecological Model: Roots of Violence and Risk Factors for Elder Abuse[14] and Protective Factors[17]

A combination of certain factors at the individual and social levels were also found to be associated with a higher risk of becoming a perpetrator of violence against an older person. While these might not be direct causes of violence, they increase the likelihood of committing it, and better understanding of these factors can contribute to identifying violence prevention measures.

**Risk factors for becoming a perpetrator of violence against older women**:[22]

- Substance abuse
- History of violence (e.g. witnessing or experiencing violence as a child; having perpetrated domestic violence in the past)
- Criminality
- Psychological problems (e.g. depression), mental impairment (e.g. dementia, degenerative processes in the brain that cause aggressive behaviour)
- Financial dependence of the perpetrator on their victim
- Cohabitation of the perpetrator and their victim
- Long-standing power and control dynamics; male domination in the family

## Protective factors

Protective factors (see also Figure 7) are conditions or characteristics, such as skills, coping strategies, resources and external support, that reduce people's vulnerability and help them deal with stressful events more effectively.[15] Currently, there is a lack of research and understanding of factors that can protect older persons from violence or promote their recovery after having experienced it. However, strong social support and social networks[16] are believed to contribute to the prevention of violence against older people.

## Multifaceted responses to violence

Since violence is a multifaceted problem that has numerous roots (biological, psychological, societal) it should be confronted at several different levels. The ecological model serves a dual purpose: each level in the model deals with different risk factors for violence, thus a**ppropriate measures/interventions are needed at all levels in order to successfully prevent or stop violence against older people**[18] as follows:

- Individual risk factors should be addressed, and steps should be taken to change behaviours associated with risks
- Families should receive professional help and support to improve relationships between their members and create healthy family environments
- Public spaces (e.g. schools, workplaces, neighbourhoods) should be monitored and measures should be taken to prevent the occurrence of problems that may lead to violence
- Gender inequality, harmful cultural practices as well as other social and economic factors that create conditions for violence (e.g. the gap between the rich and the poor, unequal access to goods, services etc) should be addressed and eliminated[19]

Such an approach to violence prevention can be called holistic as it addresses multiple elements of a complex social problem. It suggests that the issue of violence against older people cannot be solved by working only with individuals. Families and communities also have an important role to play in preventing and ending violence, and society as a whole should be involved in this effort via education and awareness raising campaigns.[20]

## Consequences of Violence for Older Persons

Possible physical and psychosocial consequences of violence are numerous and varied. Few studies have extensively examined the (long-term) consequences of violence for older victims and distinguished between them and processes related to normal ageing. Different studies that have researched how violence affect older people suggest that the following might be consequences of violence:

**Cognitive and emotional consequences**[23,24,25,26]

- Psychiatric illnesses, psychological problems, cognitive impairment, dementia
- Depression, anxiety and post-traumatic stress disorder
- More pronounced symptoms of dementia and/or depression
- Substance abuse

**Physical health consequences**[27,28,29]

- Bone or joint problems
- Lung problems
- High blood pressure, heart problems
- Injuries, cuts, bruises and broken bones
- Decreased life expectancy
- More frequent use of healthcare services
- Digestive and weight problems, gastrointestinal disorders
- Chronic pain
- Chronic diseases
- Allergies
- Pelvic problems

**Suicidal thoughts/attempts**

- There is a link between suicidal thoughts and a history of being abused[30]
- Men are more likely to have suicidal thoughts and/or attempt suicide as a result of physical and psychological abuse[31]

**Increased mortality risk**

- Three-fold increase in mortality risk[32]
- Risk of death in older women who have experienced IPV is three times higher than for non-victims
- Poor health is in general associated with lower life expectancy[33]
- Increased risk of cardiovascular-related mortality[34]
- Mortality risk might be even higher for older people with the lowest levels of psychological well-being[35]
- Coercion has been found to be significantly associated with higher mortality risk[36]

## Older women and long-term violence

The impact of violence on psychological well-being of older women may be more devastating than on their physical health, and it takes them a long time to recover from victimization.[37] Women aged 53-70 years who had experienced long-term domestic violence (had been in an abusive relationship for 37-52 years) listed the following as its effects[38]:

- Constant feelings of fear and intimidation, inability to use their own will and deal with anxiety and stress, depression, isolation, tiredness, suspiciousness, watchfulness.
- Feeling of entrapment was intensified by physical and social factors related to old age, e.g. health problems, lack of economic resources, small pension and/or other income, lack of educational qualifications and therefore inability to find a job, low prioritization of older people's needs by social services.
- Shame, guilt, self-blame and secrecy. Shame and guilt were common feelings which went hand in hand with inability to deal with an abusive situation. Attitudes within older women's families and their upbringing, religious views and perceptions of what it meant to be a woman contributed to these feelings. Abusers were able to exploit these feelings and used them against their victims. Secrecy seemed to be particularly characteristic of women whose families exhibited a culture of concealment, mainly due to religious beliefs.
- Feelings of hopelessness, powerlessness and loss. Loss meant different things to different women and took different forms: loss of self, family, children, love and sexual partner; loss of confidence, respect, income; loss of control over their lives; wasted years and loss of their lives.
- Relationships between older women and their children had suffered and turned into negative ones despite the fact that in most cases mothers had tried to protect their children from abuse.

**Older women perceive and experience violence in several ways [39]:**

- Suffering due to male domination and control
  - Psychological abuse, including ageist and sexist insults (e.g., 'old whore')
  - Aging can turn men into tyrants. For instance, they might be frustrated at not receiving the level of care they are accustomed to; women in turn might feel guilty because they are unable to provide the expected level of care
  - Physical vulnerability due to illness and aging processes as well as the feeling of being less attractive intensify suffering and make it more emotionally charged
- Acceptance of bodily pain: older women often ask themselves whether pain they feel is caused by old age or is a consequence of violence (e.g. statements like 'my body was broken anyway')
- Isolation, alienation and loneliness in one's own home and perception of time as a source of suffering
  - Home represents a static spatial experience in which violence exists; this experience is internalized by older women as 'a heavy stone' in their hearts
  - Older women's routine is built around violence: they need time to recover from one violent episode and at the same time they expect the next one to happen. Overall, older women see time as structured by years
- Cumulative suffering and perception of death: both young and older women expect death and recognize the need to deal with it; however, older women tend to view death as part of the life cycle.

## Violence-related stigma

Initially, stigma[40] was a mark or tattoo which was cut out or burnt into the skin of criminals and slaves in order to visibly identify them as morally polluted persons. Nowadays stigma refers to identification of certain individuals as 'disgraceful' and 'shameful' by other people or society in general, which might have an impact on one's normal identity. There are three types of stigma[41]:

**Stigma internalization**

Stigma internalization refers to the extent to which people internalize negative attitudes of perpetrators towards them, and is a form of self-stigma. Stigma internalization may therefore become a barrier to seeking help from formal and informal support networks. A stigmatized person feels ashamed and as if they have failed, which is related to the overall psychological distress. Perpetrators are the main source of negative attitudes and contributors to stigma internalization. The nature of abuse may be directly linked to how survivors experience violence and whether they internalize stigma. In particular, labelling and emotional abuse are two powerful mechanisms through which stigmatization operates.[42]

**Anticipated stigma**

Anticipated stigma means the degree to which people fear or expect stigmatization from others. In particular, it refers to concerns about what will happen once others find out about abuse (e.g. rejection, disapproval, discrimination). Anticipated stigma can be a critical barrier to seeking help since it intensifies a sense of shame and thus leads people to maintain secrecy around violence.

**Cultural stigma**

Cultural stigma is related to beliefs about abuse at the societal level, which de-legitimize people who experience violence. For example, a common belief is that IPV victims provoke violence themselves. Such views on abuse can lead to not considering it a problem, and they influence anticipated stigma and stigma internalization. Cultural stigma affects each stage of the help-seeking process.[43]

Stigma is linked to shame. Older women are particularly likely to feel ashamed of or embarrassed about their experiences of partner abuse, and they may also feel shame because they have endured violence for a long period of time. Older women who started a new relationship later in their life may also be ashamed to admit that they had made a mistake.[44]

## Complex/Cumulative trauma

Complex/cumulative trauma is a type of trauma caused by events and experiences that occur repeatedly over a period of time and within a specific relationship and/or context.[45] Such events and experiences are usually interpersonal in nature, involve direct harm to and exploitation of a person (this includes neglect/abandonment by close people) and occur during periods of time when a person is most vulnerable (in childhood, adolescence, old age, due to disability, depen-

dence etc). Long-term abuse results in complex/cumulative trauma that manifests itself in the following ways[46,47]:

- Mental health problems, dissociative episodes, psychotic episodes, psychiatric illness, psychogenic amnesia, difficulties in regulating affective impulses (anger, self-destructiveness)
- Difficulty trusting people or feeling intimate
- Chronic sense of guilt, regret, remorse
- Intensification of suffering after children have left home
- Loss of confidence, hopelessness, despair
- Feeling of permanent damage and loss
- Intense shame/stigmatization
- Feeling that nobody understands, loneliness
- Permanent physical damage, disability, chronic eating disorders
- Self-harm, self-neglect

Symptoms of complex/cumulative trauma are likely to be more severe in older women due to possible long-term abuse and increased frailty.[48]

## Post-traumatic stress disorder

Post-traumatic stress disorder (PTSD) is a medical term for long-term symptoms caused by (repeated) stressful event(s). Long-term symptoms are changes in emotions, behaviour, relationships, social life, personality, life situation and/or health condition of an individual, and are seen as normal human responses to overwhelming and/or unbearable experiences. Such traumatic experiences can constantly re-appear as feelings/memories in one's mind, that is a victim can be "stuck" with flashbacks of stressful events. Over time, PTSD symptoms can turn into a chronic disorder with psychiatric consequences. Although reactions to traumatic experiences do not automatically result in mental disorders, many abused women suffer from severe PTSD symptoms.[49]

**General PTSD symptoms in older people**[50]:

- Insomnia, nightmares; lack of sleep can exacerbate other PTSD symptoms
- Re-experiencing of traumatic events which occurred in the past in the form of memories (belated trauma)
- Changes in personality, psychotic symptoms associated with PTSD, avoidance

PTSD may manifest itself differently, and more intensely, in older people due to their poor health, chronic pain and cognitive impairment; retirement, reduced income, loss of loved ones and lack of social support can contribute to this as well. In addition, these factors make it more difficult for older people to cope with the memories of an earlier trauma. Overall, the interplay between complex/cumulative trauma and PTSD may become more complex with age.[51] However, adaptation and resilience (flexibility and ability to recover quickly from traumatic experiences) can develop overtime and become a source of coping mechanisms.

## Historical/intergenerational trauma[52]

If trauma is not dealt with adequately, emotional and psychological damage can be passed down from one generation to another influencing the behaviour and world view of a new generation. One example of this is trans-generational war trauma.

According to the study[b] conducted in Finland in 2015-2016,[53] parents' war-related traumas have affected next generations' lives and life choices. The "war" generation, i.e. older people, were unable or unwilling to seek help because they thought it was shameful. They considered life hard, but thought that one just had to withstand it patiently and struggle to survive. The second generation felt that their parents had left them completely alone and neglected. As a result, they reported psychological problems and were unhappy with their relationships. The third generation also felt that their lives had been affected by their parents' attitudes, in particular their inability to discuss problems at home. They, for example, had difficulties finding a suitable field of study and building strong relationships.

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# CHAPTER 5: WORKING WITH OLDER VICTIMS OF VIOLENCE

## Topics Covered

Suspecting abuse

Psychological first aid (PFA) in health care work

- Caring communication and provision of encouragement to older women
- Working with older abused women
- Secondary victimization

Understanding coping strategies of older victims of violence

- Principles of empowerment approach to interventions
- Services for female victims of violence

Why do older women stay in abusive relationships?

- Barriers to seeking help
- Challenges that older women are faced with

Older perpetrators of violence

## Learning outcomes

Participants will:

- ✓ Be able to support older abused women in overcoming barriers to seeking help
- ✓ Learn how to motivate older victims of violence to change their situation
- ✓ Be able to apply the empowerment approach in their work
- ✓ Feel empathy with older victims of violence (generational aspect)
- ✓ Be capable of carrying out safety planning

## Notes for the trainer

- ➢ The main aim of this chapter is to improve professionals' understanding of the situation of older abused women and to increase their empathy with victims
- ➢ Increased empathy is the key to preventing secondary victimization of older women by professionals

## Suspecting Abuse

As discussed previously, older people are often reluctant to report cases of abuse due to various factors, such as shame, guilt, dependence on the abuser, etc. Those who report violence usually do so in case of physical or sexual abuse. This demonstrates that older people tend to report only severe cases of violence, while choosing to hide seemingly 'milder' cases of abuse.[1] Therefore, **when a professional suspects abuse, it is important that they ask the right questions in a careful manner** as described below.

For example, it might be better to ask older women about controlling behaviour of their partner rather than physical and/or sexual violence. Since controlling behaviour is not perceived as violence by older women, they might view it as a less private and controversial matter and therefore be less reluctant to discuss it. Also, health care or social service providers might feel more comfortable asking older women about controlling behaviour instead of directly addressing violence.[2]

**When abuse is suspected, professionals should do the following:**[3]

- Create a safe environment for discussion
- Speak to a client (possibly a victim of abuse) and their caregiver/relative separately
- Establish mutual trust and respect
- Use soft words and avoid judgmental statements to make older women feel at ease
- Use "I" statements: "According to my experience, many women experience…"

**Questions to ask older women during screening, which help to identify risk factors for abuse could include the following:**[4]

- "How are things going at home/in a care facility?"
- "How do you spend your days?"
- "How do you feel about the amount of help you get at home/in a care facility?"
- "How do you feel your husband/daughter/other caregiver is doing?"
- "Do you have everything you need to take care of yourself?"

**Other tips for providing support to older women are as follows:**[5]

- Do not mistake trauma reactions and disabilities (e.g. hearing/vision impairment, aphasia) for senility
- Be aware that older women may process information more slowly than younger adults and might take longer to put their thoughts into words. This is a normal age-related change and it should not be viewed as evidence of a lack of mental capacity
- Provide sufficient time to respond
- Some older women may be reluctant to talk about abuse or seek help out of fear of losing their independence
- Avoid expressions of disgust, horror or anger in response to abuse; avoid "putting down" an abuser
- Identify victim's strengths and skills and try to use them to help her
- Give hope to a victim and suggest strategies which promote her safety and reduce her isolation; provide additional information if needed
- Support any decisions a victim makes, including a decision to stay with an abuser or leave them

**Older abused women need the following**:[6]

- Information on abuse and its consequences
- Long-term practical help and emotional support from workers in a broad range of agencies: housing, legal and social service agencies (e.g. help with claiming benefits)
- Effective coordination between different agencies (NGOs, volunteers, social and health care service providers)

**When leaving an abuser is not an option for an older woman, professionals/agencies should do the following**:[7]

- Take care of victim's safety and minimize risks
- Provide advice on what to do in emergency situations
- State a possibility of contacting you if need be
- Ensure regular assessment of risk factors
- Identify protective factors and sources of support for a victim; put her in contact with services than can help reduce their isolation
- Identify mental health problems that a victim and/or an abuser have; refer them to a mental health specialist
- Organize awareness raising campaigns and provide information about violence and services for its victims in places where it can reach older women

**To support victims in their efforts to deal with the consequences of violence and to change their situation the following questions can be asked**:[8]

- What is important to you?
- What are your hopes?
- What would you like to know/learn about?
- What do you need/expect from a professional?
- What are your goals?
- What are your concerns?
- Can anyone from your family/friends help you?

## Psychological first aid in health care settings

Traumatic events, such as experiencing violence, cause emotional distress; however, people's responses to such events differ in a number of ways. For example, the impact of traumatic events can be acute but short-lived, or it can be chronic and last for months or even years.[9] At the same time, the acute short-lived impact can turn into a chronic condition. Research has demonstrated that those people who react to traumatic events in an 'extreme' way are at risk of developing PTSD.[10] Older people in particular often suffer from long-term PTSD symptoms; therefore, it is important that health care professionals help older victims of violence in a timely manner.

**Psychological first aid (PFA)** refers to methods used to assist people in the immediate aftermath of a traumatic event to reduce the initial distress and to foster short- and long-term adaptive functioning and coping. PFA is used by first responders, e.g. primary health care and emergency medical service providers, mental health workers, police and disaster relief work-

ers. In many cases, it is the most important support that helps patients/victims to cope with a situation.[11]

**Psychological first aid entails both social and psychological support**, and it can be provided not only by professionals but also by non-professionals after brief orientation. Thus, it is important to keep in mind that **PFA is not equivalent to professional counselling** and does not necessarily involve detailed discussion of the event which caused distress. Although PFA involves listening to people's stories, it is not aimed at making them talk about their feelings and reactions to traumatic events.

**Basic principles of PFA are the following**:[12]

***Safety***: Avoid actions that might put people at risk of further harm.

***Dignity***: Treat people with respect; take into account their cultural/social norms.

***Rights***: Ensure equal access to available help and support services; make sure no one is discriminated against.

**Professionals providing PFA to victims should**:[13]

- Ensure people's safety and provide physical care if needed
- Assess basic needs of people (e.g. food, water, blankets) and address them
- Show understanding and support, comfort people, make them feel safe and calm
- Help people restore a sense of empowerment, hope, dignity
- Be an active listener, convey sincere compassion
- Do not talk about deep feelings caused by trauma and/or details of traumatic events
- Provide basic information on reactions to distress; discuss coping strategies and let people cope with the situation in their own way
- Evaluate potential risks (including the risk of suicide and/or harming others)

The use of medication in cases of acute stress reactions to traumatic events is not recommended and should only be considered if an individual has not responded to other forms of support. For example, medication may be necessary if an individual is experiencing extreme agitation, anxiety, panic attacks, psychosis and/or might pose a threat to self or others. In such cases, the use of medication should be targeted and short-term only.

## Caring communication and provision of encouragement to older women[14]

Caring communication means **supporting victims by listening to and accepting** what they have to say about their experiences of violence and neglect. Caring communication includes:

- "I" statements: "I am concerned about you…"
- Specificity: "You missed your last appointment, and today I see a bruise on your arm"
- Sensitivity to older women's feelings: "I understand that it is hard to talk about personal issues…"
- Non-judgmental and non-threatening way of communication: "Would you like to talk to me about it?"
- Empowerment: "Do you want to talk about some of the resources you might want to use?"

- Assistance in overcoming abuse related stigma: "I have seen many people who do not receive care they deserve"
- Respect for an older woman's right to make her own decisions once she is ready
- Readiness to assist an older woman in finding support services she needs

When an older woman allows you to enter her life, you can motivate and encourage her to change her situation. Therefore, support an older woman in deciding what to do and **offer her different options**. Remember that she and you are both responsible for her safety, and that your goal should be to help an abuser as well.

- Ask a victim how she has been able to deal with violence over the years
- Give her time to find motivation
- Stay in contact and address violence regularly
- Search together for new ways of dealing with the situation
- Be realistic about the situation, but do not scare her too much

## Working with older abused women[15,16]

When working with older abused women, professionals should remember the following **rules**:

- **Believe victims**. Even if victims say something that seems untrue, assume that they might have experienced trauma at some point. If you suspect a memory disorder, depression or delirium, contact a health care provider
- **Talk less and listen more**; allow victims to talk at their own pace
- **Do not assume** that the problem is being caused by stress, poor communication in the family or poor caregiving. Assume the cause lies in the power and control dynamics until proven otherwise
- **Focus on the safety of victims**
- Ensure victims' **access to relevant information**, education and other forms of social and economic support to help them make their own informed decisions which reflect their needs and interests
- **Respect older women's decisions**; support their **independence and autonomy**. However, keep in mind that decisions older women make can involve risks
- Remember that **empowerment is a process** by which women set their own goals and get access to resources which can help them achieve these goals
- Make sure that older women have **access to the judicial system** and their individual rights are protected

## Secondary victimization

Secondary victimization refers to further victimization of an older person by medical personnel or workers of other organizations that an older person is in contact with following original victimization by an abuser. **Secondary victimization includes, for example, victim-blaming, inappropriate behaviour and/or language, which might intensify victim's suffering**.[17] Therefore, **it is important to prevent secondary victimization** from happening by[18]:

- Involving victims in the decision-making process regarding their case (whenever possible)
- Taking into account their needs/expectations
- Creating a safe environment for discussion

- Being considerate and sensitive when communicating with victims
- Ensuring cross-institutional cooperation
- Providing appropriate services and information to victims
- Constantly monitoring and evaluating the situation
- Avoiding blaming attitudes
- Conducting critical/holistic analysis of the system

## Understanding coping strategies of older victims of violence

Coping can be defined as "thoughts and behaviours that people use to manage the internal and external demands of situations that are appraised as stressful." There are **two types of coping**:[19]

**Emotion-focused coping**: coping strategies are used to deal with the distress/emotions caused by specific problems. This approach is used when an individual needs to adapt to a situation they cannot control or change (e.g. IPV). It is often employed by older people.

**Problem-focused coping**: coping strategies are used to deal with problems themselves. This approach ensures better adjustment if an individual can control a stressful situation they are in.

Better understanding of how older people cope with violence and stress caused by it may give valuable insight into how to assist them in case they remain in abusive relationships for long periods of time. In such situations, older women might employ the following coping tactics:[20]

- Reassessing the situation to see it in a new light, establishing new interpersonal and relationship boundaries
- Reframing important aspects of the situation, e.g. self, abuser, relationship; refusing to let anything "wear them down," or thinking that one should "know the things you can control and accept the things you cannot"
- Focusing on culturally prescribed gender roles
- Reaching out to family, friends, colleagues to receive emotional support
- Developing certain "threatening" strategies (e.g. "I will tell him I am going to pick up the phone and call the police...")
- Blocking out violence, channelling their energy into certain activities, waiting for an abusive partner to die
- Making excuses for the abuser's behaviour

Coping strategies can be divided into two categories.[21] **Positive coping strategies** focus on self-change and/or changing the situation, for example by seeking support and information on how to solve the issue. **Negative coping** includes putting the blame on other people, self-criticism, aggression, withdrawal, resignation and wishful thinking.

## Principles of empowerment approach to interventions[22]

When action is taken to end violence and help a victim, the **following principles should be observed**:

### Victim's safety

Safety must always be a priority and intervention should not worsen the victim's situation. For example, leaving printed information where an abuser might find it, calling a victim when an abuser is at home, leaving case notes at victim's home are not acceptable/should be avoided. If the situation is life-threatening, action must be taken immediately to protect victim.

### Client's right to self-determination

- Mentally competent older people have the right to make choices that others may consider unwise or unsafe; making such a decision does not mean that an older person lacks mental capacity
- The right to self-determination must be balanced against professional duties

### Cultural appropriateness

- Cultural sensitivity is crucial to building trust between a victim and a professional; it facilitates communication and acceptance of an intervention
- Professionals should be aware of their own values, beliefs and prejudices in order to understand and accept other people's ways of life; however, cultural or religious beliefs can never justify illegal behaviour

### Focus on a client

Interventions must take into account and meet the client's needs, even if abuse is unintentional or an abuser is the client

### Holistic approach

Different aspects of the client's situation must be analysed and addressed. Providing help to an abuser or resolving the conflict between the needs of an abuser and a victim could improve the client's situation

### Access to legal aid and law enforcement system

Professionals must explain all options to a victim, including involving the police, and be ready to refer them to the law enforcement agencies

### Respect for confidentiality

- Confidentiality must be balanced against the possible consequences of inaction and risks the client is faced with. Professionals must document all matters of concern and report them to the person in charge of the case/relevant department. It should be remembered that confidentiality exists between the agency/organization and the client, not between the worker and the client
- Confidentiality cannot be used as a justification for failing to respond to abuse
- It is justifiable to share relevant information with other workers involved in the case and/or taking care of the client if this can help them better carry out their duties

## Services for female victims of violence

Multiple studies have examined different interventions/services used in cases of domestic violence/abuse of older people. **The following five interventions have been proven to bring about beneficial effects**:[23]

**Caregiver interventions** include services that help reduce the burden of caregiving, e.g. housekeeping and meal preparation services, respite care, education/training, support groups and day care. Such interventions lessen the stress experienced by caregivers and thus reduce the likelihood of violence, which renders them effective in terms of abuse prevention.

**Money management programmes** are used to assist individuals vulnerable to financial exploitation. Such programmes may include helping people with paying bills and making bank deposits, negotiating with creditors and paying home care personnel. Such programmes are especially important for individuals with some degree of cognitive impairment and those who are socially isolated. The preventive potential of these interventions is high, and well-trained and accredited money managers help minimize the risk of negative outcomes.

**Helplines** allow individuals to seek advice and assistance anonymously and can facilitate early interventions to prevent violence. Such helplines are typically staffed by trained volunteers or professionals. Their anonymity is an advantage since many older people might be unwilling to discuss violence face-to-face due to shame. Helplines have not been found to have any negative effects, and thus are considered a promising intervention.

**Emergency shelters** are one of the most important interventions/services for abused women. However, they are underutilized by older women, who are often unaware of them. What is more, 'traditional' shelters are not suitable for older women who might have physical or mental health problems. Therefore, specialized shelter programmes for older victims of abuse have been developed. Such shelters offer security and specialized services to meet older victims' needs while plans for safe return home are developed, and thus can prevent permanent relocation to a nursing home.

**Multi-agency teams** reduce fragmentation of services and ensure more effective use of resources, increase professional knowledge and improve intervention outcomes. Effective violence prevention and response can only be achieved via coordination between different agencies (police, health care and social workers, care agencies etc).

**Interventions to stop violence should be tailored to the situation** and be conducted by teams that consist of workers with different expertise. For example, long-term intimate partner violence and financial exploitation require different approaches, while an abuser with schizophrenia and an abuser with a memory disorder need different treatment.[24]

Older women who have been/are **victims of abuse need the following**:[25]

**Supportive discussion of their earlier and/or current experience**

- Victims have emotional and practical needs related to both their past and present
- Victims usually need to talk to someone about their experiences and to receive support when making decisions and adjusting to new circumstances
- Victims need someone to believe them and listen to them

**Practical advice and information**

- Victims often remain in abusive relationships because they do not know where and how to get help, especially when it comes to leaving an abuser, e.g. information about housing options and social benefits
- Older victims require help from a wide range of agencies, and resources that they need are not always readily available to them
- Effective coordination between professionals, victims' families and friends is the key to successful interventions

Older women have certain needs that require special attention, and currently some services for older people and domestic violence victims do not take these needs into account. **Older women are thus faced with the following challenges**:[26]

**Women's shelters**

- Shelters may be rather noisy with high levels of activity, which might cause inconveniences to older women
- Women may be allowed to stay in shelters only for a limited period of time, which might not be enough for an older woman to reflect on her situation and make a decision
- Shelter staff may be unfamiliar with the needs of older people and lack necessary medical training and skills
- Shelters might lack special arrangements and facilities for women with disabilities, e.g. ramps for wheelchair access

**Services for older people**

- Services for older people do not address gender issues and inequality, including when dealing with cases of domestic violence.
- These services do not see power and control dynamics as a problem in a relationship

**When providing support to older female victims of abuse, the following should be taken into consideration** by different agencies/professionals:[27]

- Abuse, sometimes severe, is often perpetrated by older, seemingly harmless, abusers
- Service providers should monitor and regularly assess the situation, including risk factors for violence/death and protective factors. The negative impact of the situation on victims' health and well-being should be minimized.
- Social support, spiritual/religious beliefs play an important role in helping older women
- To eliminate their isolation, older women should be put in touch with different service providers and support groups (agencies that provide transportation to day care centres, IPV support groups, meals on wheels, religious groups (if a woman is religious) etc.)
- If possible, providers should identify mental health problems of victims and abusers (depression, anxiety etc) and refer them to specialists for treatment; this is especially important if leaving an abuser is not an option, and may improve the victim's safety and quality of life

## Why do older women stay in abusive relationships?

In order to help older abused women, professionals should understand their needs and take into account different challenges that they are faced with and that might prevent them from seeking help and/or leaving an abusive relationship. A person-centred approach thus becomes the key to effective support since it guards against ageist and sexist assumptions and stereotypes.[28]

## Barriers to seeking help[29]

There are numerous obstacles that prevent older women from seeking help, and many of them are related to societal beliefs and attitudes. For example, older women might think, due to misconceptions rooted in ageism and sexism, that they are supposed to be able to cope with violence. What is more, they might not be aware of the existing domestic violence services or think that they are suitable only for younger women since most of the societal discussion of violence is focused on younger victims. As a result, older women often stay in abusive relationships. The reasons for this can be divided into the following categories:

### Cohort effects and traditional values[30,31]

Today's older women belong to a group of people who were born and raised during a specific period of time when independence and education of women were not encouraged. This generation's upbringing often reinforced traditional gender roles and values, including the submissiveness of women to their husbands, loyalty to one's family, viewing marriage as a permanent bond and considering divorce unacceptable, the importance of secrecy and privacy when it came to family matters. As a result, domestic violence was seen as an internal family matter and seeking help was disapproved of. What is more, when today's older women were young, domestic violence services did not exist as such. Only gradually respective changes in public opinion as well as in laws and policies regarding women's rights reduced tolerance of domestic violence and provided for specialized services for victims of violence.

### Ageing effects and health issues

Ageing brings about challenges such as health issues, fear of loneliness and stress caused by the deaths of family members and friends. Mobility problems might make it more difficult for older women to access domestic violence services.

### Financial difficulties

Although younger women also face financial barriers which might keep them in abusive relationships, these barriers are even greater for older women. Many of them were not employed when they were younger, and later in their lives it could be difficult or impossible for them to find jobs due to a lack of experience and ageism. Therefore, today older women's pensions might be very small and they might not have any savings. Also, they might not be eligible for housing or other financial support.

### Provision of care to others

Older women, in part as a result of their traditional upbringing, may find it extremely difficult to leave an abuser whom they take care of due to their strong sense of responsibility/loyalty or guilt.

### Stigma and shame[32]

Older women are particularly likely to feel ashamed of being abused, especially if they have endured violence for a long period of time. Those who started a new relationship later in

their life may be embarrassed to admit that it might have been a mistake (see Chapter 4). In addition, older women may be afraid that people/professionals will not believe them if they report violence or that they will be treated like children.

**Fears**

Older women might be afraid of being alone after years or decades of living with someone; they might fear the unknown and be unwilling to 'start over'. They might also think that leaving an abuser will result in losing their children, grandchildren and/or pets.

## Challenges that older women are faced with[33]

In addition to the reasons for staying in abusive relationships discussed in the previous section, there are other **challenges that might prevent older women from accessing services for domestic violence victims and receiving help**. They include the following:

**Violence is perpetrated by caregivers**

- Caregivers can effectively isolate older women from other people (e.g. family members) and prevent them from contacting social services or talking about their problems during doctor's appointments
- Older women may be financially dependent on perpetrators
- It might be difficult for professionals to organize meetings with (potential) victims without letting their caregivers know or involving them (e.g. if transportation is required)
- If violence is perpetrated by a child/grandchild, older women might be less likely to report abuse and blame themselves for having raised an abusive kid

**Victims have complex needs/problems or lack certain resources**

- Not having a mobile phone or a place to go, suffering from memory loss etc make it difficult for victims to leave abusers
- Older women who have experienced abuse for many years might need more time to process trauma

**Perpetrators of violence have complex needs/problems**

- Perpetrators might suffer from dementia, memory loss etc, which can contribute to violent behaviour
- Perpetrators may suffer from alcohol/drug/substance abuse and thus require special treatment
- Perpetrators may be viewed as vulnerable and therefore incapable of (serious) harm

# Older perpetrators of violence

The forms of violence that older women experience might be influenced by the age of perpetrators. Older perpetrators may reduce the frequency of physical and/or sexual assaults on their partners, which results in physical and sexual violence against older women being less prevalent than among younger women. At the same time, older perpetrators might turn to other forms of violence, for example economic abuse, which has been found to be slightly more prevalent among older women.[34,35] Psychological abuse might last for years and gradually escalate, possibly due to declining self-esteem of older men.[36]

Based on results of investigations of abuse and physical and mental evaluations of victims and abusers, Ramsey-Klawsnik[37] created a typology of perpetrators of violence against older persons. Better understanding of different characteristics of abusers may allow to develop more effective interventions to prevent violence and assist victims.

**The Overwhelmed Offender**

This is an individual who provides day-to-day care to an older person, but is incapable of meeting their caregiving needs. The overwhelmed offender realizes that their behaviour is abusive but has difficulty seeking help. This type is described in the caregiver stress theory. However, as discussed previously, this theory alone cannot explain all causes of violence.

**The Impaired Offender**

This is an individual who has physical or mental problems or suffers from substance abuse, which makes it difficult to properly carry out caregiving duties. The impaired offender tends to be neglectful, administers medication incorrectly and might use restraints. This type often does not realize that their behaviour is abusive.

**The Narcissistic Offender**

This is an individual who does not want to provide care to an older person and only does so in order to exploit them. The most common forms of abuse perpetrated by the narcissistic offender are neglect and financial exploitation.

**The Bullying Offender**

This is an individual who wants to exercise control over their victims and has little compassion for older people. The bullying offender perpetrates different forms of abuse, including physical, sexual, emotional and financial. Their victims are usually too frightened to report violence and merely try to placate the abuser.

**The Sadistic Offender**

This is an individual who enjoys humiliating and terrifying older people, and inflicting suffering on them. The sadistic offender feels no guilt or remorse for their actions.

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# CHAPTER 6: ADDRESSING VIOLENCE AGAINST OLDER PERSONS IN HEALTH CARE SETTINGS

## Topics Covered

Recognizing violence against older people and differentiating between the symptoms of disease and signs of violence

Older persons in the emergency department

- Signs of elder abuse
- Myths about the older people's use of emergency services

Violence screening tools

- Screening older persons for signs of abuse
- The Elder Abuse Suspicion Index©
- Self-Administrable Elder Abuse Suspicion Index© (EASI-sa)
- Piloting the EASI in the emergency department
- Risk on Elder Abuse and Mistreatment Instrument© (REAMI)
- Medical examination of victims of assault

Challenges of working with victims of violence

- Ethical issues
- Safety planning

## Learning outcomes

Participants will:

- ✓ Be able to recognize the signs of elder abuse
- ✓ Learn to differentiate between the signs of violence and age-related changes/diseases
- ✓ Understand the importance of sensitivity when dealing with possible older victims of sexual abuse
- ✓ Become acquainted with the comprehensive medical examination procedure that helps determine whether an older person may be/is a victim of violence
- ✓ Learn how to use screening tools and understand their importance
- ✓ Challenge their own attitudes towards older people as emergency department patients

## Notes for the trainer

- ➢ This chapter is targeted at health care professionals, especially those working in emergency departments
- ➢ The tools introduced in this chapter might be new to professionals; therefore, it is important to explain their role and significance to professionals and guide them through each step of using these tools
- ➢ It is crucial to motivate participants to use the introduced tools in their everyday work and take action if they suspect abuse

## Recognizing violence against older persons

Health care professionals and social workers rarely recognize elder abuse and take action to help victims and end violence. There are two main reasons for this.[1]

First of all, there is a **lack of formal training in elder abuse and its signs**. While in some, extreme, cases of violence and neglect (e.g. knife wounds, bite marks, signs of starvation) recognizing abuse is rather straightforward, it is not always easy to differentiate between the signs of abuse and age-related changes or symptoms of disease. Many professionals lack information on indicators of abuse in older people. Therefore, advanced training for medical professionals, especially those who are in regular contact with older people, is an important step towards improving their violence recognition skills.[2]

Secondly, in many organizations **abuse reporting procedures are inadequate or non-existent**. For example, according to the study on elder abuse identification in emergency departments conducted in Canada, over 50% of physicians, who participated in the study, stated that their emergency department did not have a written protocol for reporting and dealing with elder abuse, while 39% were "unsure" whether such a written protocol existed.[3]

Addressing these two issues is crucial to improving the situation with elder abuse identification. In what follows, the ways of achieving this in the health care settings are presented, and signs of violence against older people are extensively described.

## Differentiating between symptoms of disease/age-related changes and violence

There are many similarities between symptoms of disease and physiologic and psychological changes due to old age and signs of neglect and abuse; in many cases, it might not be clear whether abuse and neglect are actually taking place.[4,5] Therefore, it is very important that health care professionals can see the difference between normal ageing processes, diseases and injuries caused by violence.[6]

Common **normal age-related changes** are the following:

- Skin becomes thinner, more fragile, and loses the protective fat layer, which increases the risk of skin injuries and bruising
- Blood vessels of the dermis become more fragile and prone to bruising and bleeding under the skin
- Bones become thinner and less dense
- Older people might suffer from multiple chronic illnesses/conditions. As a result, certain medications or their combinations might cause side effects such as bruising and risk of fractures[7]

Signs and marks specific to abuse are rather rare, and laboratory tests as such do not detect violence. In addition, professionals may not be able to accurately determine the age of bruises or burns; however, their sizes, patterns and locations may suggest whteher they are intentional in nature. Therefore, body maps (see Appendix 2) and/or clinical photographs, done/taken with the consent of an older person, should be used to document the location and shape of skin injuries.[8]

The following are different **diseases and conditions that 'mimic' signs of violence**:[9]

| Sign | Condition/disease | Sign | Condition/disease |
|---|---|---|---|
| **Blunt force trauma/ contusion** | Allergic reactions, bleeding disorders, fractures caused by osteoporosis, subdural hematoma as a result of a fall | **Burns and scalds** | Contact dermatitis |
| **Neglect** | Constipation caused by medication or hypercalcemia, dehydration caused by medication, diabetes mellitus, faecal impaction, poor wound healing, urinary tract infection (in women), vaginitis | **Sexual assault** | Uterine prolapse, decreased function of the anal sphincter, inflammatory bowel disease, vaginal bleeding and excoriation due to low oestrogen, vaginitis |
| **Chemical restraint** | Increased drug levels due to decreased renal clearance | **Starvation** | Anorexia caused by mental illness, inflammatory bowel disease, malabsorption caused by hypothyroidism, weight loss due to diabetes mellitus |

## General and behavioural signs of elder abuse

The following signs and changes in the emotional and physical state of an older person as well as patterns of behaviour exhibited by a caregiver might indicate elder abuse:

| General indicators[10] | Behavioural indicators[11] |
|---|---|
| • Injuries, past or present, for which an older person provides an unlikely, vague or inconsistent explanation;<br>• A history of frequent injuries; multiple visits to the emergency department with similar injuries<br>• Delays in seeking (medical) help once an injury has occurred<br>• Multiple bruises/injuries at the different stages of healing<br>• Frequent change of primary care physicians or visits to multiple physicians ("doctor hopping" or "doctor shopping")<br>• Not taking medication as prescribed, not following physician's instructions, missing doctor's appointments | • Unexplained/sudden change in behaviour, fixation, confusion, excitement, agitation, unusual passivity or anger, fear (of people or unknown places), suspiciousness, paranoia<br>• Refusal to use medical/social services or their more frequent use<br>• Change in behaviour in the presence of a caregiver, a strained relationship between an older person and a caregiver<br>• Reluctance to answer questions on the part of an older person or a caregiver<br>• Eagerness of a caregiver to answer questions instead of an older person; this, however, does not always indicate abuse and could be necessary if an older person lacks mental capacity<br>• Overprotective or controlling behaviour of a caregiver, or abandonment of an older person in the health care institution by a caregiver |

## Physical indicators of possible elder abuse

When assessing physical marks/injuries that can indicate elder abuse, the following should be taken into account:[12]

- Location
- Morphology: size, shape and structure
- Extent and severity
- Quantity and variety

**Marks and injuries that can indicate violence include**:

| **Bruises**[13] | **Pressure sores (decubiti/bed sores)**[14] |
|---|---|
| • Bruises are usually a sign of physical abuse, but can also be the result of neglect<br>• Bruises may be in the shape of knuckles or fingers<br>• Parallel marks, also known as tramline bruises, indicate injury caused by a stick<br>• A person might have multiple bruises at the various stages of healing<br>• Colour of the bruise usually cannot help determine the date when it was received because bruises may heal at different rates<br>• Healing can be slower in older persons and last for months instead of 1-2 weeks | • Large infected decubiti, multiple decubiti, especially deep ones that smell of necrotic tissue, can be signs of neglect<br>• Older people might be more prone to decubiti due to certain diseases, but not just because of age<br>• Decubiti most often occur in ill or cognitively impaired individuals<br>• Bedsores usually occur over the sacrum, hips or heels, and can be caused by an acute illness, circulatory disorders, poor nutrition, limited mobility (e.g. due to being tied up), poor care standards |
| **Burns**[15] | **Abrasions and lacerations**[16] |
| • Burns may also indicate abuse or neglect<br>• Sizes, locations, shapes and patterns of burns as well as how an older person got them should be taken into consideration when examining them<br>• Burns might be caused by using very hot water when bathing an older person | • Skin thickness and elasticity decrease with age, and these changes may be exacerbated by certain medications<br>• Abrasions can occur in older persons even due to minor trauma<br>• Multiple abrasions should raise suspicions<br>• Abrasions and/or lacerations often indicate physical abuse, but might also be the result of neglect |

| Fractures[17] | Other physical indicators[18] |
|---|---|
| • Bones of older people are thinner and less dense, which, together with bone diseases, make older persons more prone to fractures (e.g. as a result of falls which are the most common cause of injury in older persons)<br>• Poor nutrition, vitamin D deficiency, alcoholism, age-related deficiency in certain sex hormones, osteoporosis, long-term steroid use and cancer increase the likelihood of fractures<br>• The most common sites for bone fractures are the hip (in those aged 75 years and over) and wrist (in those younger than 75 years). The wrist is a common site for fractures caused by falls since many older people use their hands to stop them<br>• Facial fractures include tooth fractures or partial tooth displacement, broken jaws or bones surrounding the eyes | • Bite marks, scratches, redness, swelling, soft tissue trauma, ruptured eardrums, patchy hair loss (due to hair-pulling)<br>• Mild traumatic brain injury, e.g. bruising or swelling of the brain, as the result of the shaken adult syndrome might lead to headaches, (increased) confusion, (new) vision problems, loss of balance or unsteadiness when walking<br>• Poor health due to lack of necessary nutrients in one's diet (malnutrition) might be the result of neglect; however, this might also be caused by medication or age-related changes in the sense of smell and taste which might lead to appetite loss<br>• Dehydration can be a sign of neglect, but is often caused by illness (e.g. diabetes)<br>• A caregiver might use too much medication to sedate an older person; they might also withhold some medication to use it themselves; a caregiver might not know how to use medication correctly |

## Sexual abuse of older women[19]

Older women are vulnerable to sexual abuse, including by their caregivers and adult children. The **reasons for vulnerability might include cognitive impairment, physical inability to protect themselves, financial or emotional dependence on an abuser.** In addition, due to these reasons some older victims may be reluctant to report sexual abuse and seek help.

Certain age-related changes in the genital tract and hormone levels make it more difficult to determine whether sexual violence against an older woman is/has taken place. For example, progesterone and oestrogen levels decline with age, and decreased oestrogen levels can lead to the changes in the shape of the vagina, increased vaginal dryness and thinning of the vaginal walls. These changes in turn may cause pain and bleeding during normal sexual intercourse. What is more, when working with older women, **professionals should not mistake trauma related reactions for senility** and must **keep in mind that older women might need more time to process information and formulate their replies**, which is a normal age-related change. In addition, in some cases perpetrators themselves may bring victims to a health care institution for examination. Some perpetrators may seem charming and nice to the staff, while others may threaten health care workers, which might also complicate the process of examination.

The following signs might indicate that an older woman is/has been sexually abused:

**Physical signs**[20]

- Torn and stained underwear
- Genital, rectal or oral trauma (e.g. erythema, bruising, lacerations); pain, itching, bruising and/or burning in the genital area; bruises on the breasts/abdomen
- Difficulty walking, standing and/or sitting
- Changes in bowel movements and/or bladder activity
- Sexually transmitted diseases, urinary tract infections

**Behavioural signs**

- Withdrawal, fear, depression, anger, aggression, insomnia, which might be especially severe in older women who feel isolated and have little support
- Increased interest in sexual matters and/or excessive sexual behaviour

## Examination procedure

If violence is suspected, **it is necessary to obtain the older person's consent to conduct forensic procedures and collect evidence**, which is especially important if a victim is unable to testify. However, if a victim lacks mental capacity and is unable to give consent, **they should not be forcibly examined or subjected to forensic procedures**, which are not required to ensure their health and safety. At the same time, it should be remembered that older persons may process information more slowly than younger adults and it might take them longer to put their thoughts into words. This is a normal age-related change and it should not be immediately viewed as evidence of a lack of mental capacity.[21]

During the examination, diseases and conditions which 'mimic' signs of violence and/or predispose older people to injury should be noted down. With the consent of a patient, body maps should be created and clinical photographs taken to document the location and shape of injuries such as bruises, skin tears, burns etc. If a recent sexual assault is suspected, or has been reported by a patient, a forensic medical examination should be performed by a professional who has the appropriate training and expertise. Throughout the examination, health care professionals should keep in mind the following question: "**Is the explanation provided by a patient consistent with the examination findings?**"[22]

Overall, during an examination the actions to be taken and factors to be assessed include:[23]

- **Context**
  - Circumstances in which an injury occurred
  - Lack of concern for an older person on the part of their caregiver
- **History**
  - Past abuse, other cases of abuse in the family
  - Misuse of medicines
- **Physical examination and laboratory test results**
  - Functional assessment of balance and gait
  - Assessment of nutritional status (malnutrition, dehydration)
  - Assessment of injuries (sores, bruises, burns etc), pain
  - Appearance (tidy or unkempt), hygiene (adequate or poor)
- **Mental health examination and cognitive/behavioural changes**
  - Withdrawal, fear, confusion
  - Signs of depression

## ECLM guidelines for the examination of suspected elder abuse

The European Council of Legal Medicine (ECLM) published guidelines for health care professionals and forensic practitioners on assessing and documenting suspected elder abuse (figure 8). At the core of the document is Article 25 of the Charter of Fundamental Rights of the European Union, according to which the EU recognizes and respects the rights of older people to lead a life of dignity and independence and to participate in social and cultural life. The ECLM guidelines also emphasize the importance of prevention and identification of elder abuse, especially since the older population is growing.[24]

The following are the **basic rules of carrying out an examination** if elder abuse is suspected:[25]

- Obtain the older person's informed consent prior to an examination
- If an older person does not have the capacity to give consent, appropriate steps must be taken to ensure a lawful examination
- Review circumstances of the event/situation under investigation; make inquiries about (possible) past abuse; obtain relevant socio-familial information
- Undertake a comprehensive review of the older person's medical history (undergone surgeries, gynaecological or psychiatric problems, medication history etc)
- Screen for all possible types of abuse
- Perform a full physical examination of an older person
- Collect and preserve all evidence that might indicate abuse
- If need be, request a further examination by relevant professionals; to complete an investigation, more than one examination might be needed
- If it appears (highly) likely that abuse is/has taken place, take measures to protect an older person from further abuse

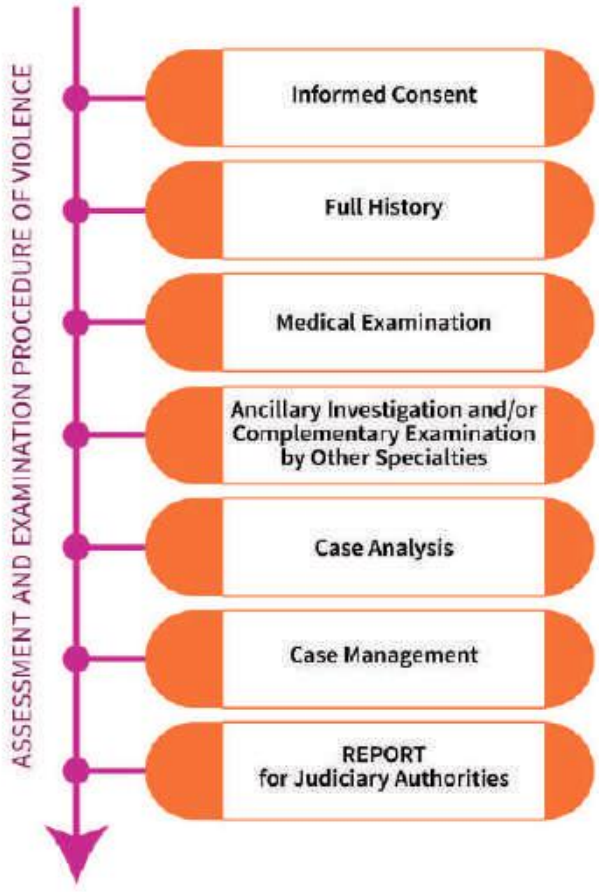


Figure 8. Suspected elder abuse examination procedure

The **ECLM examination procedure** consists of the following steps/items:

**1. Full case history:**

- History of suspected abuse: the type of a relationship between an older person and perpetrator(s), type(s) of abuse, duration of abuse, injuries and other physical and psychological consequences of abuse, received medical assistance related to abuse
- History of past abuse of an older person by the same or other perpetrator(s)
- Medical history, including relevant diseases and medications (e.g. anticoagulants)
- Physical disabilities and psychological disorders which may complicate communication, lead to the older person's dependence on third parties and create the conditions for abuse
- Functional history of an older person, including day-to-day activities such as dressing, eating, bathing, toileting, shopping and cooking; assessment of the need for the partial or 24-hour assistance and how it is provided to an older person
- History of the physical or chemical restraints use; if restraints have been used: who prescribed them, for what purpose, the duration of use

2. **A psychiatric examination, cognitive assessment, mini-mental state examination** (as required)

3. **A full general medical examination** (according to the ECLM guidelines)

- General appearance, clothing, vital signs, nutrition and hydration
- Pain intensity measured with the help of a pain scale (numeric rating scales, verbal descriptor scales, faces pain scales or visual analogue scales may be used with an older person depending on their ability to read, hear and understand the instructions)[26]
- Injuries (should be described and photographed), patterns suggestive of abuse - all evidence that might indicate abuse should be collected

4. **A gynaecological/urological examination** (according to the ECLM guidelines)

5. **Laboratory testing: general blood tests, toxicology blood test**

6. **Further examination/investigation** if required

7. **If needed, select the appropriate course of action**, as established by the law, protocols or other relevant guidelines, in consultation with local victim support services, in order to protect an older person from further violence and ensure that their rights are not violated

# Older persons in the emergency department

## Recognizing violence against older people in emergency departments

Population ageing will place an ever-increasing burden on health care services in the next two decades, including in terms of recognizing violence against older people, and evidence suggests that emergency departments in particular are well positioned to identify (possible) victims of elder abuse.[27]

Older victims of violence receive primary health care less often than other older persons; however, they use emergency care services more frequently, and visits to emergency departments might be the only occasions on which older people leave their homes and can be screened for abuse.[28] Since such visits, which might actually be the result of committed violence, are un-

planned, perpetrators and victims have little or no time to hide evidence of violence, which makes emergency settings especially suitable for identifying elder abuse.

According to the survey conducted in an emergency department in Central Lisbon, 96.7% of participants (87 older adults out of 90[a]) reported having experienced some form(s) of abuse. Psychological/emotional abuse was experienced by 73.3% of participants (66), neglect by 53.3% (48), financial/material abuse by 48.9% (44) and physical abuse by 22.2% (20). Gender was not found to be associated with self-reported abuse, while education and age were strongly associated with it. Also, a strong connection was found between symptoms of depression and self-reported abuse, which means that it is especially important that emergency care practitioners screen for abuse older people who exhibit symptoms of depression.[29]

Despite the emergency rooms' potential for abuse identification, research indicates that **emergency department staff rarely recognize or report elder abuse**. This might be due to:

a) **lack of training** in recognizing signs of violence, and therefore difficulties distinguishing between intentional and unintentional injuries;

b) **uncertainty about the procedure** that should be followed if violence is identified;

c) **doubts about the effectiveness of interventions**;

d) **lack of time and/or space** for carrying out comprehensive examinations;

e) **reluctance to become involved** in legal investigations.

What is more, while several violence screening tools have been developed for the use in emergency departments, none of them have been validated in emergency settings. In addition, recognizing signs of violence in cognitively impaired patients is particularly challenging due to a lack of tools for rapid assessment of cognitive function validated in emergency rooms, which slows down the process of elder abuse identification.[30] Delays in recognizing violence and taking action to end it in turn contribute to further suffering of victims and might result in death.

## Myths about the older people's use of emergency services

Certain myths about the older people's use of emergency services impact the attitudes and behaviour of the emergency department staff towards older people, which might make it more difficult for the latter to discuss sensitive issues, such as violence and abuse. Also, due to negative attitudes towards older persons, the emergency department staff may be less likely to recognize physical and behavioural signs of elder abuse.

For example, visits of older people to emergency rooms are often labelled as unnecessary. In particular, there is a common perception among health care professionals that older people often use emergency services for psychosocial reasons such as feeling lonely and unsafe. However, there is no scientific evidence in support of such views. Although older people indeed form the biggest group of health care service users,[b] only a small number of older patients use emergency medical services excessively, most of them seek emergency care only when they are seriously ill.

According to a number of studies, 'not coping at home' is the reason for coming to the emergency room for around 10% of older patients. At the same time, more than a half of them also have an illness that requires immediate attention, and the majority have serious issues such as cognitive impairment, dehydration, nutritional deficiencies, and are at risk of injuries due to falling and/or risk of depression. Older people who are 'not coping at home' are among the

a 31 men and 59 women participated in the survey.

b For example, in 2014 37% of people aged 75 years and over had used health care services, and the need for using both health and social care services gradually increases with age, including due to memory disorders (Teija Hammar, Minna-Liisa Luoma. Palvelurakenteen muutos sekä palveluiden saatavuus, riittävyys ja yhdenvertaisuus. In Finnish.).

most vulnerable patients as one third of them will die within a year of visiting the emergency department.[31]

Older people (aged 74–94 years), who lived in 21 community dwellings and visited the urban emergency department in Tampere, Finland, were interviewed to find out their opinions on the services provided there. Interviewees believed that the medical aspect of services provided was of high quality, but also stated that they had spent a lot of time waiting for an examination and/or treatment. Among the negative aspects were lack of information on the procedures, being left alone, uncomfortable conditions, inadequate symptom relief, insufficient consideration for feelings of thirst and hunger, lack of staff. In terms of interaction with the staff, older people's experiences were both positive and negative: compassion, kindness and taking patients' concerns seriously were cited as positive, while lack of interest and rudeness on the part of the staff were among the negative examples. In addition, in older people's opinion, the most vulnerable patients' special needs were not adequately met.[32]

# Violence screening tools

## Screening older people for signs of violence

Screening can be defined as "the process of identifying healthy people who may have an increased chance of a disease or condition… It can be helpful to think of screening like a sieve… The sieve represents the screening test…"[33] For example, cancer screening aims to select individuals at risk of cancer, and screening has become an important tool for violence identification.

Overall, when assessing a screening programme, the following criteria are usually used:[34]

- The condition people are screened for should be a well-understood health problem, with known risk factors and/or indicators
- The screening test should be simple, safe and acceptable to the population
- There must be evidence from reliable randomized controlled trials that the screening programme reduces mortality and/or morbidity and is cost effective
- There should be evidence that the screening programme is clinically, socially and ethically acceptable to health care professionals and the public
- Sufficient and well trained staff should be available to conduct screenings
- Effective interventions should be available to follow the test

The US National Screening Committee developed a set of criteria that focuses on four questions:[35]

- Do we understand the natural history of disease?
- Is there a good screening test for it?
- Is there an effective treatment?
- Is the programme acceptable to the population?

Screening for elder abuse is a process of obtaining information about violent experiences in a family or other relationship from older (vulnerable) persons who do not exhibit obvious signs of abuse, such as physical injuries, in order to identify victims of violence. The rationale for screening is that **(early) identification may prevent future/further violence and reduce the risk of negative health consequences as a result of violence**. In the case of older people,

screening is particularly important since elder abuse might have grave health consequences and its identification rates are rather low.[36] The two types of screening are universal, i.e. everyone is screened, and selective, i.e. only those who meet specific criteria are screened.[37]

Screening should be done using standardized tools. What is more, screening should not only be carried out in case abuse is suspected since this might increase the risk of stigmatization of people who belong to minority groups or are of lower socioeconomic status. In addition, in public health, the term 'screening' emphasizes the need for follow-up; therefore, **screening should be just the first step in elder abuse prevention and identification and should be followed by an appropriate multidimensional response**.[38]

Several risk assessment tools that can be used to screen individuals for violence have been developed based on studies and/or clinical experience.[c] Some of the tools are sets of questions which either can be asked by someone (usually a professional) or completed by an older person themselves (self-disclosure tools). Other risk assessment tools are based on recognizing signs of different types of violence. The main goal of all of these tools is to raise suspicion that an older person might be abused; they only suggest that violence might be taking place, and if suspicion is raised an in-depth interview with a possible victim should be conducted.[39]

In order to use screening instruments correctly, health care professionals should receive specialized training in applying them as well as training in elder abuse (risk assessment, safety planning, multi-agency cooperation, specific needs of older women etc). They should also understand how to behave with older people (e.g. they should be respectful and sensitive). What is more, it is crucial that health care professionals know the existing protocols/procedures for reporting and addressing violence (those that exist in their workplace as well as local/regional ones) and understand the roles played by different professionals in preventing and ending elder abuse. Therefore, a **system for support and consultations between professionals should be established**.

While there are still some gaps in our knowledge about signs of elder abuse and effective interventions to stop it and the existing screenings tools could be further improved to increase their accuracy, this should not prevent health care professionals from playing an active role in identifying and ending violence. Since violence can have a huge negative impact on an older person's life, helping them change their situation is one of the most gratifying experiences for physicians and other health care professionals.[40] In the following sections, different tools for elder abuse identification, which have been published and validated and can and should be used by health care professionals, are presented.

## The Elder Abuse Suspicion Index© (EASI)

One of the tools for screening older people for abuse is the Elder Abuse Suspicion Index© (EASI).[41] The EASI's aim is to raise doctor's suspicions about elder abuse to a level at which they deem it reasonable to discuss possible abuse in more detail or refer an older person to social services for further assessment. The EASI is based on the idea that a simple tool can help older patients talk about their experiences and thus raise suspicions about abuse (but it cannot give a definitive answer).[42]

The EASI (see Table 1) consists of six questions: a doctor asks an older person to answer five questions, and the last question is answered by the doctor based on their observation of a patient. One or more "yes" responses to questions 2-6 should cause concern.[43] If elder abuse is suspected, the next step should be to assess the older person's mental capacity.[44] While the tool was originally designed for the use by physicians, it has also been used by other professionals,

c Most of the tools have been developed in Northern America.

for example by social workers in Spain. Currently, the EASI is not used in emergency departments; however, there have been attempts to study the nurses' use of EASI in emergency rooms and nursing homes.[45]

The EASI was developed based on a comprehensive review of the literature dealing with risk factors for elder abuse and existing elder abuse screening tools, and used the WHO definition of elder abuse[d] as well as the WHO/INPEA definition of neglect.[e] Initially, nine questions were selected for further testing.[46]

The selected nine questions were then discussed in focus groups, which consisted of professionals working in the fields related to elder abuse (social workers, nurses and physicians), from clinical, research and community perspectives. After the discussion, professionals (n=31) were asked to independently and anonymously rank the importance of each of the nine questions. Despite having different conceptual approaches to elder abuse, the three groups identified five questions as fundamental to screening for elder abuse. The sixth question was added to take into account physicians' observations, for instance about the older person's appearance and behaviour.

At the final stage, 663 community-living English and French speaking cognitively intact older persons aged 65 years and over were screened with the EASI. Social workers, who were unaware of the EASI results, conducted in turn the Social Worker Evaluation (SWE) with the participating individuals. The SWE is a standardised assessment form for the in-depth evaluation of the situation of older people who are at risk of being abused; it includes 67 questions and takes on average 66 minutes to complete.[47] The EASI and SWE results were then compared, and the EASI was found to have sensitivity of 47% and specificity of 75%, which is comparable to longer tools. Family physicians also reported that the EASI was simple to use, could be carried out quickly, and was a convenient means of learning about possible elder abuse. The EASI is appropriate for the use by family physicians in ambulatory care settings to screen cognitively intact competent older people with Mini-Mental Status Exam scores of 24 or higher, who understand the questions.[48] It is available online in several languages.[49]

Table 1. The Elder Abuse Suspicion Index ©

| ELDER ABUSE SUSPICION INDEX © (EASI) | | | |
|---|---|---|---|
| **EASI Questions**<br><br>**Q.1-Q.5 asked from patient; Q.6 answered by doctor**<br><br>**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 aids 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 |

d WHO 2002. World report on violence and health.

e WHO/INPEA 2002. Missing voices: views of older persons on elder abuse.

| | | | |
|---|---|---|---|
| 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 during the last 12 months? | YES | NO | Not sure |

The EASI[41] was developed to raise a doctor's suspicion about elder abuse to a level at which it might be reasonable to propose a referral for further evaluation by social services, adult protective services, or equivalents. While all six questions should be asked, a response of "yes" on one or more of questions 2-6 may establish concern. The EASI was validated for asking by family practitioners of cognitively intact seniors seen in ambulatory settings.


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In 2008, the WHO used the EASI as the basis for developing an elder abuse screening tool which would be culturally acceptable outside Canada. Focus groups from eight countries (Australia, Brazil, Chile, Costa Rica, Kenya, Singapore, Spain and Switzerland) participated in the tool testing. The findings of this study indicated that the EASI was simple to use, covered the main types of elder abuse and, despite minor differences in interpretations, was culturally transferable. Although the EASI was developed for the physicians' use, the WHO suggested that in some situations nurses could use the tool.[50]

**The EASI covers the following types of violence (as well as some risk factors and signs of abuse)**:[51]

1: Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals? (Dependence on other people, a risk factor for abuse)

- This is not a screening question (thus, a positive answer does not suggest abuse); it only identifies possible dependence of an older person on others, which is a risk factor.

2: 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? (Neglect)

- Neglect refers to situations in which the basic needs of an older person are not being met by someone who is responsible for providing care and/or assistance to them.

3: Have you been upset because someone talked to you in a way that made you feel shamed or threatened? (Psychological/Emotional abuse)

- Psychological/emotional abuse is speech and/or behaviour that is aimed at inflicting mental pain, anguish or distress on an older person.

| |
|---|
| 4: Has anyone tried to force you to sign papers or to use your money against your will? (Financial abuse)<br>• Financial abuse is illegal or improper use of older person's money, property or other assets, theft or fraud, pressure related to wills and inheritance. |
| 5: Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? (Physical/sexual abuse)<br>• Physical violence most often causes bruises, cuts and contusions.<br>• The majority of older victims of sexual violence are women, but the issue has been largely ignored. |
| 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 during the last 12 months? (Physical and behavioural signs of abuse)<br>• A doctor, or another health care professional, assesses the situation of an older person based on what they see and how an older person behaves during an appointment(s). |

**The following points should be considered when asking the EASI questions:**[52]

- Questions 1-5 should be asked in order since each new question is, theoretically, more serious/'threatening' than the previous one
- One or more "yes" answers to questions 2-6 should raise suspicions
- No answer ("Did not answer") or "Do not know" answer do not affect the tool, and an older person's failure to respond may raise additional concerns
- Older people should be questioned in private (family members or other accompanying persons should not be present), in a quiet environment
- An introduction to the questioning could be the following: "Our primary concern is the well-being and safety of older people; therefore, I would like to ask you a few questions about the events that may occur in older people's lives"
- Professionals should stay friendly and supportive throughout the conversation to help older people relax and talk about their situation
- Older people should be given enough time to reply since it might take them longer than younger people to process the questions
- Keep in mind that if an older person has experienced abuse, it may be difficult for them to answer the questions due to trauma caused by violence (e.g. depression, apathy, loss of self-esteem)
- If an older person answers the questions, thank them ("Thank you for answering my questions. I know it can be difficult to answer such questions")
- If an older person refuses to answer, tell them that they can talk about their concerns later, with you or another trustworthy person
- It is important to be careful when interacting with the alleged abuser so that they do not limit/block access to the vulnerable older person; if possible, this should be done by professionals with the appropriate expertise

- If the carer is the alleged abuser and a health care professional needs to interview them, an empathetic approach should be taken (e.g. "caring for your mother must be very difficult, how do you cope?") and professionals should try to remain non-judgmental, even if the history of abuse has been confirmed

**If the EASI results indicate abuse, the following actions should be taken**:

- If it turns out that an older person is abused, assess the urgency of the situation and discuss with them what can be done
- If there is no sense of urgency, see an older person again and ask their permission to repeat the EASI
- Assess the older person's mental capacity; if they are not competent, you may contact their next of kin (keep in mind, however, that they might be an abuser)
- If you have the competence and time, you may conduct a more detailed interview during the same or another visit

## The Self-Administrable Elder Abuse Suspicion Index© (EASI-sa)

The original EASI was adapted for self-completion by older people on paper (bold font, font size 14). The first five questions, which are focused on older people's experiences, were kept, while the sixth question, which should be answered by a physician, was removed from the from. The EASI-sa also offers only two response options: 'yes' and 'no' (see Table 2).[53]

A number of older people were approached by a research assistant to discuss their participation in the EASI-sa testing in the hospital waiting rooms. Those interested in participation received further information on the study. Following participants' oral consent, the MMSE (Mini-Mental State Examination) was administered to assess their cognitive functions. Participants filled in the EASI-sa form and evaluation questionnaire anonymously. After that, the MOS Health Survey Short Form (SF-12) was administered to assess participants' mental and physical health, and demographic data was collected. Those who participated also received brochures on elder abuse.[54]

In total, the EASI-sa was completed by 210 cognitively competent older people. The readability and acceptability of the tool were positively evaluated, and the non-completion rate was low. Older people spent from two to five minutes on completing the EASI-sa, and the tool was seen as an elder abuse awareness raising method by 27.2% of the participants, who improved their understanding of elder abuse manifestations. 8.6% of participants (18/210) answered "yes" to the first question (dependence on others), and 2.9% (6/210) responded positively to (some of) the remaining EASI-sa questions, which might indicate abuse: 1.9% (4/210) answered "yes" to the question on emotional/psychological abuse and 0.95% (2/210) to the question on physical/sexual abuse. It is important to note that the study had no statistical power to estimate the prevalence rates of elder abuse due to its sample size; the aim of the study was to assess the feasibility of the self-administrated use of the EASI form.[55]

Table 2. The Self-Administrable Elder Abuse Suspicion Index © (EASI-sa)[56]

| ELDER ABUSE SUSPICION INDEX © (EASI-sa) | | |
|---|---|---|
| EASI-sa QUESTIONS: OVER THE LAST 12 MONTHS | CIRCLE ONE ANSWER FOR EACH QUESTION | |
| HAVE YOU RELIED ON PEOPLE FOR ANY OF THE FOLLOWING: BATHING, DRESSING, SHOPPING, BANKING, OR MEALS? | YES | NO |
| 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 |
| HAVE YOU BEEN UPSET BECAUSE SOMEONE TALKED TO YOU IN A WAY THAT MADE YOU FEEL SHAMED OR THREATENED? | YES | NO |
| HAS ANYONE TRIED TO FORCE YOU TO SIGN PAPERS OR TO USE YOUR MONEY AGAINST YOUR WILL? | YES | NO |
| HAS ANYONE MADE YOU AFRAID, TOUCHED YOU IN WAYS THAT YOU DID NOT WANT, OR HURT YOU PHYSICALLY? | YES | NO |

The EASI has been adapted for self-completion in paper form by older people[f] called EASI-sa. The research was funded by the New Horizons for Seniors Program of Human Resources and Social Development Canada, project #6496426. Republished with permission from Mark J. Yaffe MD McGill University, Montreal, Canada: mark.yaffe@mcgill.ca

## Piloting the EASI in the emergency room

The Malmi Hospital in Helsinki actively participated in the WHOSEFVA Project; in particular, its employees took part in the Mutual Learning Workshops (for more information on Mutual Learning Workshops, please see Chapter 8 on page 117). The Malmi Hospital has been a pioneer in the implementation of a number of best practice protocols, for example PAKE (a best practice protocol for battered patients' medical examination). Therefore, this hospital was chosen to pilot the EASI tool in its emergency department and short-term care units. The EASI was selected because it is validated, user-friendly and short tool meaning it can be administered when there is lack of time, which is the case in emergency departments.

The EASI was piloted twice, in January 2018 and in June 2018, each time during one week. Before the start of the pilot implementation, the staff of the emergency and short-term care units were trained to use the EASI and received written instructions for implementing it and using the data gathering forms. The staff was also introduced to the feedback questionnaire and received training on ethical issues such as privacy, respect etc. In addition, all information on victim support services was put in writing in case referrals were needed.

The EASI was used to screen for abuse in seemingly competent patients over 75 years of age, who arrived at the emergency department. The EASI questions were asked either before the patient's discharge from the emergency room or during their stay in the short-term care unit. The EASI was administered by registered and licensed practical nurses. No identification codes were written on the data gathering forms (see Table 3).

f Mark J. Yaffe, Deborah Weiss, Maxine Lithwick 2012. Seniors' self-administration of the Elder Abuse Suspicion Index (EASI): a feasibility study. Journal of Elder Abuse & Neglect 24(4):277-292, 2012.

Table 3. **The EASI data gathering form**

| | |
|---|---|
| Place the form was filled in | □ Emergency room<br>□ Unit, what? _____ |
| Gender | □ Male □ Female |
| Birth year | |
| Postcode of the patient's address | |
| The reason for arriving in/being admitted to the emergency room | |
| The relation of an escort to the patient | □ Relative, who?<br>□ Someone else, who? |
| Accommodation | □ Lives alone □ Lives with a spouse<br>□ Lives with someone else, with whom?_____ |
| Provision of care to the patient | □ Home care □ Sheltered housing, what?_____<br>□ Something else, what? _____<br>□ No care |
| The use of alcohol | □ Yes □ No □ Doesn't answer |
| Recognized injuries | □ Physical injuries, what? _____<br>_____<br>□ Psychological signs, what? _____<br>_____<br>□ Behavioural signs (for example agitation), what?<br>_____ |
| Follow-up care | |
| Patient refused to answer | Reason(s) |
| Patient refused follow-up interview | Reason(s) |
| It was not possible to ask questions | Reason(s) *(for example being too tired)* |

In total, during both periods of the EASI pilot implementation, 38 patients were screened for abuse using this tool. Suspicions were raised in five cases. Two of the alleged victims were older women; however, they did not want to talk about their experiences and did not want any help.

The feedback from the ten professionals, who participated in the EASI pilot implementation, revealed that routine screening for elder abuse is new to doctors and nurses, who work in the busy hospital setting such as emergency room. Therefore, these **professionals would need more training, support and guidance on using elder abuse screening tools, and establishing their use as a daily routine might be a long process**.

## The Risk on Elder Abuse and Mistreatment Instrument© (REAMI)

While the EASI was designed to be used in the ambulatory care settings, there is also a need for instruments that could be used by professionals to identify elder abuse in the home environment. Such a tool, called the Risk on Elder Abuse and Mistreatment Instrument© (REAMI), was developed in Belgium. It is a validated screening instrument, which can be used by professionals, who know an older person, their family and social environment.[57] See Figure 9 on pages 100 and 101 for the REAMI form.

**The REAMI takes into account both signs of elder abuse (e.g. suspicious bruises) and risk factors for abuse (e.g. the relationship between an older person and a possible perpetrator) as well as the physical and social environments of older people**. The REAMI is a short, but thorough tool, which makes it possible to accurately assess the situation under time constraints. The tool can be used by informal and formal carers, health care and social service workers.[58]

The unique feature of the REAMI is that **it takes into account different types of (possible) perpetrators**, who are referred to as 'key figures'. **A key figure is close to an older people and usually has some sort of bond with them.** This could be an older person's partner, one of the children, a neighbour or a professional caregiver.

The REAMI questionnaire is filled in by professionals, who are asked to what extent they feel the proposed 22 statements apply to their client. The response options range from completely disagree (1) to completely agree (4). The 22 statements were developed based on the literature, results of previous studies and three rounds of consultation with academics, health care professionals and professionals, who deal with elder abuse on a daily basis.[59]

In 2012, the REAMI was tested and validated by home carers in cooperation with Familiehulp vzw (the largest home care organization in Flanders). All home carers from the Care Region 3 (Antwerp and Brussels) were instructed to screen their clients aged 55 years and older for abuse using a standardised survey instrument. In total, 1,922 clients were screened: 2.9% were aged 55-64 years, 13.5% 65-74 years, 45.5% 75-84 years and 38.1% were 85 years or older. 69.6% of the clients were women. According to the findings, the REAMI and its three dimensions (risk factors for abuse – older person; risk factors for abuse – environment; signs of abuse and mistreatment) have good internal reliability and internal validity.[60]

In 2013-2014, 24 professionals who used the REAMI in their work were randomly selected to be interviewed to assess their satisfaction with the REAMI and its user friendliness. Most participants described using the REAMI as a positive experience. In particular, filling in the questionnaire did not take much time (from 2-3 minutes to 10-15 minutes), and was particularly quick when the professional knew the living conditions of their client (however, using the REAMI with a new client proved to be impossible). In addition, several professionals stated that their knowledge about elder abuse had improved and they had become more alert to signs of elder abuse (for some professionals, using the REAMI was their first encounter with the topic of elder abuse).

Despite many positives of the REAMI, respondents also mentioned several issues. Some participants reported having difficulty scoring statements such as history of violence in the family, financial problems of the older person and signs of emotional and sexual abuse. What is more, professionals did not know what to do after having administered the REAMI and it indicated possible abuse. Some organizations had developed instructions on what their employees should do in case abuse was suspected, but most respondents had no guidelines on further actions, which highlighted the need for adopting comprehensive strategies on detecting and reporting violence in organizations. In addition, even when respondents were willing to report violence, they encountered certain barriers, e.g. lack of evidence and disbelief among other professionals since they were reporting the risk of violence, not violence per se.[61]

## Medical examination of assault victims in emergency departments

In Finland, the procedure for the examination of assault victims called PAKE[g] has been in use since 2002. This procedure involves using a form, which was introduced in the Helsinki Malmi Hospital's emergency department in September 2002 (see Appendix 1) and adopted by the Network of Malmi in 2006. The form consists of two sections: the first one covers the documentation of injuries; the second one provides a framework for an interview to record all important details of the assault. **The aim of PAKE is to improve the legal protection of assault victims and develop closer cooperation between relevant organizations**, primarily the police and health care organizations.[62]

**PAKE includes: instructions for medical examination; body maps and guidelines on photographing and documenting injuries; best practice recommendations for multi-agency cooperation and the work of the police, paramedics and social workers.** The emergency department is responsible for a careful examination and injury documentation, regardless of whether they need treatment. The doctor, in some cases together with the nurse, marks injuries on a body map according to their types, locations and sizes. A digital camera is used to photograph injuries as well. The background information and details of the event are filled in by the nurse during a talk with the patient before the latter is seen by the doctor. The doctor can add further information if necessary. The filled in form and photographs are then added to the patient's record.[63]

Patients often do not wish to immediately report the offence to the police. However, from a legal point of view, it is important that all details of the assault are available for possible later use. Thus, the aim is to complete PAKE forms for all assault victims. Patients who report that their injuries were the result of an accident are interviewed to exclude violence. PAKE therefore supports healthcare professionals in detecting and dealing with cases of abuse; this in turn can help victims of violence to start to change their situation.[64]

During a one-year period after its introduction, the use of the form was monitored, and in August 2003 a survey was conducted among professionals involved, in which they were asked about their experiences with and opinions on the form. The survey revealed that the police found the form extremely useful and necessary in their work, e.g. for conducting investigations of assaults. Prosecutors also considered the form beneficial to their work since the assault victim's immediate description of violence was better evidence than descriptions provided months later. Nurses and doctors felt the form was useful as well, as it contributed to the **systematic data collection on assault cases**. In addition, closer cooperation between health care services and the police was achieved.[65]

g PAKE stands for assault, battery and body map in Finnish.

Figure 9. Risk on Elder Abuse and Mistreatment - Instrument (REAMI ©)


## Risk on Elder Abuse and Mistreatment - Instrument (REAMI ©)

**Personal characteristics:**

| | |
|---|---|
| Date | |
| Gender | ☐ male ☐ female |
| Age | |
| Cohabiting? | ☐ no, living alone ☐ with partner<br>☐ with children ☐ with others |

To which extent do you agree with the following statements about the older person and his environment? (Please tick boxes)

A = I completely disagree
B = I rather disagree
C = I rather agree
D = I completely agree

**PART 1**
**To which extent do you feel that:**

| | A | B | C | D |
|---|---|---|---|---|
| …the older person is dependent from one key figure[1]? (e.g. for care, finances, administration, housing, …) | | | | |
| …the older person is isolated? | | | | |
| …there are signals that the older person cannot handle the situation anymore? (e.g. signals of overburdening, fatigue, emotionality, irritation, short temper, indifference, feelings of powerlessness, frustration, anxiety…) | | | | |
| …the older person faces physical constraints, dementia, depressive symptoms, addiction, psychiatric or psychosocial problems? | | | | |
| … radical and stressful changes in the life of the older person have recently occurred? (e.g. move house, death of partner …) | | | | |
| … there is a history of violence in the family? | | | | |
| **Total (Count how many times A and B, C and D are answered)** | | | | |

**PART 2**
**To which extent do you feel that:**

| | A | B | C | D |
|---|---|---|---|---|
| … the relationship between the key figure and the older person is problematic? (e.g. stress, tensions, conflicts, …) | | | | |
| … the relationship between the key figure and his close environment is problematic? (e.g. stress, tensions, conflicts, …) | | | | |
| … the key figure is dependent from the older person? | | | | |
| … the care, provided by the key figure, for the older person is too much? | | | | |
| … the care knowledge of the key figure is insufficient? | | | | |
| … the key figure is isolated? | | | | |
| … there are signals that the key figure cannot handle the situation anymore? (e.g. signals of overburdening, fatigue, emotionality, irritation, short temper, indifference, feelings of powerlessness, frustration, anxiety…) | | | | |
| … the key figure faces physical constraints, dementia, depressive symptoms, addiction, psychiatric or psychosocial problems? | | | | |

[1] An older person has often a key figure in his/her community (particularly related to care). This person can, for instance, be a partner, an adult child (or his/her partner), a neighbour, or a professional. A key figure is someone close to the older person and they share an emotional bond.

| | | | | |
|---|---|---|---|---|
| … the key figure has financial problems? | | | | |
| … radical and stressful changes in the life of the key figure have recently occurred? | | | | |
| **Total (Count how many times A and B, C and D are answered)** | | | | |

**PART 3**
**To which extent do you feel that:**

| | A | B | C | D |
|---|---|---|---|---|
| …there are signals of violation of rights? (e.g. hindered to read their mail, to meet friends or acquaintances …) | | | | |
| … there are signals of emotional abuse and mistreatment? (e.g. feeling anxious, ashamed, threatened by accusations, being belittled…) | | | | |
| … there are signals of neglect ? (e.g. lack of getting dressed, groceries, meals, household …) | | | | |
| … there are signals of financial abuse and mistreatment? (e.g. forced to sign papers or to give money or goods, forced changes to a will, sudden unexplainable changes in the financial situation …) | | | | |
| … there are signals of physical abuse and mistreatment? (e.g. physically injured, assaulted …) | | | | |
| … there are signals of sexual abuse and mistreatment? (e.g. unwanted touching, obliged to undress himself …) | | | | |
| **Total (Count how many times A and B, C and D are answered)** | | | | |

**TOTAL SCORE OF THE REAMI**
Note down the totals from the grey boxes, from part 1, part 2 and part 3.
Multiply these totals with the corresponding number (1, 10 or 1000).
Sum these three numbers.

| | | | |
|---|---|---|---|
| Part 1: | | X 1 | = ..... |
| Part 2: | | X 10 | = ..... |
| Part 3: | | X 1000 | = ..... |
| | | **Total REAMI score** | = ..... |

| TOTAL REAMI score | Explanation |
|---|---|
| 0 | The situation is good. There is no risk at all. |
| 1 / 2 / 3<br>10 / 11 | The older person has a low risk of elder abuse and mistreatment. |
| 4 / 5 / 6<br>12 until 106 | The older person has a moderate risk of elder abuse and mistreatment. At this moment, there might be no visible signs of elder abuse and mistreatment, there is however a moderate risk. Further attention is required. |
| 1000 until 6106 | There are indications that the older person is being abused. There is a high risk of elder abuse and mistreatment. |



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## Challenges of working with victims of violence

As discussed previously, there are numerous abuse reporting barriers that older people face (e.g. fear, shame, depression etc). Following section presents the way of dealing with challenges of working with older victims of violence.

**If an older person does not want help**:

- Do not insist or pressure them into accepting help
- Explain why you think they may be experiencing violence
- Ask what they would like to do instead of telling them what they should do
- Document your concerns/suspicions and evidence that they are based on

**If an older person is intoxicated**:

- Try to not talk too much
- Give an older person time to recover before talking to them
- Follow the official procedure that is in place, e.g. an older person might be contacted by a social worker within the next few days (usually 1-3 days)

**If an older person is hostile/abusive**:

- Respect older person's feelings. Anger is often the result of trauma caused by violence and/or inability to get help (for instance, anger and frustration might be caused by inadequate responses of professionals)
- If an older person lacks the capacity to understand their behaviour due to illness, stress or trauma, remain calm and ensure the safety of all persons involved
- Offer support, including referrals to relevant specialists, but do not put pressure on an older person

**If an older person wants to leave as soon as possible**:

- Make sure their contact details as well as contacts of their caregiver(s) are noted down
- Offer an older person possible follow-up care services (with the consent of a competent person)
- Assess their safety

**If an older person is seriously ill or hallucinating**:

- Give them time to recover before interviewing them
- Refer an older person to the follow-up care services (with the consent of a competent person or mental health professional)
- Keep in mind that an older person might be confused as the result of experienced violence

**If an older person cannot understand you due to a language barrier**:

- Request services of an official interpreter (an interview can be conducted by phone)
- The interpreter must not be a spouse/partner, child, other relative or friend of an older person
- In case a (possible) victim is an older woman, services of a female interpreter must be used

**If an older person is accompanied by another person (spouse/partner/child)**:

- Remember that the accompanying person can be the abuser
- An older person has the right to be examined in private; explain this to the accompanying person and do not leave the decision to an older person
- You may need to arrange another face-to-face appointment
- If an accompanying person is required for cultural reasons, try to find a trustworthy person with the older person's consent

**If an older person mentions partner's jealousy**:

- Many victims actually talk about intimate partner violence when they describe partner's jealousy
- Keep in mind the difference between 'violent' jealousy and 'normal' jealousy as well as the difference between disagreement and violence
- Ask an older person if the behaviour of their spouse/partner has changed recently, and remember that sometimes dementia can be the cause of violent and/or jealous behaviour. If the answer is 'yes', refer an older person to the appropriate services

**If an older person talks about alcohol consumption in their family**:

- Keep in mind that alcohol-related behaviour can 'mask' violence in the family, and that alcohol abuse increases the risk of violence
- If alcohol abuse is caused by illness (e.g. dementia), refer an older person to the appropriate services

**If an older person talks about mental health problems and stress in their family**:

- An older person may use mental health problems and/or stress to understate or justify violence
- Explain to them the connection between mental health problems and stress and violence, and refer them to the appropriate services

Depending on the situation, **you may need to do the following**:

- Refer an older person or their caregiver to the appropriate support services (e.g. caregiver services, women's services, social services)
- Refer an older person or their caregiver to the relevant specialist for medical examination/treatment (e.g. geriatric, gynaecological, mental health, substance abuse)

- Arrange for an older person to stay in emergency accommodation
- Report the case to the police
- Make sure cultural differences are taken into account (e.g. religious beliefs)

## Ethical issues

When working with older people, **it is important to make sure that their rights are not violated and that decisions are taken to ensure their well-being**. Sometimes, however, professionals face with difficult choices, for example when an intervention may result in an older person losing their only family member. Therefore, all situations should be carefully assessed to maximize benefits for an older person.

- **Older people's privacy and dignity should be respected at all times**. The least restrictive interventions that ensure older person's autonomy are preferable
- **Older people should be involved in making decisions about their lives as much as possible**. If needed, they should receive help with making conscious and informed choices, especially when the subject in question is very complex (e.g. banking arrangements)
- Older person's **mental capacity can be temporarily affected by stress, anxiety, medication, illness or injury**, and therefore lack of capacity does not necessarily indicate dementia. However, if an older person seems to be unable to make a decision, a formal assessment might be required to assess their capacity
- **Older people's freedom of choice must be respected**, and mentally competent individuals have the right to refuse help. For example, if an older person is competent and chooses to stay with an abuser, this should be accepted. In such cases, professionals should assess the older person's safety and give them the necessary safety information
- **Professionals must know the legal requirements related to reporting violence**. If there is a (high) risk to older person's physical safety/life, they must consult the police and/or social workers, and take the appropriate actions, even if this goes against the older person's wishes
- In case a crime is suspected or has been committed, professionals must **act according to the laws** of their country
- **Older people's right to confidentiality must be respected**, but should not be a barrier to taking action
- **Cultural differences, religious beliefs, gender, older people's abilities and resources should be taken into account** when communicating with them[66]

## Safety planning

As discussed previously, leaving an abuser might not be an option for some older women due to a number of reasons (e.g. sense of responsibility if a woman is a carer). Therefore, if an older woman decides to stay with someone who physically abuses her, a safety plan must be created to help her restore control over her life.

**A good safety plan is victim-centred and is based on the older person's goals and needs** rather than the opinions of others. It is a form of solving problems before they arise, and **professionals should support the empowerment of an older person** by:

- Building rapport with an older person, including via active listening to help them feel safe
- Learning about the older person's fears related to the perpetrator
- Asking an older person about their wishes, reasons behind their decisions and their goals, which might allow a professional to offer other options for reaching the same goals
- Brainstorming solutions and ideas together

**When creating a safety plan for an older person**, ask the following questions:

- Has an older person had experience with safety planning and protection strategies before? If yes, which strategies have worked/been affective?
- How has the perpetrator behaved in the past? Is the perpetrator likely to re-offend?
- Does the perpetrator have access to weapons? Have weapons been used in the past?
- Is there a restraining order in effect? If so, how long will it remain in effect? Ask an older person to share this information with friends, neighbours and service providers.
- Can an older person recognize the signs of violence/a violent act?
- What is the living situation of an older person? Discuss possible ways of leaving their home/hiding if the situation escalates into violence:
  - the safest way to leave; the safest room to hide in (with door locks and a window to call for help);
  - agree in advance on a safe place for an older person to go and/or temporary living arrangements
- If an older person has a disability, are there any physical barriers to safely leaving their home and/or getting to a safe place?
- Does an older person have a peephole in the door as well as door locks and chains (if the perpetrator does not live with them)?
- Where does an older person keep important phone numbers and personal documents/items (medication prescriptions, bank cards, ID card, health insurance card, money, clothes)?
- Have pet care arrangements been made?
- Has an older person practised giving precise information on where they will go if there is danger? (This can be practised together)
- Is an older person willing to move to a safe place (e.g. shelter)?
- Has an older person been advised to write down/document all violent incidents? (date and what happened; text messages, emails and phone calls should be saved)
- What are older person's community and social support networks?
- Does an older person have information about different support services?
- What challenges may affect the older person's safety and/or their ability to implement a safety plan (e.g. alcohol/substance abuse, mental health issues, memory disorders etc)?
- Is an older person comfortable with the safety plan and willing to accept its (possible) restrictions, at least in the short term?[67]

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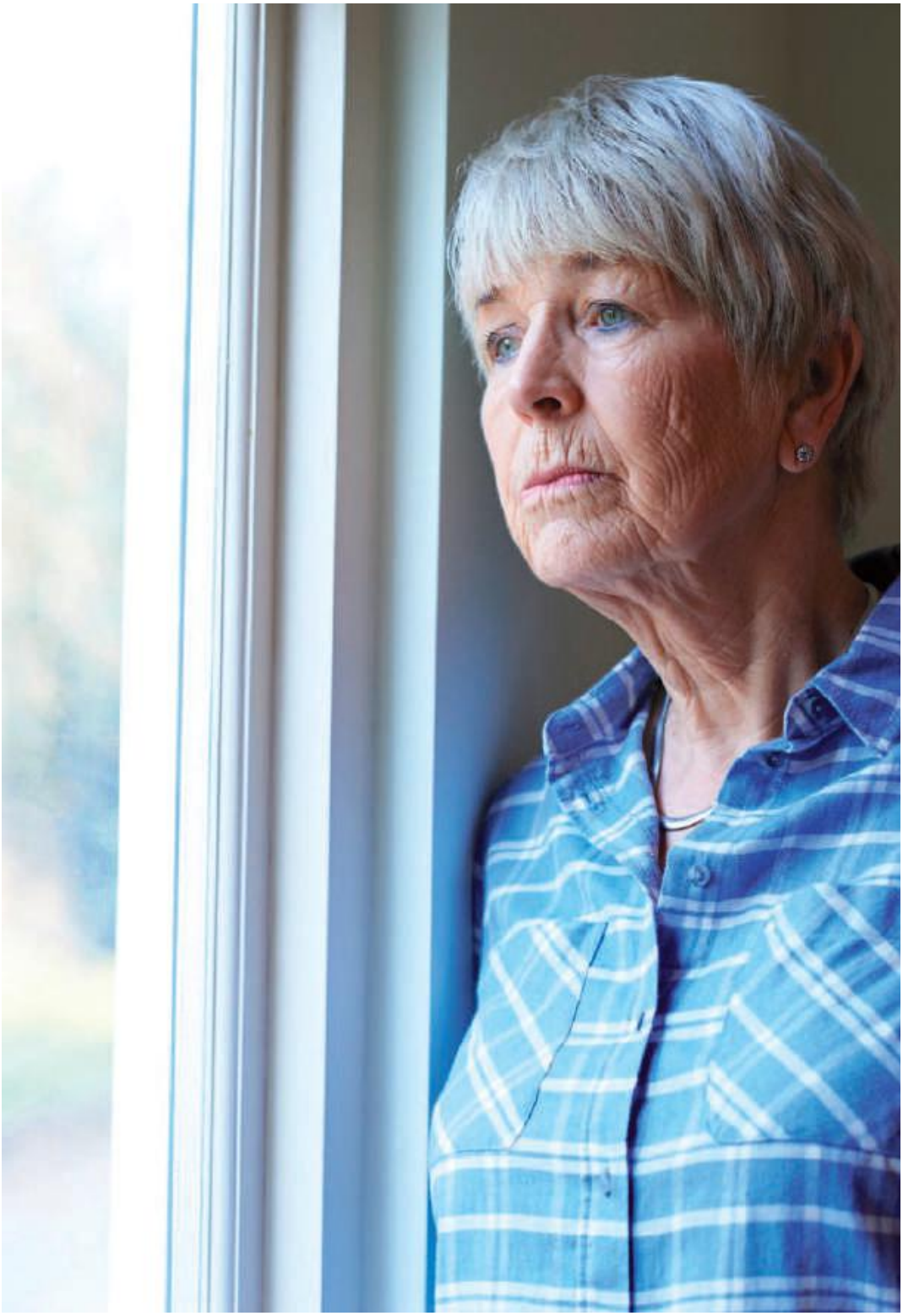

# CHAPTER 7: PROFESSIONAL CHALLENGES IN WORKING WITH OLDER VICTIMS OF VIOLENCE

## Topics Covered

Dealing with elder abuse as a professional

Professional challenges in working with older victims of abuse

- Vicarious traumatization
- Secondary traumatic stress
- Compassion fatigue
- Professional burnout

Risk and protective factors for vicarious traumatization, secondary traumatic stress, compassion fatigue and burnout

## Learning outcomes

Participants will:

- ✓ Be able to assess their attitudes and values and understand how they influence their work
- ✓ Become aware that they have a role to play in addressing violence against older persons
- ✓ Learn what measures should be taken to prevent and/or minimize the effects of emotional and psychological burden of working with older victims of violence
- ✓ Understand how to maintain their wellbeing

## Notes for the trainer

- ➢ It is important to demonstrate understanding and sympathy for professionals who might feel confused when dealing with older victims of violence
- ➢ It might be beneficial to address the professionals' feeling of insecurity which they might experience when working on elder abuse cases

## Dealing with elder abuse as a professional

Health care centres, emergency departments, social and home care services are at the forefront of efforts to identify, prevent and end violence against older persons. Violence is a complex issue, which requires sensitive and skillful handling by social workers and health care professionals. These professionals in turn require the support of their organizations; for example, clear protocols for reporting violence and assisting its victims should be in place, and cooperation between different support services should be enabled. In addition, professionals should understand that **working with victims of violence differs from working with other groups**. In particular, they should take a clear stance against violence, since neutral approaches do not work in such cases, and make sure that victims feel that they are believed.

The work of professionals might be influenced by their own experiences of violence, experiences with support services as well as their attitudes and values, and working with older victims of violence can create ambivalent feelings. **Professionals might experience the following**:

- A feeling that they do not have adequate skills for handling the situation
- Feelings of helplessness or withdrawal from the case due to the realization that there are no easy or quick solutions
- Fear (of the perpetrator), anger, frustration, empathy, confusion, overprotectiveness, which can be present at the same time
- A feeling of knowing 'what is best' to solve the problem
- Frustration at the lack of and/or poor quality of support services, or at the lack of support from other professionals

Thus, **self-awareness is essential when working with victims of abuse**, and a safe and supportive working environment can help professionals cope with the challenges of their work.

## Professional challenges in working with older victims of violence

Emotional and psychological risks associated with direct work with vulnerable people have been largely overlooked in educational curricula and professional training. It is however crucial that practitioners understand the risks and associated symptoms in order to prevent and/or minimize the effects on their well-being and work. There are two primary forms that such risks can take:[1]

| |
|---|
| ***Trauma-related stress conditions***: negative psychological reactions that professionals may experience when working with victims of violence include vicarious traumatization, secondary traumatic stress and compassion fatigue |
| ***Professional burnout***: a more general phenomenon which may occur in any professional |

### Vicarious traumatization[2]

Vicarious traumatization refers to the **transformation of the worker's inner experience as a result of empathetic engagement with trauma survivors' experiences**. It can be characterized by profound cognitive changes in the worker's sense of identity, world view and beliefs about self and others.

Although vicarious traumatization can interfere with professionals' emotions and cognitive schemas, memories and sense of safety, these are not considered pathological and are viewed as normal reactions to traumatic events. For example, professionals who listen to clients' stories of fear, pain and suffering may feel them as well because they care about their clients. However, **vicarious traumatization can intensify the professionals' sense of vulnerability and feeling of unsafety**. For example, therapists who work with rape victims may develop a feeling of disgust for rapists which extends to all men; this can in turn lead to emotional abandonment of victims, cynical and dismissive attitudes, loss of motivation and apathy. The symptoms of vicarious traumatization, often unnoticed, might include:

| |
|---|
| **Psychological symptoms:** anxiety, avoidance of social contact, judgmental attitudes, anger, depression, sleep disorders, nightmares, powerlessness, exhaustion, disruption of beliefs about self and others |
| **Physical symptoms:** nausea, headaches, changes in body temperature, dizziness, fainting spells, hearing impairment |

## Secondary traumatic stress[3]

Secondary traumatic stress refers to responses of people to working with trauma survivors. It is a result of an empathic relationship with an individual who has experienced trauma when a professional 'becomes a witness' to their horrific suffering. In such cases, a professional wants to help their client, but eventually might also develop a number of PTSD symptoms.

## Compassion fatigue[4]

Compassion fatigue describes a syndrome, which combines the symptoms of secondary traumatic stress and professional burnout. Compassion fatigue differs from vicarious traumatization by being a more general phenomenon that refers to the overall emotional and physical exhaustion, which professionals might experience due to the continuous use of empathy when working with people who are suffering in some way. Thus, compassion fatigue is not limited to professionals who work directly with trauma survivors.

## Professional burnout[5]

Professional burnout is a gradual process which occurs when work-related stress, caused by the repeated use of empathy, combined with the day-to-day workplace challenges and hustle, results in emotional, as well as physical, exhaustion. Professional burnout is similar to compassion fatigue since it does not require direct contact with trauma survivors. However, in contrast to compassion fatigue, and also vicarious traumatization, which might occur suddenly, professional burnout develops over time, and factors related to the individual themselves, population served and professional's organization contribute to this process. Professional burnout manifests itself in the following:[6]

| |
|---|
| ***Emotional exhaustion*** is a state that occurs when practitioner's emotional resources are depleted by the complex needs and high expectations of their clients, supervisors and organizations |

***Depersonalization*** (also referred to as cynicism) refers to the negative, cynical or excessively detached responses to co-workers' or clients' situations, requests etc

***Reduction in one's sense of personal accomplishment*** occurs when professionals feel inadequate if clients do not respond to treatment/intervention, despite efforts to help them

Professional burnout can be experienced by workers who have low job satisfaction and feel powerless and overwhelmed at work. It might be caused by lack of role clarity and large amount of work, new technologies and large flows of information, financial constraints, shift work, lack of continuous education, poor communication and lack of support from colleagues and management.[7]

Although not limited to, compassion fatigue and professional burnout[8] are common among individuals who work directly with trauma survivors, e.g. health care workers, psychologists and first responders. **When professionals struggle with their responses to trauma suffered by their clients, their mental health, relationships, effectiveness at work and physical health are at risk, including due to the changes in views on their own lives and the world in general**. In health care, it is contributed by 'culture of silence', poor training in the risks associated with high-stress jobs and lack of knowledge about symptoms of related psychological problems.

## Risk and protective factors for vicarious traumatization, secondary traumatic stress, compassion fatigue and professional burnout

### Risk factors

There are several risk factors for the conditions and burnout described in the previous section. These include:[9,10]

**At the micro level – professionals at risk are with**

- pre-existing anxiety disorders and mood disorders
- personal history of trauma (e.g. child abuse and neglect)
- many cases that involve trauma survivors despite little experience in working with such clients
- poor coping skills (e.g. suppression of emotions)

**At the macro (organizational) level – the risk factors are**

- Inadequate supervision and lack of support from colleagues
- Poor on-the-job training
- Lack of control over one's own work and heavy caseload
- Unfair organizational rules
- Lack of support services and resources for clients

Organizations should acknowledge the existence of vicarious trauma, secondary traumatic stress and compassion fatigue, view them as normal reactions to working with trauma survivors, and help their workers cope with them. This will ease stigmas that professionals might experience if they feel incapable of dealing with a case that involves trauma survivors.[11]

## Compassion satisfaction and vicarious resilience[12]

Recently there has been a shift in the literature that places a stronger emphasis on defining and measuring the positive aspects of working with trauma survivors, rather than focusing solely on the negative ones. **Compassion satisfaction refers to rewarding and fulfilling aspects of work in which empathy and compassion are the driving forces**. Therefore, while working with trauma survivors may cause stress, compassion satisfaction suggests that this can also be a source of development, for example, in terms of expertise. The sources of compassion satisfaction include positive interactions with clients, colleagues, organization and community in general.

The term **vicarious resilience suggests that the process of trauma recovery has the potential to foster resilience and growth** not only for the client but also of the professional who is working with them. Both compassion satisfaction and vicarious resilience put forward an idea that helping clients to recover from trauma and witnessing this process allows workers to experience professional and spiritual satisfaction in a unique way. This should be considered both a reward of the job and an opportunity to truly appreciate the importance of this work.

## Empathy as a protective factor

Empathy is an ability and willingness to understand other person's thoughts, feelings and struggles by imagining oneself in this person's situation.[13] Empathy is a crucial skill for professionals who help people, especially those who work with trauma survivors, and it contributes to positive therapeutic outcomes.[14]

There are different ways of putting oneself in other person's shoes (e.g. emotionally or cognitively, on a moment-to-moment basis or by trying to grasp an overall sense of what it is like to be that person). There are also many ways of expressing empathy, for instance empathic reflections, empathic questions and conjectures etc. Therefore, empathy should be viewed as a complex construct that consists of various acts used in different ways.[15]

Every person is unique and has their distinctive personality traits, history and life circumstances. Therefore, it is impossible to feel exactly what someone else is feeling; however, if someone cares about another person, it is possible to relate to this person's experiences, at least to a certain extent. The victim's grief, fear, anger and despair become part of the professional's experience, and they feel them 'together' with the victim in some way.[16]

Although having to constantly 'share' emotions with victims may contribute to burnout and secondary traumatic stress, empathy might be a protective factor and help address these issues. The study that explored the relationship between empathy, burnout, secondary traumatic stress and compassion satisfaction in social workers suggested that empathy could help them maintain their well-being.[17]

In particular, according to the findings of the study, **training of social workers in self- and other-awareness, could help prevent burnout and secondary traumatic stress by increasing their compassion satisfaction**. The latter was also found to be significantly associated with affective response to clients' situations. While having to share pain and trauma with clients, professionals can also share joy and sense of achievement with them. This can contribute to higher levels of job satisfaction, which is linked with the lower risk of compassion fatigue.[18]

## Other protective factors[19]

Protective factors for vicarious traumatization, secondary traumatic stress, compassion fatigue and professional burnout can reduce the likelihood of their occurrence. They exist on two levels and include the following:

**Macro (organizational) level**

- Safe, comfortable and friendly working environment in which professionals can express their fears and concerns
- Provision of support to employees: encouragement to take care of themselves and maintain work-life balance; training in working with trauma survivors, risks of such work and coping strategies; possibility to receive formal advice from expert workers/organizations; provision of formal and informal support to individuals who need to process (their clients') traumatic experiences (e.g. regular consultations with peers and supervisors)
- Possibility to work on a diverse range of cases
- Creation of professional networks
- Regular use of tools such as the Maslach Burnout Inventory, Secondary Traumatic Stress Scale and Professional Quality of Life scale to assess professionals' compassion satisfaction, secondary traumatic stress and possible burnout

**Micro (individual) level**

- Utilization of skills and strategies to satisfy one's personal, family related, social, emotional and mental/spiritual needs while meeting the needs of clients; development of coping skills
- Realistic workload goals; sufficient rest and relaxation, including during lunch breaks
- Asking for and receiving support from colleagues if needed
- Appreciating the little things, e.g. a cup of tea, hearing the sound of the wind in the trees or developing connections with others
- Maintaining social contacts, gathering with friends to celebrate holidays/joys and mourn losses
- Expressing oneself through creative activities (e.g. journal-writing, drawing, dancing, singing, etc.)
- Taking time to reflect on one's experiences and/or express gratitude by reading, writing, praying or meditating
- Psychotherapy if needed, especially if a person has experienced trauma in the past

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# CHAPTER 8: CONDUCTING TRAINING FOR SOCIAL AND HEALTH CARE PROFESSIONALS

## Topics Covered

What is required from trainers and how to develop a training agenda

Results of WHOSEFVA Mutual Learning Workshops

Lessons learned from WHOSEFVA focus groups

## Learning outcomes

Participants will:

- ✓ Become aware of multiple competencies that trainers need and be able to improve their skills to work effectively
- ✓ Learn how to communicate with the audience by listening to them
- ✓ Be able to effectively share information on how to prevent secondary victimisation of older victims of violence

## Notes for the trainer

- ➢ This module is a brief introduction to the trainer's work; it is aimed at demonstrating that training is not just about giving information to professionals, but also about conveying understanding and sympathy for older victims of violence

## What is required from trainers?

Convincing busy social and health care professionals that they have an important role to play in addressing domestic violence is not an easy task.[1] Some health care professionals can be open and supportive, while others will see this role as an additional burden on top of their existing duties. Therefore, the first key task is to prepare health care professionals and other staff for accepting and implementing new innovative practices. This can be achieved by making presentations on domestic violence and its health implications, using local data, during staff meetings; drawing staff's attention to national policies/recommendations regarding social and health care sectors duties/work; and providing information on local support organisations. In addition, lectures and discussions on domestic violence, awareness raising campaigns, distributing posters as well as 'corridor' conversations with professionals can help create a sense of understanding and a sense of ownership of the new role among professionals.

## Key competences

In order to be successful, trainers need a number of skills and competences. The following key competences have been adapted from the Teachers' Guidebook developed within the European Commission's Lifelong Learning Programme in 2010.[2]

**Professional competence** refers to having the necessary and most recent specialized knowledge in the specific field and utilizing up-to-date research findings. Thus, trainers should:

- Understand the multifaceted nature of violence against older persons/older women
- Be aware of the challenges that older abused women are faced with
- Know methods of and procedures for recognizing sings of violence and preventing it
- Understand the challenges of conducting training on violence against older persons/older women
- Continuously acquire new knowledge about the topic

**Socio-communicative competence** means building mutual understanding and respect in relationships with professionals, victims etc. Thus, trainers should:

- Understand what their audience need
- Be able to listen to and empathize with their audience
- Be able to sense (potential) conflict situations and resolve them in a calm and effective manner through finding consensus or compromise
- Be flexible and adapt the training program if needed (including content, methodology, objectives) to ensure that it is user-friendly

**Methodological competence** means the ability to make accurate assessments of the situation and to take correct and appropriate decisions. Thus, trainers should:

- Use different teaching methods and mentoring approaches
- Be able to handle difficult situations that might arise during training
- Understand what is happening and might happen, based on the context and non-verbal behaviour
- Engage in problem-solving

**Personal competence** refers to the ability and willingness to reflect on one's own actions and take an ethical stance when necessary. Thus, trainers should:

- Be able to deal with stress to fulfil their responsibilities effectively
- Develop new ideas and initiatives and remain open to new experiences
- Be aware of their own attitudes to/beliefs about violence against older persons and older women and understand how this influences their work
- Be able to assess their own learning process (beliefs/facts, knowledge/attitudes) and be committed to continuous learning
- Be able to analyse their training program and methods
- Ask training participants for feedback

It is crucial to understand that training is a sharing event where participants that have different professional backgrounds share their experiences and (practical) knowledge. Therefore, it is important to:

**Create trust and friendly atmosphere** by:

- introducing oneself briefly (work experience)
- asking participants to introduce themselves briefly (name, profession, place of work)
- allocating time for questions and possible concerns, ask participants to share their opinions on training
- showing respect for participants' skills and knowledge

**Create/use opportunities for experience sharing**:

- share your knowledge and experience as a domestic violence expert
- ask health care professionals to share their experiences of working with older victims of abuse; keep in mind that your task is not just to teach, but to draw knowledge and wisdom from existing experiences of professionals
- if someone asks a question, redirect it to the group and ask participants to express their opinions; this technique creates an interactive and engaging environment and opens up new resources for learning (from other participants)
- ask participants to work in pairs (with different people) and small groups (three to six people) to discuss possible answers to questions

These are only suggestions, and other collaborative and creative ways of learning can and should be used when training professionals.

## How to develop a training agenda and structure

Trainers can select those chapters and topics from this manual that are most relevant and useful to participants, and can adjust their order. The duration of training will depend on the participants' level of knowledge and experience. Since the work of health care professionals working in emergency departments can be hectic and they might not be used to long training hours, and taking into account the length of this manual, it might be beneficial to divide training into several (short) sessions. For example, sessions can take place once per week, which will give participants time to reflect on their new knowledge and allow to combine theory with practice.

## Results of WHOSEFVA Mutual Learning Workshops

All WHOSEFVA partner organizations in Austria, Estonia, Finland, Greece and Latvia conducted Mutual Learning Workshops for social and health care professionals. The goal of these workshops was to allow professionals to share their knowledge of and experience with working with older victims of violence, including treatment they require, gender- and age-specific perspectives on violence and existing practices.

Over 300 professionals participated in the workshops, and more than 50% were registered and licensed practical nurses; the rest were social workers, paramedics, medical doctors and administration staff. Pre- and post-evaluation questionnaires were used to assess the training needs of participants and collect feedback. Each workshop lasted approximately 1.5 hours, which was conducive to knowledge-sharing rather than deep exploration of the topic.

Over 200 professionals reported that they had never received training in elder abuse prevention. The needs of participants varied slightly depending on their profession and country. For instance, Finnish health care professionals stated that they needed knowledge on the challenges associated with population ageing, signs of elder abuse, provision of Psychological First Aid to victims, documentation of elder abuse cases and multi-agency cooperation. In other countries, participants were interested in topics such as human rights of older persons, Psychological First Aid, signs of elder abuse, case documentation and multi-agency cooperation. Lectures and case studies were preferred teaching methods.

According to the collected feedback, Mutual Learning Workshops helped participants understand the meaning of population aging population for their work and improved their knowledge of different dimensions of elder abuse. Participants also indicated that they had received useful information on professional challenges in working with older abused people. In addition, the feedback suggested that elder abuse was relevant to the work of social and health care professionals and thus there was a need for discussing this issue regularly.

## Lessons learned from focus groups

### Older people's experiences of violence

In each partner country, participating organizations conducted local focus groups or interviews with older female victims of domestic violence in order to bring their perspectives into the project. The topics discussed included older women's experiences of seeking help from social and health care services, their needs and circumstances, and their opinions on elder abuse training for professionals. The gathered information was incorporated into the training program for professionals.

125 older persons participated in the focus groups or were interviewed; the average duration of a focus group or interview was 1-2 hours. 114 participants were women; one third of participants were 75–84 years old, a quarter were 55–74 years old and the rest were under 55 years old. Some participants were victims of domestic violence.

Participants identified different forms of violence against older people (physical, psychological, verbal, emotional, economical and sexual) and defined the difference between conflict and violence (when violence is used as a tool to end disagreement). Participants also stated that men could be victims of abuse as much as women, but that such cases often went unnoticed. At the

same time, they believed that women were less protected and more vulnerable to violence than men.

Participants defined psychological violence as making an older person feel 'small' and not treating them like an adult (infantilization). Also, they reported that sometimes their caregivers made them feel as if their needs and concerns were not important/not taken seriously or if they were a burden ("You aren't worth anything, you are a burden"). When talking about financial violence, participants reported that a partner or adult children controlled their money or limited older person's use of it. Some women stated that on occasion they had been unable to say no to sexual intercourse, had been threatened with weapons (e.g. knives) or had a spouse who behaved in a controlling and tyrannical manner. In addition, some female participants mentioned that alcohol abuse was a cause for violence. However, other participants stated that their partner had been violent both when intoxicated and when sober; thus, the type of personality, rather than alcohol abuse, was believed to contribute to violent behaviour.

When talking about leaving an abuser, some participants believed that it was easier for older women to leave an abusive relationship and divorce since they had no small children to take care of and therefore could be less economically dependent on their partner/spouse than younger women. However, participants also believed that, in comparison with younger women, older women had less to look forward to, which created a sense of being "doomed."

## Experiences with seeking help

Older women's experiences with seeking help from professionals varied. When they did so, they often turned to the police, psychosocial emergency services, helplines and psychiatric institutions. Many victims used phone counselling services instead of visiting counselling centres in person. In addition, neighbours could play an important role in helping older victims (e.g. by calling the police). At the same time, some women reported that often they felt nobody believed them when they raised the issue of violence.

For example, some women stated that the police only reacted when there was actual physical harm otherwise dismissing victims' claims. Overall, the attitude of the police towards violence, which they often called a "family conflict," was considered horrible by participants. For example, one woman reported that the police officer laughed at her when she reported violence and told her it was her problem. When it comes to health care professionals, many participants felt that they would not help victims since they did not have time for that, which was perceived as the major problem. What is more, it was difficult for participants to talk about violence if the doctor did not ask them about it. In addition, one woman mentioned that her doctor was willing to help her, but did not know how (e.g. what organization to contact).

Participants mentioned several obstacles that could prevent older people from seeking help, for example not having a mobile phone, lack of digital skills, language or physical barriers. What is more, some participants considered shame to be an obstacle to seeking help, and some older women felt that it was easier to do nothing about their situation. Also, participants believed that there should be special support centres for older women since they thought women's shelters did not have room for women without children. In addition, some women expressed concern that, in contrast to younger women, they did not know where to seek help, which might slow down the process and give a perpetrator a chance to find witnesses who would be willing to support their claims.

## Older victims' concerns over support services and treatment

Overall, problems related to victim support services that were mentioned by focus group and interview participants include the following:

- Lack of time: usually health care professionals do not have time for thorough examinations and might be too stressed to ask questions about violence
- Language and cultural barriers: the needs of migrant women might be different and should be taken into account
- Lack of communication and coordination between professionals (family doctors, health care and social service professionals)
- Frequent change of professionals: older people suffer if professionals who work with them change repeatedly since they need to build trusting again
- Lack of procedures: organizations that provide care to older people should have procedures for addressing (suspected) violence
- Lack of knowledge: professionals should have better knowledge of different forms of violence and of memory disorders
- Need for a clear stance against all forms of violence: professionals (the police, medical staff, lawyers) whom older people seek help from should provide support to victims
- Need for elder abuse awareness raising campaigns

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# ADD-ON SECTION BY MARVOW PROJECT[A]

# MULTI-AGENCY COOPERATION MODELS FOR WORKING WITH OLDER VICTIMS OF DOMESTIC VIOLENCE

## What is multi-agency cooperation, and why is it important in responding to domestic violence?

It has long been established that public services are increasingly performed in settings of networked actors that include public agencies, nonprofit organizations, and private companies[b]. This is especially true for complex social services, which address problems that cannot be solved easily by single organizations acting alone[c]. This is significant because such networks require coordinated cooperation between multiple agencies/organizations who must work together without any authority over each other to compel action. These entities often come into conflict due to questions of jurisdictional boundaries – in some cases two agencies wish to have primacy in a particular area (i.e. local government social department vs prosecutors office) leading to a defense of their 'turf', lack of cooperation and/or redundancy or even counterproductive services. In other situations, agencies may oppose taking responsibility for an area – leading to service gaps (this often occurs with 'difficult' and/or resource intensive groups are involved, such as the homeless). A major factor in this regard may be that these organizations often compete with each other for the same or scarce resources, such as shares in a municipal budget or lines in the state budget. Furthermore, these organizations may have no experience of collaboration with each other or worse yet, may have histories of problematic interactions due to different priorities, cultures or expertise – such as when they are staffed by professionals whose ethics, standards and practices differ from each other. For example, imagine the collaboration of criminal justice agencies and substance abuse treatment programs. Police may view substance abusers as threats to public safety who should be held accountable if they commit crimes, whereas a treatment center is more likely to see them as patients in need of help in treating the disease of addiction.

Multi-agency cooperation is one important approach that can be used to address the difficulties described above. Generally, this occurs at either the **client level** (service coordination) or at the **system level** (sometimes referred to as service integration):

- At the **client level**, agencies work together to align their services and activities for specific individuals to address their unique needs and achieve better outcomes. The results of this effort may or may not be used to try and improve system performance. These approaches often involve more rapid, sometimes adhoc actions responding to actual client needs in almost real time.
- At the **system level**, agencies providing services within a specific sector (i.e. education) or serving specific types of clients in a shared region (such as serving the homeless in a city) seek to unify or align services to reduce service fragmentation, fill gaps, and create a con-

a This section was prepared within the framework of the 2nd work package of the MARVOW project, led by Women's Support and Information Centre NPO

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tinuum of services for clients. Other goals are to increase efficiency by reducing the duplication (and cost) of services and to decrease inappropriate service use. System approaches tend to involve a great deal of planning, often consider resource allocation issues, might promote shared guidelines or protocols and make administrative changes across agencies to foster longterm collaboration.

Although these two levels of practice are often carried out separately, they are not mutually exclusive and could reinforce each other. For example, system wide approaches could make it easier to implement client-based coordination by eliminating or reducing institutional barriers. On the other hand, client-based approaches can help to uncover gaps or barriers to be addressed. Whether addressing the system or specific clients, multi-agency cooperation approaches should identify who provides services, where and how often they are provided, create mechanisms for communication between agency personnel as well as ways of sharing data.

## Multi-agency Cooperation in Domestic Violence Services

Responses to domestic violence would benefit from multi-agency cooperation as DV affects victims in multiple ways and responses cross into many service areas within social services, criminal justice and healthcare. Within these domains, services are carried out by a wide range of institutional and professional actors operating inside and out of the public sector. Furthermore, domestic violence services have at least three target groups with widely differing needs and issues: victims, perpetrators and affected third parties such as children or other family members. These issues and thus service responses can vary widely depending on various characteristics such as age of those involved (minors, adults or elderly), the form of abuse (physical, emotional, financial, etc.) or relationship between abuser and victim. An additional complexity is that domestic violence as a phenomenon is greatly affected by societal norms, attitudes and beliefs of different local, regional and national contexts.

Furthermore, multi-agency cooperation is not static throughout the DV response process, it varies depending on the goal of the specific service component as described below:

Domestic violence responses must start with the **identification of potential cases**, which can be greatly improved when different agencies work together. Police may respond to domestic calls (which may or may not lead to an arrest of the potential perpetrator) and could make a referral to the social services agency and/or a domestic violence shelter to follow-up with support services for the victim. When perpetrators are arrested (or other measures are in place), referral to support workers is essential, as this is an important opportunity for intervention with victims. An alternative identification pathway would be one in which a victim contacts a shelter directly, which can then consult with public agencies (police, prosecutors offices, court records, etc.) to confirm details of the case. A third pathway could be through the healthcare system, as medical providers identify potential victims based on injuries or other factors, making referrals to police, social workers or others. Appropriate collection, preservation and transfer of information and evidence documenting injuries to law enforcement agencies is vital to pursuing cases against abusers. Thus, it is clear that in all these situations, poor communication and cooperation between different service providers can greatly weaken the ability to identify potential domestic violence cases.

An additional area in which this is true is during **risk assessment** of situations - conflicts can emerge between different service providers regarding how serious they think the risk of harm is in a particular case. This is often the result of differing underlying priorities of service providers. Victim support organizations, whose primary responsibility is the protection of victims are far more likely to seek removal of a possible abuser from the home than organizations whose priority is to try and keep couples together. Some wish to focus risk assessment on identifica-

tion of the cases that pose the most severe threat to victims' physical well-being (to conserve resources or to focus on those with highest perceived needs). Others prefer to use risk assessment to focus on identifying early warning signs of abuse to try and prevent escalation (and are situations which typically require lower levels of support). Institutional considerations may also affect decision-making in these situations, for example, a severely understaffed agency may prefer to set a higher threshold for assessing high risk situation because of a lack of capacity. Multi-agency cooperation models seek to balance these competing needs and concerns, to try and reach negotiated and agreed upon approaches towards risk assessment.

Once risk has been assessed or domestic violence otherwise identified, cases typically require a wide range of **victim support services and/or interventions**. DV victims often face a multiplicity of issues that must be addressed for them to be able to leave an abuser and build an independent life free of violence. This includes psychological support (counseling/therapy, drug/alcohol treatment); legal services (criminal prosecution of perpetrators, orders of protection, child custody or support arrangements, etc.); economic support (e.g. moving/relocation, job training/placement, obtaining housing, setting up bank accounts) among many others. The interrelated nature of these issues makes overcoming these barriers even more important. A drug addiction could hinder ability to get and keep a job; depression or other psychological issues can weaken resolve to leave an abusive relationship; continued harassment or legal issues can prevent a victim from starting over. Comprehensive provision of victim support can also be greatly hindered by organizational boundaries, lack of information sharing and different institutional priorities.

Increasingly it has become clear that dealing with domestic violence requires special attention not just on victims but on perpetrators as well. **DV perpetrator** responses focus on reducing their violent behaviors, often by exploring the underlying conditions, beliefs or values that lead to such behaviors and in identifying internal triggers that instigate violent acts. These responses can be implemented as mandatory elements of the criminal justice system, such as part of alternatives to incarceration or probation/parole arrangements. They can also be voluntary in nature and can benefit from the involvement of multiple service providers. Programs for perpetrators of violence need to be closely linked with survivor support services, in order to ensure that safety and needs of survivors are prioritized.

Finally, underlying societal norms, attitudes and beliefs that support violent behavior or enable acceptance of DV must be addressed by **awareness raising campaigns**. Like the above, involvement of different agencies can greatly improve the efficacy of such campaigns. For example, police officers and shelter workers could speak at together at local schools to discuss the negative physical and psychological consequences that DV can have. Different service providers can use their various communication channels to reach relevant audiences. Importantly, agencies can work together to present coherent messages that reinforce each other and avoid contradictions that could confuse the public. For example, that bystanders should report suspected abuse, that victims should not be stigmatized or that anyone can be a victim.

## Client-based multi-agency cooperation - MARACs

Client-based multi-agency cooperation models focus on bringing together service providers who work directly with clients to discuss the case and coordinate responses. They are fundamentally a method of sharing information and overcoming organizational boundaries when providing complex services to clients. This form of collaboration can be applied to any stage of the domestic violence service system, such as case conferencing for providing victim support services. A major benefit of this form of cooperation is that it can be implemented immediate-

ly as it relies on the interactions of direct service providers and not necessarily institutional assessments. A clear negative is that case-based approaches tend to be reactive -responding to problems as opposed to anticipating them. As a result, these approaches do not address system-wide or institutional barriers that can hinder cooperation. Further limitations can arise based on how client-based cooperation is carried out, such as whether important service providers are included. Another issue regards how frequently interactions take place - too often can be time consumptive for staff while too infrequent adversely affects response times.

One of the most prominent examples of client-centered cooperation is the Multi-Agency Risk Assessment Conference (MARAC) model, that was developed in the UK in the early 2000s. MARACs have since been implemented throughout the UK, Europe, the US and elsewhere. Multiple studies have found that MARAC's, when implemented correctly, have significant impacts on reducing harm to victims of DV.

MARAC conferences usually occur monthly or twice a month, during which representatives from various agencies/service providers come together to discuss high risk cases. Typically, these can include police, judges, victim protection facility, offices for youth & family, child protection, educational institutions, counselling centers, hospitals, probation & perpetrator programs, housing offices etc. After sharing all relevant information about the victim/survivor, participants discuss options for increasing the safety of the victim/survivor and their children. These are in term used to create a coordinated action plan for the specific person. In addition to managing the risk to the victim/survivor, MARACs should consider other family members, including children and should seek to manage the behaviour of the perpetrator.

MARAC's protect the rights of victims in two important ways. First, all information shared at MARAC conferences should be kept confidential and only used to reduce risk of harm to those at risk. Second, all conferences should include representatives of victims, such as victim support organizations or domestic violence shelters.

Increasingly, MARACs are also considering interventions to be made regarding perpetrator(s), to reduce risks to victims, hold perpetrators accountable and promote changed behavior if possible. This requires involving representatives of perpetrator intervention programmes into the MARAC conferences. It also typically requires identification of the range of interventions that are available to perpetrators in the community. Doing so could help professionals share ideas and interventions across agencies and help develop more holistic responses to perpetrators.

Various success factor have been identified for effective MARACs, which includes:

1. Individual assessment of high-risk victims to determine whether they are at risk of new and repeated victimization, intimidation and retaliation, and what assistance and protection measures they need.

2. The danger to the victim and the resulting risks to the victim shall also be assessed and interventions planned.

3. Providing services and interventions to the victim based on their need for assistance, including the possible effects of trauma.

4. Optimizing the work and resources of victim support agencies - A systematic approach based on needs and risks will help agencies to make better use of resources and provide more effective assistance.

5. Risk assessment and support activities are planned and monitored. A common information space on the risks of violence will be set up between the agencies to protect the victim. The

identified risk is shared and analyzed with other institutions at the same time so that their interaction can be assessed.

6. The chances of re-victimization is reduced, as the victim does not have to "prove" his or her status in several different institutions.

## System-based multi-agency cooperation – CCR

The dominant system-based multi-agency cooperation approach, known as Coordinated Community Response (CCR), was first developed in 1980 in Duluth, Minnesota, to improve responses to domestic violence perpetration. It has subsequently been widely applied to helping victims of intimate partner violence. CCR is a holistic approach to addressing IPV, and are implemented by local councils of service providers, who work together to ensure that victim support organizations effectively work with services providers from other parts of the system to ensure that the holistic needs of victims are adequately met. Service provider networks involve community-wide agencies such as the police, legal system, social service providers (e.g., victim advocates), government, health care systems, and educational and vocational programs.

CCRs are considered to be most effective when they are guided by an underlying philosophical framework that minimizes conflicting theories about abuse, how to protect victims and how best to hold offenders accountable. This may require participants to examine and debate assumptions that they hold regarding abusers and victims. A second important element is that CCRs should lead to the development of policies, procedures, and protocols that standardizes the actions of practitioners responding to DV. These should be aligned to reduce contradictions and fill in gaps in policies between different agencies, identified via a system-wide map that charts out the roles, possible intervention actions, and procedures of each actor in the system.

Coordinated systems should outline how data will be collected and information exchanged between different agencies and actors in the system, including feedback loops to ensure that service providers are notified when they have failed to comply with agreed-upon policies. This can best be achieved via data collection systems that monitor and track cases from initial contact through case closure to ensure practitioner and offender accountability. Of course, such systems require that agency activity is digitized, which is increasingly the case in most larger municipalities. They could be directly connected via a joint database or by some other means of sharing data that would enable system-wide analyses to be conducted. Other forms of information sharing should also be established between agencies such as via interagency meetings, or regular one-on-one interactions between individual service providers.

Effective CCRs should also ensure that victims and other at-risk family members receive the resources and services needed to protect them from further abuse. This potentially includes a wide range of services including emergency housing, legal assistance, access to job training and other financial resources, substance abuse treatment, counseling and other psycho-social support. Within well-functioning CCRs, alongside with survivors' safety, there should be a focus on perpetrators' accountability. All interventions need to clearly pose a responsibility for violence on perpetrator.  During CCRs, all possible interventions to keep perpetrators accountable are discussed (criminal sanctions, protection measures, referral to perpetrator programmes…), as well as implementation of those measures. In cases of violence against older women, implementation of some measures can be challenging, so CCRs have very important role in this context.

A final component of effective CCRs is the presence of ongoing training and evaluation to ensure that the system continues to meet the needs of victims and the community. Training should fo-

cus on ensuring that all participants understand the goals of the CCR, are aware of new policies and have up to date skills. Regular monitoring and evaluation of the system should be done to assess the effectiveness of policies and procedures in protecting women and reducing abusive behaviors.

## Challenges to multi-agency cooperation for elderly victims of abuse

Services responding to domestic violence involving older victims (and perpetrators) is particularly difficult to provide. This is because it falls into the gap between 2 forms of family violence: intimate partner violence (IPV) and elder abuse. IPV can be a continuation of longstanding spousal abuse or start only at old age. In either case, older women can face barriers that keep them in the relationship, such as inability to obtain employment or sense of obligation caring for their abuser[d]. Complicating the issue is that abusers or victims may have cognitive impairments or psychiatric illness. In elder abuse, perpetrators are typically adult children, grandchildren, other relatives or paid caregivers. In some instances, the relationship may even be reversed, where the victims are caregivers being abused by the care recipient. Thus, issues related to cognitive and physical functioning are especially important, as they may be a cause of abusive behavior or can strip from victims the capacity to protect themselves.

This complex phenomenon makes multi-agency cooperation especially difficult as it involves a greater number of agencies/individual actors, such as eldercare facilities, adult protective services, homecare agencies and the like. These cases often require intervention by several institutional actors at once. Furthermore, many service providers lack adequate procedures for dealing with such cases, such as criminal justice providers dealing with older abusers.

## MARVOW Multi-agency model

The MARVOW model links together system wide CCR models with client-focused MARAC conferences in such a way that they reinforce and improve upon each other. At the same time, they incorporate considerations of the specific aspects that arise in cases of elder abuse. This model is depicted in figure 10.

Individual case conferencing involves all relevant front-line workers from the region. They should represent the various elements including: criminal justice; perpetrator interventions; domestic violence support providers; and senior support services. Within conferences, participants can respond to actual cases to identify intervention strategies or archetypal cases of 'victim personas' that reflect different elder abuse scenarios (spousal, child to parent, caregiver to patient, etc.) In working through these cases, gaps in services and workarounds are identified and documented. These conferences should occur more frequently – at least monthly.

Individual cases in turn feed into the system-wide meetings, that should involve key decision-makers from relevant agencies. These system-wide meetings should occur less frequently (perhaps quarterly) but must result in concrete action items that can be followed up on. This requires that responsibilities for each action item be clearly identified as well as timetables for their completion be set.

d Seaver, 1996; Wolf, 2000

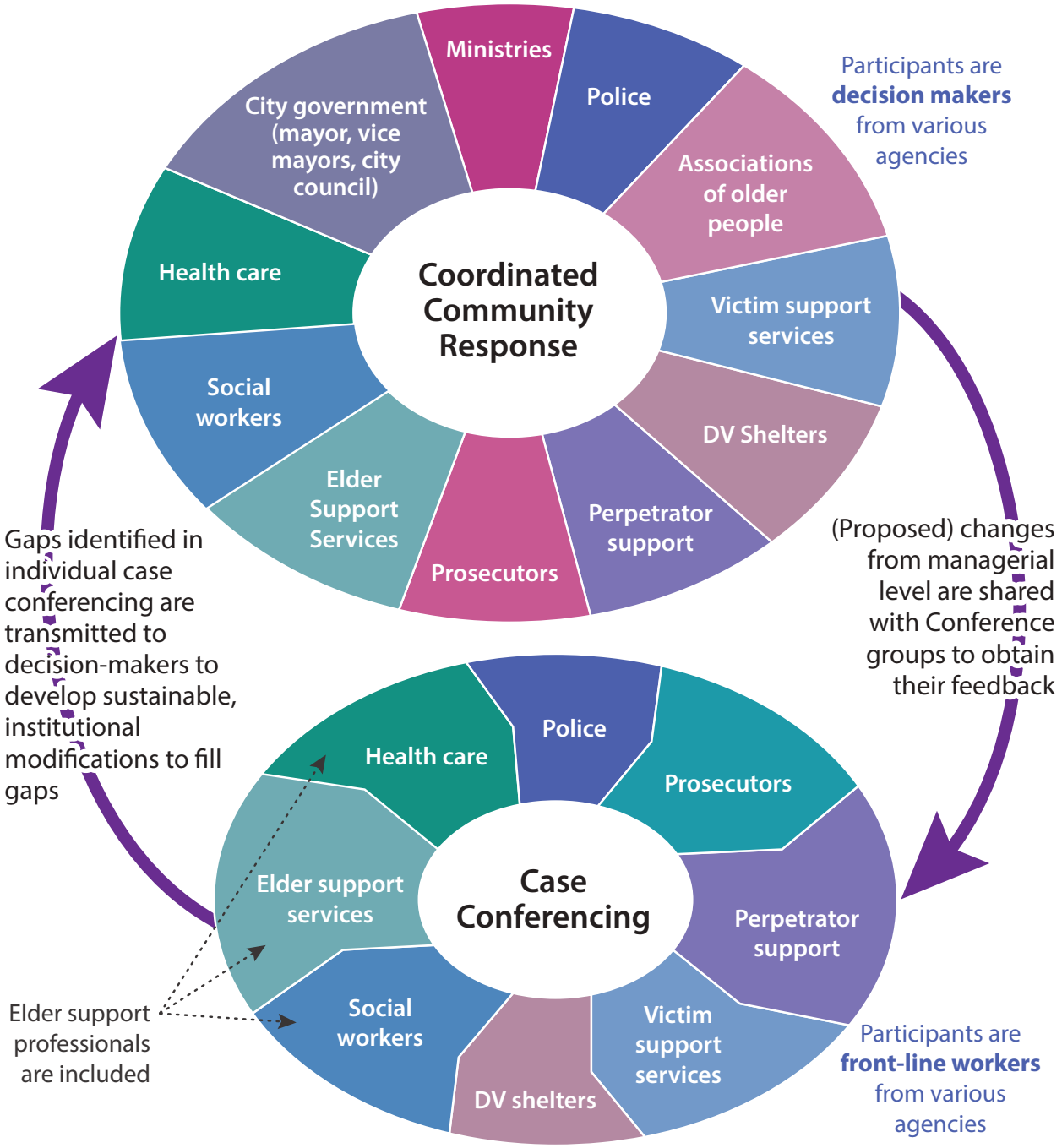


Figure 10. Multi-agency model developed in MARVOW project.

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# APPENDICES FOR WORKING WITH VICTIMS OF ELDER ABUSE

# APPENDIX 1: MEDICAL EXAMINATION OF ASSAULT VICTIMS IN EMERGENCY DEPARTMENTS

**The name of the patient, ID**

**ASSAULT FORM**

**Background information (documented by the staff)**

Escorted by: _____ Date_____ Time _____

Identification __ Driving license __ Passport __ Other, what __ Absent __ Unclear

**DETAILS OF THE INCIDENT** described by the patient (documented by the staff)

_____

**Place where it occurred** **Date_____** **Time _____**

__ Home __ Other dwelling Address: _____

__ Somewhere else, where:_____

**Person who inflicted injuries:**

__ known, who (relationship to patient): _____

__ Unknown, how many: _____

__ Don't want to tell

__ The same person has been violent before

Further information (e.g. restraining order, where is the perpetrator now)

_____

**Description of the incident:**

_____

**Act/threat**

__ Hit, where/with what: _____

__ Knife/sharp object (also threat)

__ Firearm (also threat)

__ Kicked, where:_____

__ Pulled / twisted, where: _____

__ Choked, with what: _____

__ Knocked to the ground/Fell down __ Assault occurred __ Continued on the ground

__ Lost consciousness __ Yes __ Partly __ No __ Doesn't know

__ Sexual violence

__ Verbal violence, how: _____

__ Other way, how: _____

**Pain, which was inflicted by the act, assessed by the patient**

_____

*Attach the form and photographs for the court to the medical statement. With the patient's consent the copy of the form and photographs can be given straight to the police by the emergency unit/health centre.*

**Date** _____ **Time** _____

**Signature of the patient** _____

___ The patient is not able to sign

___ Patient has given oral permission to give the form and photographs to the police

**The name of the patient**

**ID**

**DOCUMENTATION IN THE UNIT**

The police were present at the incident location __ Yes __ No __ Not known

Offence reported to the police __ Yes __ No __ Not known

**Children**

__ Pregnant; weeks: _____

__ Yes, age: _____

__ Present at the incident location; where and cared by whom now? _____

__ Violence against children/dependants? _____

__ Report to child protective services done, where? _____ Not done__

__ Will be done later/person responsible: _____

**Other dependants of the patient** (relatives, animals): _____

Where and cared by whom now? _____

**Mental state** (nurse's assessment): _____

**Alcometer** _____ 0/00 Time: _____

**Further treatment/support** Date _____ Time _____

__ Hospital/Health Centre unit

__ Another hospital, where: _____

__ Home

__ Elsewhere: _____

__ Submitted written material: _____

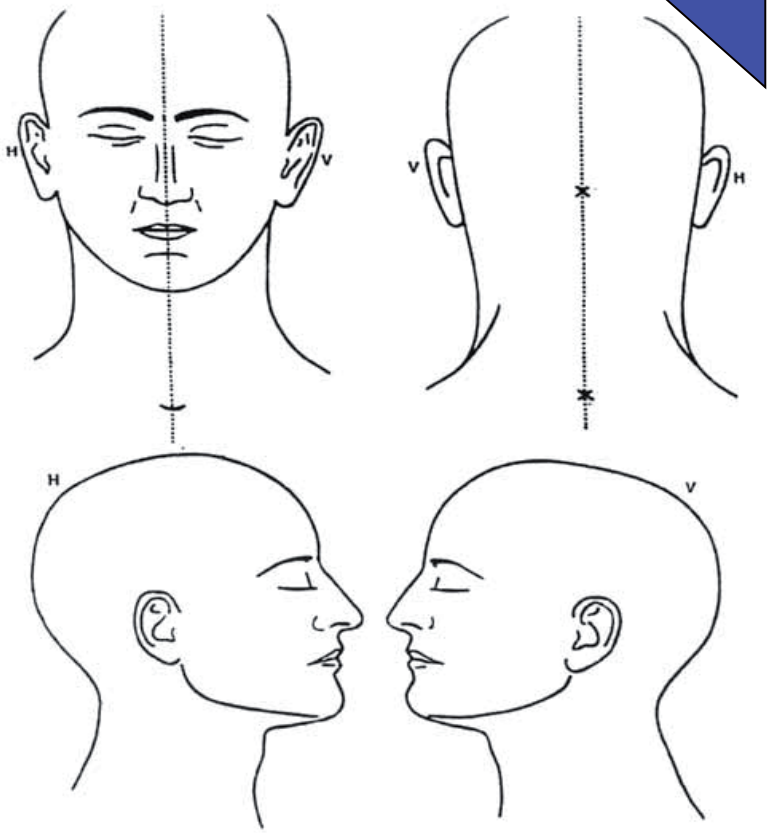
Follow-up: _____

Additional information: _____

# BODY MAP

Name of the hospital
Address of the hospital
Phone

| |
|---|
| Name |
| Identification |




**EXAMINATION:**

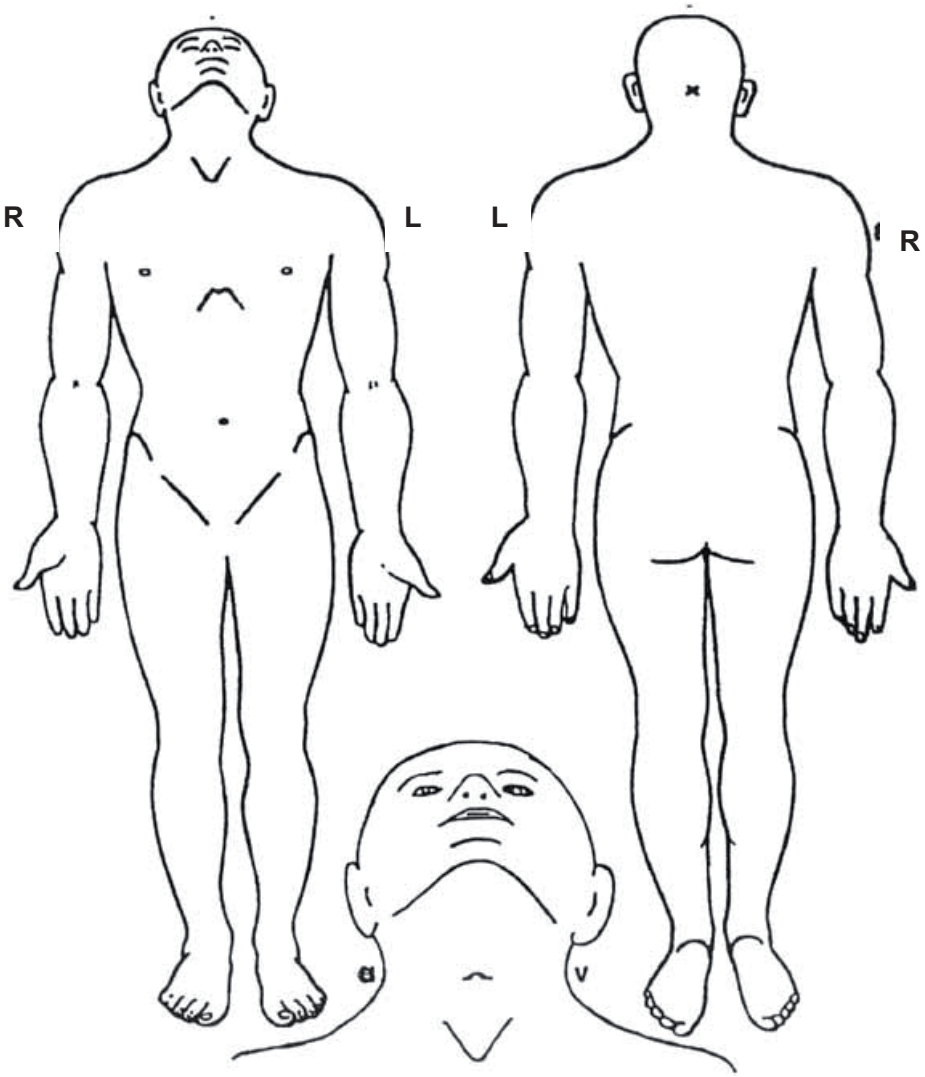
**DATE/TIME**_____
**DOCTOR** _____
**NURSE** _____

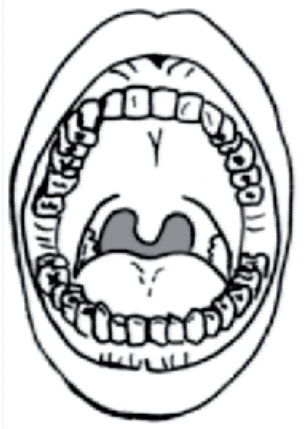
**PHOTOGRAPHS** yes _____ pieces no_____

**DRAW THE INJURIES (INCLUDING THEIR MEASUREMENTS) ON THE DIAGRAMS:**

**X bruise --- scratch ● black mark ⊢⊣ wound**

**○ lump/swelling /// pain ▲ fracture / luxation**



# APPENDIX 2: MULTI-AGENCY COOPERATION FOR ELDER ABUSE PREVENTION IN HELSINKI

In 2013, the Department of Social Services and Health Care of Eastern Service District of Helsinki established a multi-agency working group[1] in response to a serious violence case that demonstrated numerous problems with the elder abuse prevention system, in particular:

- Inefficiency and duplication of effort
- Reliance on interpretations instead of facts
- Lack of communication between professionals working on the same issue/case
- Inadequate case documentation
- Unclear procedures
- Difficulties in identifying, preventing and ending violence

The established multi-agency working group was tasked with developing violence identification and intervention methods. The group consisted of the representatives from Suvanto Association – For Safe Old Age, home care provides, social workers, Comprehensive Service Centre and hospitals. The working methods (figure 10) included seminars, workshops, consultations with professionals and experts in different aspects of elder abuse. Issues related to the well-being of employees were also discussed.


Figure 10. Solution development cycle

The group used four case studies of different forms of violence (neglect, financial, physical and sexual violence) to identify gaps in and problems with existing systems, procedures and measures. Based on the analysis of the case studies and the results of workshops conducted in 2014–2017, the core six issues to be solved were identified:

- Complexity of intervention processes – need for training and development of working models for dealing with different types of cases
- Separate digital information systems of relevant authorities/services – need for improving documentation and information flow

- Lack of clear instructions – e.g. need for guidelines on compulsory reporting and documentation of cases
- Unclear division of responsibilities – need for clarification of what responsibilities different organizations have and how they should work together
- Unclear criteria for defining situations as urgent – the crisis intervention working group issued instructions for addressing crisis situations at home in 2016
- Lack of knowledge on the part of professionals about how to handle violent cases – need for better training

The working group developed a working model for elder abuse prevention (see Figure 11), which has been disseminated among professionals working at Helsinki district social and health care services.

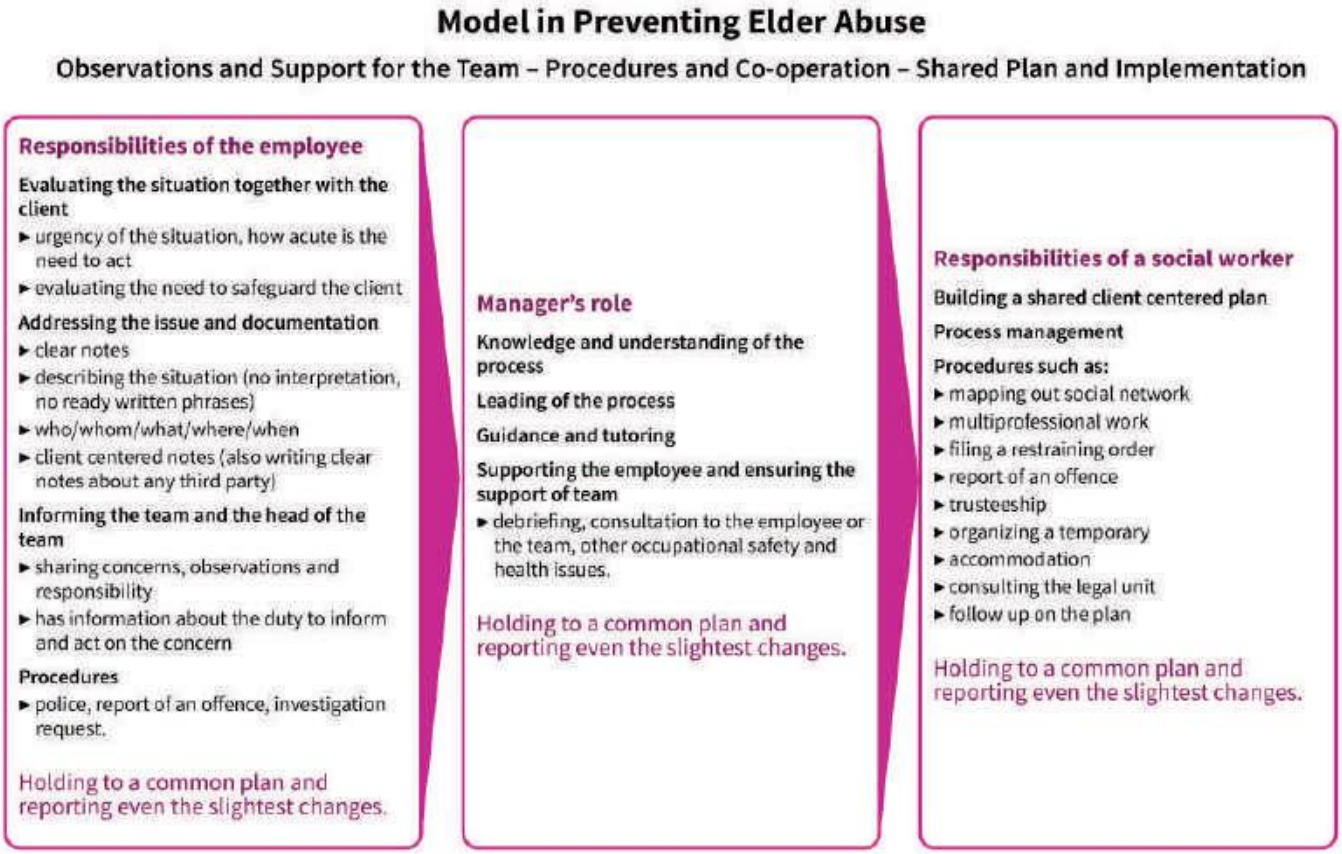



Figure 11. Elder abuse prevention model

(Chapter references)

1 Adopted by Sirkka Perttu from the presentations of Senior Social Worker Riikka Muinonen, District Manager Johanna Koli and Registered Nurse Janne Rantala, by their permission.

# APPENDIX 3: INTERNATIONAL INSTRUMENTS CONCERNING VIOLENCE AGAINST OLDER WOMEN

## Topics Covered

International documents in the fields of human rights, rights of women and rights of older persons

- Universal Declaration of Human Rights
- United Nations Principles for Older Persons
- Charter of Fundamental Rights of the European Union
- Madrid International Plan of Action on Ageing (MIPAA)
- Recommendation CM/Rec(2014)2
- Women's rights perspective on violence against older people (Convention on the Elimination of All Forms of Discrimination against Women, Istanbul Convention)
- United Nations Open-ended Working Group on Ageing

## Learning outcomes

Participants will:

✓ Learn about different international instruments that protect older persons from violence

✓ Understand that violence against older women is human rights and women's rights violation

## Notes for the trainer

➢ When discussing international human and women's rights instruments, it is important to evaluate the situation in your country. For example, have these instruments been ratified by your country and have they influenced relevant legislation?

# International documents in the fields of human rights, rights of women and rights of older people

## Universal Declaration of Human Rights

The Universal Declaration of Human Rights is the **most important international human rights instrument**. It was adopted by the General Assembly of the United Nations (UN) on the 10th of December 1948 in response to the atrocities of the two world wars. This was the first time when countries agreed on a comprehensive set of inalienable human rights. The Universal Declaration is not legally binding, but it has had a huge impact on national legislations.

The core idea of the document is set out in Article 1, which states that **all human beings are born free and equal in dignity and rights**. The rights included in the declaration are the **right to life, liberty, due process, ownership of property, education, political participation, work and leisure etc**. The declaration also **promotes non-discrimination and equality** by stating that "everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."[1]

## United Nations Principles for Older Persons

The UN General Assembly has encouraged all governments to incorporate the **following principles** for older persons into their national legislation/programmes, according to **which older people have the right to**:[2]

| **Independence – older persons should** |
|---|
| 1. Have access to adequate food, water, shelter, clothing and health care through the provision of income, family and community support and self-help. |
| 2. Have the opportunity to work or to have access to other income-generating opportunities. |
| 3. Be able to participate in determining when and at what pace withdrawal from the labour force takes place. |
| 4. Have access to appropriate educational and training programmes. |
| 5. Be able to live in environments which are safe and adaptable to personal preferences and changing capacities. |
| 6. Be able to reside at home for as long as possible. |
| **Participation – older persons should** |
| 7. Remain integrated in society, participate actively in the formulation and implementation of policies that directly affect their well-being and share their knowledge and skills with younger generations. |
| 8. Be able to seek and develop opportunities for service to the community and to serve as volunteers in positions appropriate to their interests and capabilities. |
| 9. Be able to form movements or associations of older persons. |

| Care – older persons should |
|---|
| 10. Benefit from family and community care and protection in accordance with each society's system of cultural values.<br><br>11. Have access to health care to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness.<br><br>12. Have access to social and legal services to enhance their autonomy, protection and care.<br><br>13. Be able to utilize appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.<br><br>14. Be able to enjoy human rights and fundamental freedoms when residing in any shelter, care or treatment facility, including full respect for their dignity, beliefs, needs and privacy and for the right to make decisions about their care and the quality of their lives. |
| **Self-fulfilment – older persons should** |
| 15. Be able to pursue opportunities for the full development of their potential.<br><br>16. Have access to the educational, cultural, spiritual and recreational resources of society. |
| **Dignity – older persons should** |
| 17. Be able to live in dignity and security and be free of exploitation and physical or mental abuse.<br><br>18. Be treated fairly regardless of age, gender, racial or ethnic background, disability or other status, and be valued independently of their economic contribution. |

## Charter of Fundamental Rights of the European Union

The Charter of Fundamental Rights of the European Union states that "**any discrimination based on any ground such as sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation shall be prohibited**." Article 25 of the Charter is dedicated to the rights of the elderly and states that the EU "**recognises and respects the rights of the elderly to lead a life of dignity and independence and to participate in social and cultural life**."[3] In addition to this, Article 23 of the European Social Charter is aimed at ensuring that older persons can exercise their right to social protection and "remain full members of society for as long as possible."[4]

## Madrid International Plan of Action on Ageing (MIPAA)

The objective of the Madrid International Plan of Action on Ageing is the **elimination of all forms of neglect, abuse and violence against older persons**. The Plan states that the oldest old (80 years old or more) are the fastest growing group of the older population, and pays particular attention to older women: "older women outnumber older men, increasingly so as age increases. The situation of older women everywhere must be a priority for policy action. Recognizing the differential impact of ageing on women and men is integral to ensuring full

equality between women and men and to the development of effective and efficient measures to address the issue. It is therefore critical to ensure the integration of a gender perspective into all policies, programmes and legislation" (Article 8). The plan also proposes a number of actions to eliminate neglect, abuse and violence against older persons and recognizes the fact that "older women face greater risk of physical and psychological abuse due to discriminatory societal attitudes and the non-realization of the human rights of women."[5]

MIPAA/RIS is the Regional Implementation Strategy for MIPAA for the UNECE Region, which includes European countries. The Strategy was adopted in 2002 in order to take into account the specific demographic and economic situation in the region. It consists of 10 commitments that cover different aspects of population and individual ageing, and the first of these commitments is "to mainstream ageing in all policy fields with the aim of bringing societies and economies into harmony with demographic change to achieve a society for all ages."

Commitment 8 recommends "to mainstream a gender approach in an ageing society". In particular, it states that "addressing the consequences of demographic change from a gender perspective is crucial for improving the situation of older persons, especially older women". This commitment also pronounces that "many women, particularly older women, are still at a disadvantage in the economy and in the labour market. They often receive lower wages, have lower levels of social protection than men, are underrepresented in decision-making positions, and experience barriers to achieve sufficient formal education and adequate vocational training. As a consequence of the traditional gender specific division of work and family responsibilities, they still perform most of the domestic work and are the key providers of care for children and older persons. Moreover, women are more often living in poverty and subject to social exclusion."[6]

Every five years, UNECE countries analyse the state of MIPAA/RIS implementation and propose actions to achieve further progress on this. The Working Group on Ageing facilitates this process by preparing guidelines for country reporting, and the Secretariat synthesizes country reports. According to the 2017 Secretariat's synthesis report, certain barriers to the full inclusion and participation of older persons in society still exist, and it is important to protect their rights in order to prevent all forms of abuse, violence and neglect.[7]

## Recommendation CM/Rec(2014)2

The Recommendation CM/Rec(2014)2 of the Committee of Ministers to Member States on the Promotion of Human Rights of Older Persons was adopted on the 19th of February 2014. It is based on the European Convention on Human Rights and the European Social Charter, and it was the first European instrument that deals specifically with human rights of older persons and recommends action against age-discrimination. The aim of the recommendation is "to **promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all older persons, and to promote respect for their inherent dignity.**" The document includes recommendations for **protection of older persons from violence** and describes best practice examples from several European countries.[8]

## Women's rights perspective on violence against older persons

### Convention on the Elimination of All Forms of Discrimination against Women

Certain international instruments focus specifically on women's rights. On the 18th of December 1979, the Convention on the Elimination of All Forms of Discrimination against Women was adopted by the UN General Assembly. It entered into force as an international treaty on the 3rd

of September 1981 after twenty countries had ratified it. The Convention was the result of the work by the UN Commission on the Status of Women which was established in 1946 to monitor the situation of and promote women's rights.[9]

The implementation of the Convention is monitored by the Committee on the Elimination of Discrimination against Women (CEDAW), which was established in 1979. CEDAW consists of 23 independent experts in women's rights from around the world. Countries that are parties to the treaty are obliged to submit regular reports on the Convention implementation to the Committee. The Committee also issues general recommendations and suggestions to states.[10]

The Convention consists of 30 articles. The 1979 document does not explicitly mention violence against women and girls, but the General Recommendations 12 (1989) and 19 (1992) were adopted to clarify this and pronounced that the Convention does address abuse of women. In 1993, the World Conference on Human Rights recognized violence against women as a human rights violation, and the Declaration on the Elimination of Violence against Women became the first international document that explicitly deals with this issue and provides a framework for analysis of the situation and national and international action. The **Declaration defines violence against women** as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."[11]

In 2010, the UN General Assembly ratified the General Recommendation No. 27 on Older Women and Protection of Their Human Rights. This Recommendation was adopted to address the gap in the Convention on the Elimination of all Forms of Discrimination Against Women since it does not pay attention to the fact **that lifelong gender discrimination together with ageism can lead to abuse of older women**.[12] In addition, the CEDAW was concerned that older women's rights were not systematically addressed in the state reports.[13]

**The Recommendation identifies numerous forms of discrimination that women experience as they age and addresses issues such as gender stereotypes, inequality, violence, neglect and health.** In particular, it states that "while both men and women experience discrimination as they become older, older women experience ageing differently. The impact of gender inequality throughout their lifespan is exacerbated in old age and is often based on deep-rooted cultural and social norms… Many older women face neglect as they are considered no longer active in their productive and reproductive roles and are seen as a burden to their families. Gender stereotyping and traditional and customary practices can have harmful impacts on all areas of the lives of older women, in particular, older women with disabilities."

### Istanbul Convention

The 2011 Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention) is the first instrument in Europe that sets legally binding standards for preventing gender-based violence, protecting victims and punishing perpetrators. It came into force on the 1st of August 2014. The document is based on the understanding that violence against women is a form of gender-based violence and is committed against them because they are women. The states are obliged to address all forms of violence and to take measures to prevent it, protect its victims and prosecute perpetrators.[14]

GREVIO is an independent expert body responsible for monitoring the Istanbul Convention implementation. In particular, it is tasked with preparing and publishing evaluation reports on legislation and other measures taken by participating countries in the field of violence against women. GREVIO can consist of 10 - 15 members, depending on the number of parties to the

Convention, and is formed taking into account gender and geographical balance as well as multidisciplinary expertise in the field. The first meeting of GREVIO was held in September 2015.[15] In addition, many countries have established national bodies to monitor the Istanbul Convention implementation.

## Protecting older women from violence

Below is an overview of international document articles and provisions that aim to promote human rights of older women, in particular to protect them from violence and abuse:[16]

| Year | Instrument | Legally binding | Articles focussed on 'Older Women' |
|---|---|---|---|
| 1948 | United Nations Universal Declaration of Human Rights | No | Article 16, Article 25 |
| 1982 | Vienna Plan of Action | No | Article 45, Article 73, Article 66, Article 89 |
| 1991 | United Nations Principles for Older Persons | No | Resolution No. 46/91 (although this is relevant, the document refers only to 'older people') |
| 2002 | Political Declaration, Madrid Plan of Action | No | Article 6, Article 8 |
| 2010 | Convention for the Elimination of all Forms of Discrimination against Women | No | General Recommendation No. 27 |

## The Open-ended Working Group on Ageing – towards the convention on the rights of older persons

While a number of international documents address the rights of certain groups and protect them from discrimination and violence (Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of Persons with Disabilities and the Convention on the Rights of the Child), **there is no legally binding instrument that would protect older persons from violence, neglect, abuse and discrimination**.[17] Therefore, there has been a call for the development and adoption of an international convention on the rights of older persons in order to establish international obligations in the field.

Such a convention is seen as the most effective way to make sure that all women and men can exercise their human rights in old age, including their right to freedom from all forms of violence and abuse.[18] Such a document will provide guidance on drafting and adopting national laws on protecting older persons and establish a more effective system for monitoring elder abuse situation, at both national and international levels. One step towards its creation was the establishment of the Open-ended Working Group on Ageing (OEWGA) by the UN General Assembly resolution 65/182 on the 21st of December 2010.[19] The OEWGA meets every year and consists of the delegates from various countries and organizations. The group assesses the existing international framework of older people's human rights, identifies gaps in it and suggests ways of addressing them.

(Chapter references)


1 The Universal Declaration of Human Rights 1948, Article 2. http://www.un.org/en/universal-declaration-human-rights/.

2 United Nations Principles for Older Persons. Adopted by General Assembly resolution 46/91 of 16 December 1991. http://wwda.org.au/wp-content/uploads/2013/12/oldpers1.pdf.

3 Charter of Fundamental Rights of the European Union 2000. Chapter III Equality, Article 21 paragraph 1 and article 25. http://www.europarl.europa.eu/charter/pdf/text_en.pdf.

4 European Social Charter, revised 1996. Council of Europe 1996. https://rm.coe.int/168007cf93.

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