Breaking the Taboo - Empowering health and social service professionals to combat violence against older women within families

Breaking the Taboo

Overview of research phase

Italy

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1 Introduction

“Breaking the Taboo” is a project supported by the European Commission within the Daphne II Programme that is focusing on preventive measures to combat violence against children, adolescents and women, furthermore it concentrates on the protection of these victims and groups at risk. The general aim of the project is to raise awareness that violence and abuse against older people, in particular against women in need of care, also happens in family settings. The specific objectives of the project are

- to empower health professionals to combat violence exercised against older women within their families, and
- to develop and define guidelines for social and health professionals to recognise and cope with situations of violence and abuse in families.

Researchers and experts on social and health services from Austria, Finland, Italy and Poland are collaborating in this project that is coordinated by the Austrian Red Cross.

The group responsible for the project development in Italy is emmeerre S.p.A, a consultancy agency accompanying the planning, implementation and evaluation of policies aiming at the improvement of the quality of life, social cohesion and territorial development.

The first phase of the project focused on drafting national reports based on:

- an analysis of existing literature;
- questionnaires; and
- interviews with health and social professionals, who may have collected any already existing material with regard to the topic of the project, knowing their intervention strategies could be of potential support.

The national reports were to investigate on the relevance of “violence against older women in their families”, and on the perception of professionals in relation to the phenomenon.

The questionnaire has been sent to three types of organisations:

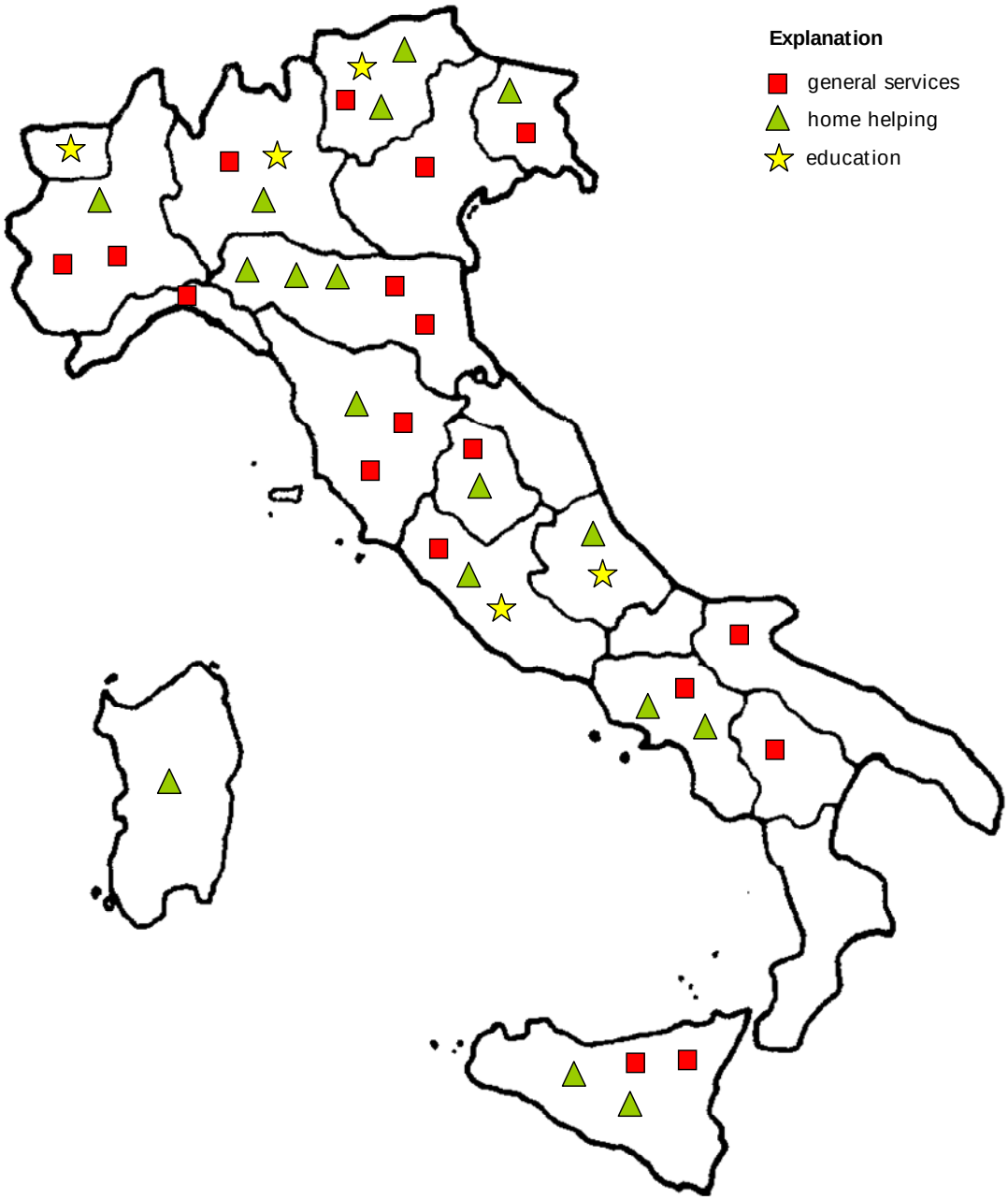
- organisations providing social and health care for older persons in the community
- organisations providing professional education in the field of health and social care
- organisations providing general services for older people

2 Methods

The literature overview was carried out from April until July 2007. The identified literature is composed of scientific journals (48%), books (44%) and conference proceedings (8%).

The questionnaires were sent to more than 100 organisations distributed evenly throughout the country, as depicted in Figure 1:

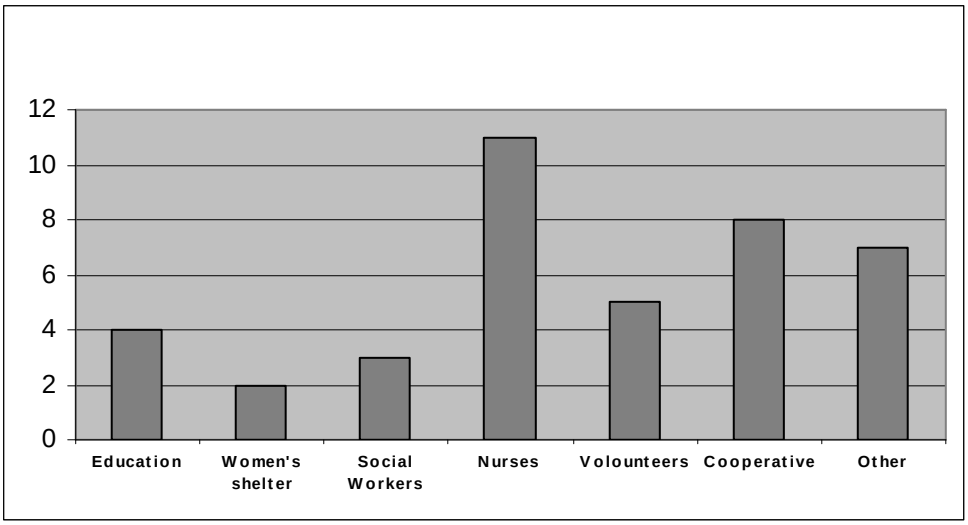
Figure 1 Types of organisations contacted during Phase 1



Most of the organisations were retrieved by means of an internet search or by searching specialised social and health policy databases.

The typology of the organisations that responded is specified in Figure 2.

Figure 2 Type of organisations



Source: Questionnaire.

At the beginning of July 2007, the questionnaire was sent by e-mail to approximately 115 organisations. Until August, the total response rate was exceptionally low: about 4%. In September we therefore made an attempt to resend the questionnaire to these and some additional organisations. This time the response rate – 13% – was slightly higher but far from being satisfactory.

The *questionnaires* were generally sent by e-mail. Only when e-mail addresses of organisations were not available we also used snail mail. Following some reminders by phone, a total of 38 organisations responded to the questionnaire (42 with the organisations providing training programs).

Furthermore, 16 *interviews* were carried out with hands-on staff (10 social workers, 2 home nurses, 4 medical doctors) and 4 with managers of services (1 additional interview was carried out with a union representative; see Annex).

The literature survey was created based on internet research and/or thanks to the suggestions of the interviewed professionals.

Unfortunately, in Italy violence against older people is an underresearched topic. Therefore, most of the references are concerning studies conducted in the UK or the US, where the abuse of older people was first described by G. G. Burston in his article “Granny Bashing”, published in the British Medical Journal in 1975.

3 The general background of violence against older people with a special focus on elderly women

3.1 Definition of used terms: Abuse/Maltreatment/Violence

In 2002 The World Health Organisation published the first "World report on violence and health" with an important part dedicated to violence against older people, that discusses (amongst others) the relation to the different cultural, social and economic facets. In addition it discusses the measures which were undertaken to prevent this kind of violence. The report uses the following definition of violence, worked out by WHO in 1996:

> *"The intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation."*

The main types of abuse against older people are (Barbagallo et al., 2005):

- **domestic** (maltreatment of older people living in their own home or in the caregiver's home)
- **institutional** (maltreatment of older people in residential settings)
- **self inflicted** (self-damaging behaviour)

More specific elements are:

- **perpetration:** intentional violence by family members or the caregiver in general
- **omission:** not being able to provide appropriate care and support for the elderly, which can be further divided into
    - **intentional:** an abusive action accomplished consciously and intentionally
    - **unintentional:** abuse caused by lack of knowledge, ability, effort or resources.
- **carelessness:** negligent treatment
- **maltreatment:** damaging, hurtful treatment

Physical and economic abuse are reported as the most frequent ones. Psychological abuse and negligent behaviour are often not identified as abusive situations, as the feelings and needs of older people are not taken into consideration. Often these abusive situations are not identified due to the lack of knowledge about the ageing process.

Negligence, as a phenomenon, can be unintentional and can derive from ignorance or from the inability to act as a caregiver. For example the caregiver might be unable to bathe, feed and/or dress an older person.

3.2 Forms of violence

On the basis of the literature survey, the abuse against older people is classified in:

- physical
- psychological
- economic

A more accurate classification is provided in the following Table 1.

Table 1 Typologies of abuse and maltreatment

Abuse typology	Modality
Physical	- pain - physical injuries (slaps, burns)
Psychological	- verbal violence - humiliation - intimidation - threats
Economic	- stealing - extortion - anticipated legacies - forced signatures of documents
Medical violence	- encouraging overuse of certain types of medicine, or on the other hand withholding necessary medication - neglecting health problems due to age (ageism).
Civic violence	- arbitrary lack of respect to the older people
For omission	- Lack of daily care, negation of basic necessities (food, health services), omissions.
Sexual	- Sexual exploitation and abuse
Self-inflicted	- Behaviour of older people endangering their own health and safety (refusal to receive help, medicine, food, adequate clothes; conscious or unconscious thoughts of suicide)

Source: NEAIS.

3.3 Prevalence, statistical data

Violence against older people is an increasing problem which is also related to the increasing number of older people (increasing life expectancy), in particular concerning the increase of the “oldest old”, i.e. the population over eighty.

During the second World Assembly on Ageing (Madrid 2002) the UN Secretary General presented a report, the “Abuse of Older Persons: recognising and

responding to abuse of older persons in a global context" examining the abuse of older people around the world. The report was based on about 20 different studies.

The report maintains that abuse is very common, usually not denounced, and with heavy human and economic costs.

It is very difficult to quantify the extent of abuse (physical, psychological, etc.) due to the lack of statistical data. However, the few studies available, attest that between 4-6% of the older population suffers abuse inside their own homes, the perpetrators being family members in 75% of the cases.

Other studies, interviews and newspaper articles highlight the fact that the abuse and economic exploitation of older people is more common than the society is willing to admit.

Unfortunately, organisations such as, for instance, the American NEAIS (National Elder Abuse Incidence Study) which systematically collects and monitors data, do not exist in Italy.

Only in 2006 the Italian National Institute of Statistics (ISTAT) published a survey about the violence against women in general. Deriving from this survey, some information related to violence (only physical and sexual) against older women (until 70 years) can be obtained.

Table 2 Physical or Sexual violence against women experienced during the life-course and during the past 12 months, 2006

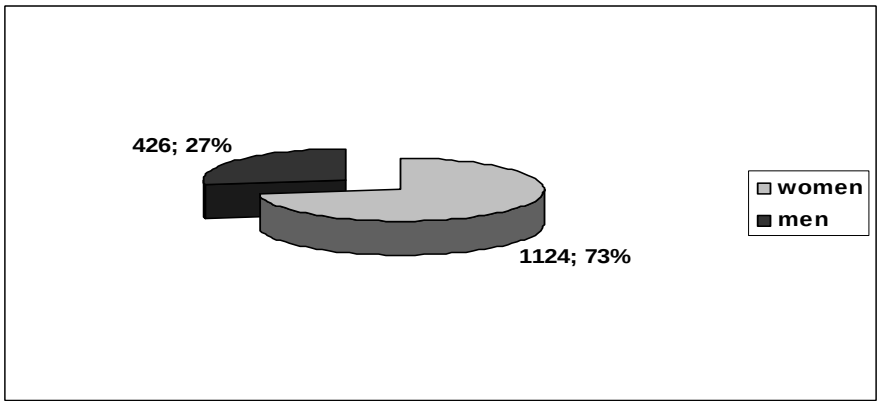
Age	During the life-course	Past 12 months
16-24	33,2	16,3
25-34	37,9	7,9
35-44	35,3	4,2
45-54	32,3	2,8
55-64	26,1	1,8
65-70	**20,0**	**0,8**

Source: ISTAT, 2006.

Some more data are available from the Department of Social Services in two major Italian cities: Rome and Turin. Both municipalities have installed a Counselling Centre – the "Sportello per Anziani Vittime di Reato" (Rome) and "Aiuto Anziani Vittime di Violenza" (Turin) – dedicated specifically to older people and in particular those in need of care (see Figure 3 for some more detailed information).

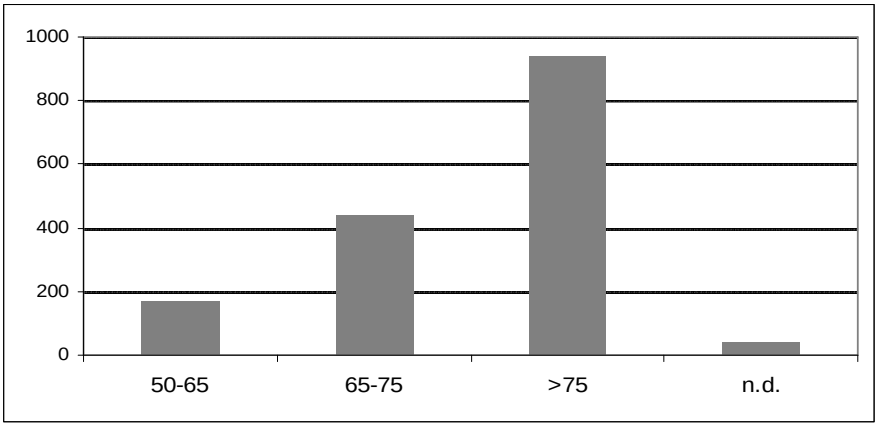
Still, also these data only underline what Molinelli et al (2007: 177) concluded in a recent article: "The cases of maltreatment against older persons which are denounced to the public prosecutor represent most probably a minor part of the real extension of the phenomenon (...)"

Figure 3 Victims of violence, 2007 (aggregate data, Turin and Rome)



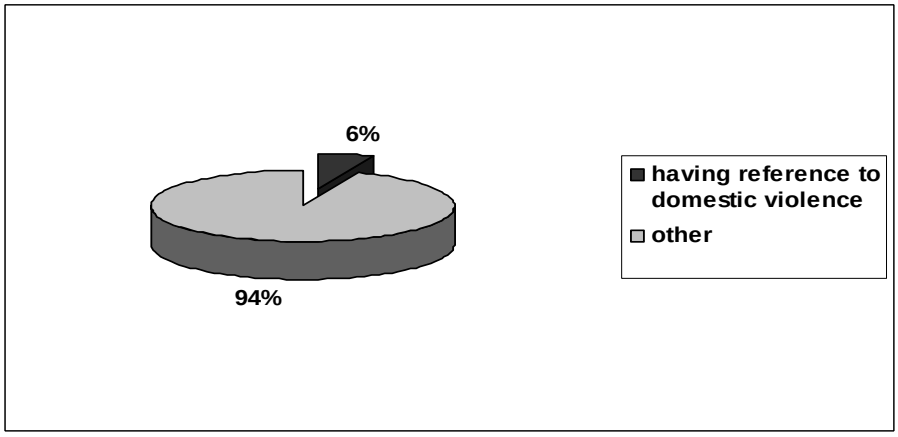
Source: SAVeR (2007), Aiuto Anziani Vittime di Violenza (2007)

Figure 4 Age of victims, 2007 (aggregate data, Turin and Rome)



Source: SAVeR (2007), Aiuto Anziani Vittime di Violenza (2007)

Figure 5 Incidence of domestic violence, 2007 (aggregate data, Turin and Rome)



Source: SAVeR (2007), Aiuto Anziani Vittime di Violenza (2007)

3.4 Cultural and historical background

During the past few years we have witnessed debates on the future of the welfare state all over Europe, in particular in relation to strategies how to adapt to the new economic, cultural and social context.

Changing family structures better living standards and health conditions and other developments have caused an increase especially of very old people with a rising possibility to be subject to severe pathologies and in need of care. The loss of autonomy is asking increasing efforts to provide care to the families, in particular partners and (step) daughters. In this context also social and health services provided by public and or third sector organisations (cooperatives) are growing.

It is important to underline that, in Italy, the ageing process is faster than in other European countries, so that Italy, today, has the “oldest” population in Europe: The ageing of the over-80 cohort is faster than growth of the “younger old”; specially the number of the over-90 years old persons is rising quickly.

The average life expectancy gap between men and women (in Italy men: 76.9 years, women: 82.9 years), is responsible for the fact that women are suffering more often and for longer periods from health problems (men: 19.1 % - women: 24.5 %) and disability: 13.9% of men as against 19.6% of women are living with a disability (Facchini, 2005).

Table 3 Demographic tendencies in Italy (2000-2030), in % of age groups

Age group	2001	2005	2010	2015	2020	2025	2030
>60 yrs	24.1	25.2	27.2	28.9	30.9	34.0	37.4
>65 yrs	18.2	19.6	20.6	22.4	23.9	25.7	28.6
>80 yrs	3.9	4.9	5.7	6.4	7.1	7.5	8.5
Avg Age	40.2	42.2	44.4	46.6	48.7	50.7	52.2

Source: Population division of the department of economic and social affairs of the UN secretariat, world population prospects, the 2000 revision; www.un.org/esa/population/demobase.

At the same time, the changes of the Italian family model should be taken into consideration. The traditional family, composed of two parents and several children has been in crisis since the 1970's, partly due to occupational instability, general uncertainty and the growth of individualism. For these reasons we have to consider, today, a pluralism of family ethics, family models, and the erosion of the traditional family solidarity.

In this context, the ageing process of the Italian population and restructuring on the labour market put increasing pressure on pension and health systems. Paradoxically, piecemeal health reforms are partly increasing the crises, in particular concerning chronic illness and long-term care systems. For instance, the introduction of the DRG (Diagnosis Related Group) financing in hospitals is limiting severely the length of stay in hospitals, in general without any age reference.

As a consequence, (older) patients are discharged from hospital with partly heavy care needs, putting the relatives under pressure to provide care; sometimes in situations, where the older spouse him/herself is suffering from a critical health situation. The Italian welfare state is based on the assumption that the family and its members are responsible to help in difficult situations. Families are thus often forced to provide care which is in many cases overburdening their capacities This concept “passes the buck” to the families and leads to inadequate and unevenly distributed service provision, in particular for older people living alone (Taccani, 2002).

3.5 Public awareness of abuse against older people

Public awareness concerning the problem of abuse against older people is very low. This is reflected also in the lack of respective scientific research. Even organisations providing social and health services are not always completely conscious of the phenomenon of violence against older people, as was noticed through the questionnaires.

Nevertheless there are several initiatives in Italy with the aim to raise awareness. These are still occasional and disconnected from each other. Therefore, the interviewed experts stressed, more effort of public agencies would be necessary.

3.6 Policies against abuse / policy background

The recognition of violence/maltreatment/abuse is, first of all, a cultural feature. New social practices and new legal instruments are lagging behind cultural change. Therefore, it is necessary to create new models, define new instruments, and raise public awareness (Scortegagna, 2007).

To reduce the effects of stereotyping, prejudices and the lack of comprehension of social phenomena, local authorities, media, schools, associations and churches are called to improve the situation.

Media campaigns, educational efforts to increase awareness also at a younger age, conferences / workshops, and the creation of adequate services dedicated to older people are necessary. For instance, the examples of counselling centres in Turin, Genoa and Rome should be followed in other cities.

Concerning legal regulations, in 2004, the Italian Parliament passed Act n.6/2004 which introduced a new protection instrument in the civil code, namely the “amministratore di sostegno” (guidance counsellor; solicitor). This function can be fulfilled by volunteers who are taking over tutorial functions for safeguarding persons in need of care, usually by taking over the administration of property and financial affairs. Health and social services are requested to apply for guidance counsellors when they notice abusive facts against older people.

4 Domestic violence against older people with a special focus on older women

4.1 Context of violence, social and biographical factors

The following model uses a four-level social-ecological model considering the complex interplay between individual, relational, community, and societal factors. The model allows to address the factors that put people at risk for experiencing or perpetrating violence.

Table 4 Determinants of potential abuse in four contexts

Level 1 Individual	Biological and personal factors that influence the older person's growing risk of becoming a victim or perpetrator: - demographic factors (age, education, income) - personality disorders, addictions - experience/participation in violent conduct
Level 2 Relational	Family or proximity relationship: stress and tension in the relation between the potentially abused person and the caregiver are very important risk factors.
Level 3 Community	Settings, such as schools, workplaces, and neighborhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming victims or perpetrators of violence.
Level 4 Societal	Broad societal factors that help create a climate in which violence is encouraged or inhibited. These factors include social and cultural norms. Other large societal factors include the health, economic, educational and social policies that help to maintain economic or social inequalities between groups in society.

Source: Dahlberg & Krug, 2002.

Older persons in need of care are often vulnerable and dependent on daughters/sons, husbands/wives, other relatives, or other carers, and thus also exposed to abuse situations. In particular, if care arrangements become tedious and difficult to manage some caregivers might transform their frustration with unsatisfying and ungratified care activities into violence against the older person.

Victim profile:

Some persons in need of care seem to have a higher risk of being abused than others. Lachs et al. (1997) have identified the following risk factors (predictors) during a US-American research study:

- being a women
- being over 75 years old

- physical disabilities (being bedridden, using a wheelchair) and resulting dependence
- social isolation
- personality disorders
- mental disorders: loss of emotional control, molesting
- depressive syndrome, which can be associated with continuous grievance, ingratitude
- poverty or preoccupation with the economic status of the family

The perpetrators usually can be found in the same family as the victims. According to APS (Agency of Services and Protections – USA) there is an equal distribution of the perpetrator role between men and women (Aravanis et al, 1993). The difference between male and female abuse is in the fact that women usually are responsible for "simple" negligence, while men account for other, more violent forms of abuse, including sexual and economic exploitation.

Table 5 The typology of perpetrators

Type 1	Type 2
Absence of sadistic, criminal and exploitation intentions	Sadistic personality with criminal intentions.
Well-intentioned and skilled caregiver, loosing control when under great stress. Optional: Well-intentioned caregiver but without competences, that perpetrates due to ignorance, incapacity, lack of resources.	Caregivers who intentionally inflict pain. They can also abuse in economic terms.
The perpetrating caregiver answered questions with a defensive attitude, without intimidating the victim.	The perpetrating caregiver faces the official with hostility, trying to avoid contact between him and the victim; situations of intimidation are also a possibility
The perpetrator often feels guilt, or tries to justify his/her behaviour with his own incompetence.	The perpetrator tries to protect himself from the potential consequences of his or her behaviour. He does not feel guilt.
The perpetrator is usually conscious of the damages inflicted.	The perpetrator often firmly negates the accusations and shows hostility and anger.
The perpetrator accepts help, to improve the quality of life of himself/herself and the victim	The perpetrator does not collaborate with the official, considering him/her an intruder or an unwelcome witness.
Ideal intervention: to provide support for the caregivers without commencing legal proceedings.	**Ideal intervention**: to protect the victim commencing legal proceedings.

Source: Ramsey-Klawsnik, 1995 (cit. in Carretta, 2004: 64).

Most of the perpetrators are younger than the victims (65% are under the age of 60), the perpetrators of economic abuse are notably younger: 45% of them are under the age of 40, 40% in the range between the ages of 41-59.

Another division into two groups of perpetrators, based on personality characteristics, was proposed by Ramsey and Klawsnik (1995, see Table 5): the first type are persons without criminal, sadistic or violent intentions. Their harmful behaviour can be related to ignorance, incompetence, the feeling of being overburdened or to the lack of adequate resources. The second type is related to personalities inflicting pain, and other damages intentionally.

4.2 Risks and consequences of violence

Determinants of direct and indirect costs of abuse are listed in Table 6.

Table 6 Determinants of the costs of abuse

Direct costs
- Legal proceedings - Health assistance - Prevention programmes - Research and education
Indirect costs
- Reduced productivity - Less quality life - Emotional distress - mistrust - reduced self-esteem - premature decease
Health, physical, psychological long-term problems
- permanent physical damages - medicine or other substance dependence - crisis of immune system - chronic nutrition disorders and poor nutrition - self-inflicted injuries and negligence - depression - fear and chronic anxiety - suicidal tendencies

Source: Barbagallo et al, 2005.

4.3 Gender Aspects

As previously described, statistical data on the violence towards older people are scarce in Italy. Thus it is even more difficult to assess gender aspects of this phenomenon.

An important aspect to consider is certainly gap in average life expectancy between men and women, as already mentioned above. In Italy men have a life expectancy at birth of 76.9 years, while women may expect 82.9 years of life at birth. With higher age, women also face a higher probability to meet disability (19.6% as against 13.9 % of older men) and health problems (24.5 % as against 19.1% of older men).

Thus it is not a coincidence that both the literature overview and interviews suggest as a typical victim profile a woman over 75 years of age.

5 Perspectives of health and social service professionals with respect to violence against older women within families

5.1 Experience with domestic violence against older women

Based on our 16 interviews with social and health care professionals working in the home of older persons (hands-on staff), we were only partly able to retrieve cases of violence against older women in their family.

First of all, it was difficult to even get in contact with home helpers and home nurses, as provider organisations (managers) did not allow us to interview staff. Secondly, home helpers or home nurses are usually activated by an indication of the GP who seems to be the professional generally capable of noticing and assessing abuse situations. Thirdly, once the public prosecutor is informed, it is usually social workers who carry out the role of a case manager. And finally, the few workers we were able to interview have reported only some rare cases of violence against older women. In three of these cases the following typologies could be observed:

- Physical violence: older women were beaten by their relatives, kept in isolation within the house/apartment, sometimes restricted to their own rooms:

  "I remember the case of an old woman. She, a widow with a strong character, lived isolated in a two rooms flat within her only son's family house. Her problems could be attributed to the son and to the daughter-in-law. I knew the situation when a relative of her addressed me to know how to cope and to limit the unfair behaviour of the son and of the daughter-in-law. I went to the house. I noted the absence of the old woman's name on the doorbell, even though she and her son's family lived in two different parts of the house. The son's wife decided to open, and sometimes she did not. Once even the GP had to climb over the fence. Notwithstanding the situation was degenerating day by day, the old woman did not have the courage to deplore the son. She suffered

a lot of maltreatments. For example the TV power cable had been cut – and you know how important the TV is for an older person – the neighbours and the relatives were not allowed to visit her." (AS10)

"The old woman was bedridden and abandoned. The sheets full of feces. It was quite shocking. When the poor woman went to the hospital, the doctors denounced the fact to the police as the law prescribes." (AS2)

- Economic abuse: keeping older women at home makes it easier for other family members to exploit them financially by confiscating their whole pension.

  "I remember a situation where this old woman was kept at home only for her pension. The son and his wife were unemployed. When one of them got an occupation they literally abandoned the woman in front of the hospital and then they left. Now the woman lives in an old-age home." (AS3)

- Psychological abuse:

  "The old woman in question lived with her only granddaughter. She was a former drug addict. She prostituted herself in the grandmother's house. The old woman felt terrified by the situation, due to the fact that every night a lot of unknown men would appear in the house. The psychological stress was enormous: the old woman was worried about her safety as well as about the safety of the daughter. After a long period she contacted the social services of the municipality and now we assist both of them." (AS8)

- Sometimes the typologies of abuse are mixed:

  "An 84 year old woman lives together with the son, widowed since the last year. Until the painful death of the daughter-in-law, her life had been calm and the familiar relationship, too. Due to that event the son started to drink heavily and became an obsessive gambler. For this fact he started to force his mother for give him money. In a polite way at first and then more and more violently. Every night he came back home drunk and used to beat his mother. The older woman suffered physical violence as well as psychological violence. That's why she realized that the patrimony earned by hard work was going to be squandered. The old woman, with the help of the social services, eventually denounced the son at the local police station." (AS 9)

Abuse against older people has to be considered as a complex health and social problem with several aspects. The typologies of perpetrators and victims are as ample as the causes and the consequences. Therefore it is even more problematic that the very health and social services organisations and their staff working with older people are not conscious enough of the phenomenon of abuse against older people. Sometimes this is due to the fact that health and social professionals are just at the beginning of their career, without adequate training. Another explanation might also be that hands-on workers do not suspect that such problems could apply to their patients, or assign the symptoms of abuse to other causes.

In some cases, sexual abuse might not be taken into account with reference to older people due to traditional prejudices. Often service providers tend to identify only those forms of violence in which they are already experienced.

Symptoms of abuse or maltreatment can often be confused with other chronic pathologies or problems. For example, burns, injuries and fractures can be consequences of abuse but might also be a fall due to household accidents or falls. (Carretta, 2002)

> *"In theory many symptoms may occur. Theoretically all of them can be discussed with reference to an abuse situation. The biggest problem is the lack of time. We would need more time to understand and to 'investigate' the real situation. I am convinced that making a comparison with other colleagues' experiences is absolutely useful. Especially when we meet and discuss about the single cases." (INF1)*

Furthermore, social isolation of the victims usually is not being recognised as social services or other external persons do not even know the victim.

A specific situation is given if a hands-on worker of social and health services has recognised maltreatment and shared his/her impression with the victim but the victim denies the abuse, especially if the perpetrator is a relative, or if the victim is scared of a potential revenge of the abuser. Other victims might even consider the abuse as normal for their age.

> *"The son of a woman was an obsessive gambler. He took away the money of the woman's pension but she didn't want to denounce the fact to the authorities."* (AS3)

5.2 Recognising domestic violence against older women

The identification of violence is a crucial moment for any intervention due to the difficult relationship between the hands-on worker, the victim and his/her perpetrator, the family member(s). Only in a few cases it is unmistakably evident:

> *"When we arrived, the old woman lay on her bed. We saw a chilling scene: the room was full of garbage, the floor was filthy. You can image the sheets, the pillow ... The woman was famished and absolutely dehydrated. The bedsores were very severe, similar to holes… While we were visiting the old woman, the relatives were absolutely indifferent as if the situation was absolutely normal. We carried her to the hospital. She has been immediately hospitalized. The attending physician promptly denounced the fact to the police officer of the hospital." (INF2)*

In many cases intra-family violence is considered a private family affair; and women sometimes perceive violence as a "normal" behaviour of their husband or son, as part of their biography or family history.

From the literature review there emerged a number of additional obstacles that prevent the recognition of violence by staff members (Carretta, 2002)

- They might not have enough knowledge about the diffusion and gravity of the phenomenon
- They do not have sufficient methods/tools to identify abuse
- They might not consider the problem as pertinent to their profession
- They might not feel able to provide adequate help
- They do not have enough time to verify the presence of violence
- They have experienced difficulties in similar previous cases
- They might fear the time consuming activation of penal and civil justice systems.

Based on interviews with doctors and other medical staff (Carretta, 2002) provided a list of abuse indicators that could be helpful for the development of guidelines (Table 7)

Table 7 Potential indicators of abuse and negligence

Indicators of physical abuse
• scratches, bites, contusions, burns • bone fractures, absence of glasses, partial dentures, acoustic prosthesis (being withheld by the perpetrator) • black eyes or broken teeth, ripped hair • wounds on face, neck, chest • retarded medical treatments • cancelled appointments for medical examinations • refusal to undress (for a medical examination, or bath) not wanting to expose a violated body
Indicators of physical negligence
• poor nutrition signs (weight loss, asthenia, sleepiness) • dehydration signs • poor hygiene (dirty clothes, damaged teeth, black nails, dirty bed sheets) • bedsores • diarrhoea • pharmaceutical overdose • contracture of muscles due to not enough physical activity
Indicators of psychological abuse
• insomnia • changes in appetite • sadness evolving into depression • paranoia; fear of strangers • confusion and lack of orientation • anxiety • apathy
Indicators of psychological negligence
• lack of involvement in the decisional processes • physical and/or social isolation • low self-esteem • nervousness

Indicator of economic abuse
• sudden impossibility to pay bills, • mismatch between economic faculties and life conditions • a sudden decrease in a bank account • cheques signed by unauthorized persons
Indicators of economic negligence
• food scarcity at home • absence of prescribed medicine • accumulation of bills and not cashed cheques
Environmental indicators of abuse
• lack of electricity, heating, running water • presence of expired medicine, unidentifiable or prescribed by several GP • lack of minimal hygienic conditions or lack of food

Source: Carretta, 2002.

Also GPs could apply the above indicators. However, the American Medical Association has proposed a protocol concerning the recognition of abuse during medical visits, which has been reported in Italian literature (Barbagallo et al, 2005).

Prevention and Diagnosis

The GP plays a very important role in prevention and diagnosis. Hands-on workers reported that, if signs are only subtle or difficult to be noticed, they would depend on the GP's expertise:

> *"If the medical doctor had not indicated it [the abuse, n.o.a.] to me, I wouldn't have noticed. Certainly, small signs are difficult to recognise: this needs preparation ... and time!"* (AS5)

Prevention with a focus on abuse and maltreatment should be accomplished by:

- taking account of the clinical history
- clinical evaluation
- assessment of the relationship inside the family
- assessment of the social and domestic situation
- an analysis of existing risk factors (for example caregiver stress).

Physical examination

The GP has to be able to recognise the seriousness of the violence distinguishing between different stages of abuse. At the same time the GP has to consider the likelihood of severe carelessness despite the presence of adequate resources. An accurate physical examination is certainly essential. The GP has to examine the whole body, in particular by trying to localise and count the number of skin lesions, and the seriousness of inflicted wounds.

Legal aspects

According to Capo II art. 29 of the deontological code the General practitioner must contribute to protect older patients especially when the environment is not healthy, or site of maltreatments, violence or sexual abuse".

In case of recognition of maltreatment or abuse, the general practitioner is obliged, ethically and legally, to contact the public prosecutor.

In Italy the abuse against older people is not approached adequately by law. It is included within "offence against the person" as offence against family assistance (art 571-572 Penal Code) which stipulates imprisonment from 6 months to 20 years (Molinelli et al, 2007).

For getting a procedure on its way is necessary to register a complete case history, including testimonies of victims, pictures of lesions, etc.

If the abuse is confirmed, the GP must protect the older person's safety. The GP has also to respect the older person's sovereignty, taking the victim's cognitive capacities into account.

Victim interviews

Interviews with victims, according to AMA protocol, should be conducted without family members or relatives. The interview could start with general inquiries on home safety such as: "Do you feel safe at your home?"

This could be followed by questions related to the caregiver: "Who prepares your food? Who handles the money?" (Lachs, 1995, cit. in: Barbagallo et al, 2005)

More precise screening questions could ensue: (Aravanis, 1993, cit. in: Barbagallo et al., 2005):

- Did somebody inflict you lesions at your own home?
- Does anyone ever touch you without your agreement?
- Does anyone ever touch you in a way that bothers you?
- Are you obliged to perform in a certain way at home?
- How does your daily routine look?
- Does anybody take your things without permission?
- How do you pay your bills/ How do you receive money every month?
- Do you receive any types of punishment and/or are you ever reprimanded?
- Did you never sign documents without knowing the use of them?
- Are you scared of somebody at your own home/ Does anybody make you feel uneasy?
- How often are you alone at one stretch?
- Did somebody refuse to help you when you were in need of something?

- Do you take your own medication or does somebody supply you with it?

The GP should also evaluate the work load of the caregiver, in order to obtain a more precise clinical picture and to identify specific factors, for example behavioural disturbances related to a syndrome of dementia,. Actually these kinds of pathologies can increase the stress of the caregiver (Scortegagna, 2002).

If the assumption about the abuse turns out to be true, obtaining information from relatives, neighbours, nurses and other people from the immediate surroundings of the victim can be very useful. Ideally, a visit to the home of the victim should be included.

Treatment

Following a positive assessment of abuse, there are two fundamental aspects to be considered:

- Does the older person accept or the GPs intervention or not?
- Is the older person able to accept the intervention or not?

The treatment options, *if the older person accepts the intervention*, are (Lachs, 1995, cit. in: Barbagallo et al, 2005):

- If the older person is in immediate danger: introduction of a safety plan (for example transfer to a safe location, legal protective act, hospitalisation).
- Attention should be given to the causes of maltreatment (rehabilitation should be provided if the perpetrator is addicted to alcohol or other psychotropic substances; respite services should be stipulated for exhausted caregivers).
- social services available and ready to help should be made aware to support both the victim and the perpetrator.

If the patient is able to understand but refuses the intervention, the GP has the following options:

- To inform the older person about:
    - other incidences of maltreatment against older people
    - the consequences of further maltreatment
    - the rights of the patient
- To inform about emergency phone numbers
- To develop a safety plan
- To plan follow-up actions

The GP must take into consideration the opportunity to contact the judiciary authority if the older person cannot decide about the intervention.

5.3 Coping strategies

As violence against older people and especially against older women is not a well-known or acknowledged phenomenon health and social care workers need guidelines to distinguish the individuals in danger and those who are already suffering abuse.

> *"I think that I'm not able to recognise the signs of a potential abuse or mal treatment in an older person."* (AS1)

The most adequate intervention is certainly an early prevention of abuse which can be achieved by:

- Promoting an active education about ageing
- Avoiding discriminatory social and cultural behaviour against older people
- Evaluating the real situation of the family, it's ability to provide appropriate care
- Promoting a culture of solidarity

The lack of training emerged during the interviews with hands-on operators. Very often they feel that they are not able to recognise the indicators of abuse and to act accordingly. Furthermore, once they suspect situations of abuse, they are afraid to take action as they have the impression that they can only worsen the delicate situation. Adequate training is thus certainly an important instrument for these professionals to overcome their discomfort with this problem.

Frequently asked questions that were reported by hands-on staff:

- If I suspect my patient is victim of abuse. What can I do?
- If I believe my patient is a victim of violence, to whom can I turn to/to whom do I report this violence first?
- If my patient is a victim of abuse, which possibilities does he/she have to defend himself/herself?

A training for hands-on staffs should satisfy the following general objectives (Carretta, 2002: 71):

- To learn to recognise the typical ageing characteristics in order to distinguish other pathologies
- To learn to use specific methods in order to evaluate the physical, functional, and mental status, above all when older people are totally dependent on others.
- Informing both older people and public opinion about the growth of violence against elderly people, encouraging the media to speak about it.
- To know about laws and the denunciation proceedings.
- To support and help the family caregiver .

Table 8 The intervention cycle: From prevention to implementation

LEVEL I **Prevention strategies**
• Education initiatives to sensitize public opinion • Training programmes • Magazine/newspaper articles, advertisements • Hotlines, making aware of such possibilities • Self-defence training • Legal measures • Direct assistance to families
LEVEL II **Immediate effects of maltreatment - Identification and treatment strategies**
• reporting the maltreatment to the authorities • providing appropriate documentation • penalty measures for the perpetrator
LEVEL III **Strategies to implement after the abuse**
• physiotherapy, occupational therapy • provision of requested aids • assistance in daily activities • socialization activities: daily programmes • counselling and psychotherapy • individual counselling (victim and perpetrator) • family counselling • evaluating the admission in a old people's home (a retirement home)

Source: Carretta, 2002.

General indications

Some Italian organisations, for example "Anti Violence Against Women Centres", provide guidelines to their staff, with some issues that are valid especially for older women. One of these specialised centres, the *Casa delle donne per non subire violenza* in Bologna recommends the following general guidelines (Gruppo di lavoro, 1999):

- Communicate directly with the older woman, if possible, and pay attention to every signal indicating violence.
- First of all, respect the woman and her rights.
- Investigate with attention the causes of illness or physical lesions: it is easy to make a mistake relating a problem to other causes.

- If you suspect that the older woman is scared by her caregiver, try to speak with her alone.
- Clarify immediately that she (the woman) is not responsible for the violence and there are different solutions, not only moving away from the caregiver.
- Assure that the older person has the opportunity to make his/her decisions independently or that she/he has the opportunity to participate in support-groups.
- Assure that the caregiver has the necessary support and the opportunity to participate in support-groups.

5.4 Further support/ strategies needed

Given the above mentioned difficulties to recognise situations of abuse, and the fact that adequate training is lacking, the following strategies should be developed:

- An education package on elder abuse for the training of primary health care and social care professionals.
- A European/global inventory of good practice for the prevention of abuse and maltreatment, in particular concerning older women in need of care.
- Following the above mentioned protocol for GPs, all GPs should introduce some specific screening questions when visiting older patients.

6 Perspectives of organisations with respect to violence against older women within families

6.1 Experience with domestic violence against older women

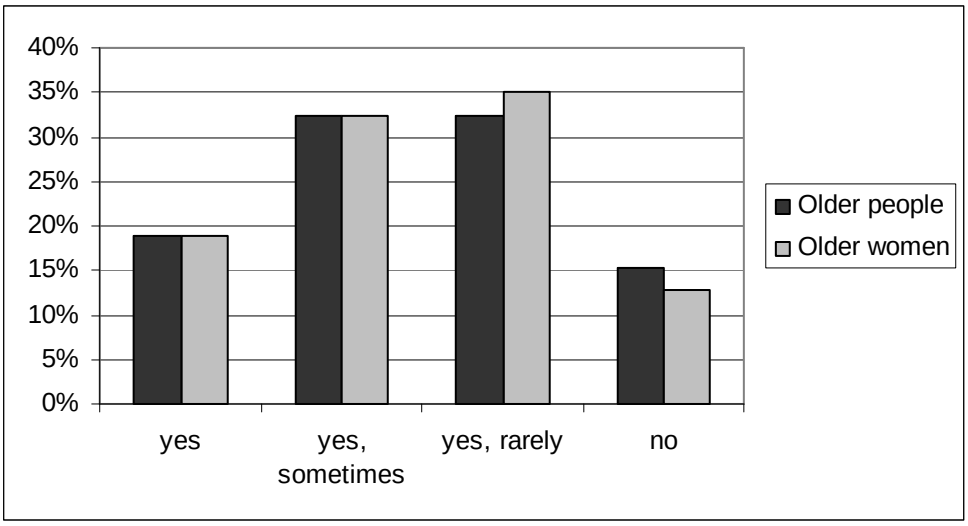
Only a few of the interviewed organisations have experience with the topic of domestic violence and abuse of older people in the family (Figure 6). A typical case concerns older women living alone or with adult sons/daughters who suffer from some sort of physical or mental illness.

A further possibility is living with adult sons/daughters without an occupation. Or possibly also living with divorced sons/daughters:

> *"The older women suffer from abuse because of these factors. The sons or daughters steal their money, beat them, make verbal insults. The older women have a great disease, they lose their autonomy, their safety. They get depressed…"* (SG1)

> *"The older woman becomes like an hostage. She is morally and emotionally blackmailed by sons, daughters, grandchildren …"* (SG1)

Figure 6 Does violence against older people/women pose a challenge to the work done by your organisation?



Source: Questionnaire (Question n°1); N=38.

The reported experiences related to violence against elderly women within the families are not so numerous but a lot of "hidden" violence behind the doors of older person's households can be assumed as pointed out:

> *"…this is a submerged phenomenon. We need to know more about it. Serious research would be useful, research that would make it possible to understand this phenomenon … to recognise the signs of elderly abuse and to translate the signs into indicators."* (SG2)

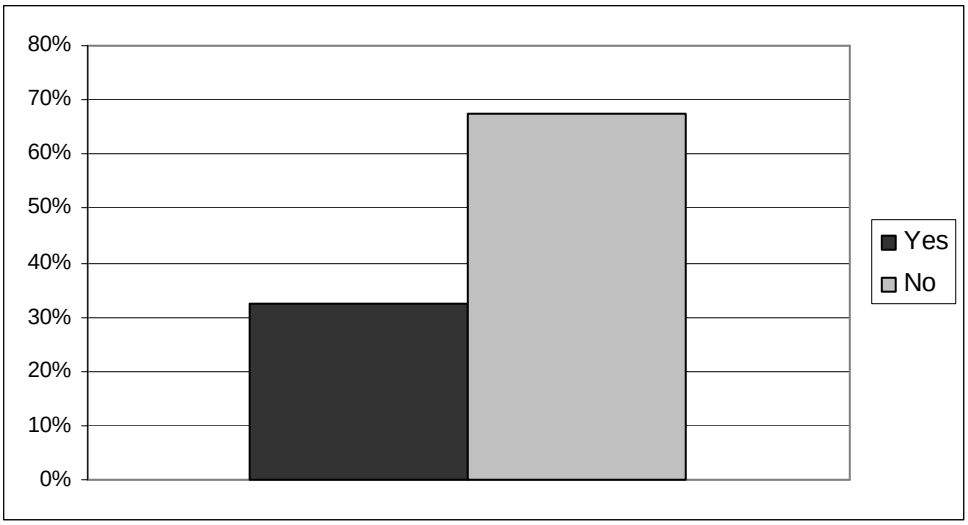
> *"…There is lack of data because most of the violence occurs within families. Moreover we have to consider that our culture ignores the older people's values. The older people are disrespected just because they are over a certain age."* (SG3)

A blunt sum up concerning violence against older women is that we live in a violent context, in a violent society, in which violence is particularly directed against the weakest people.

> *"The maltreatments against older people are many, with different kinds of manifestations. We need to develop a certain type of sensitivity towards this phenomenon."* (SG4)

> *A supplementary problem is that "… there is a tendency to hidden violence. Additionally, there is also violence which does not get recognised as violence. This is a very worrying cultural occurrence."* (SG5)

Figure 7 Has your organisation developed a policy for promoting the prevention of violence/abuse/maltreatment of older people?

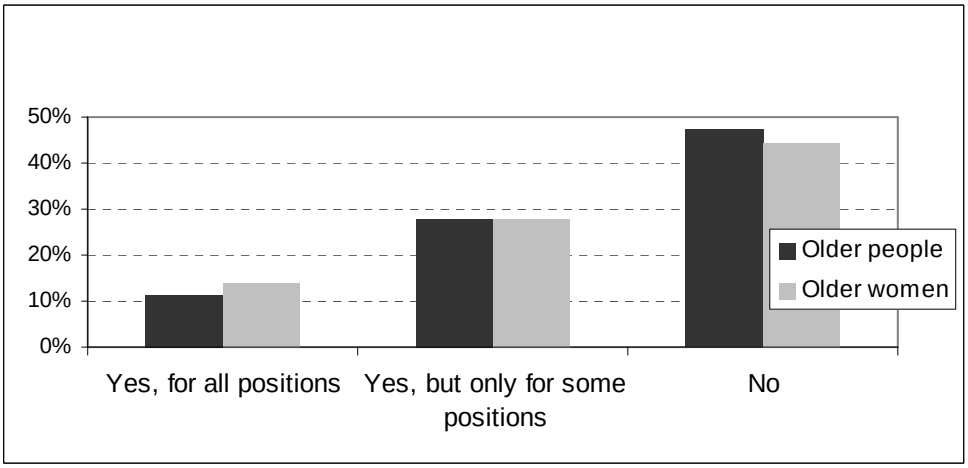


Source: Questionnaire (Question n°4); N=38.

6.2 Recognising domestic violence against older women

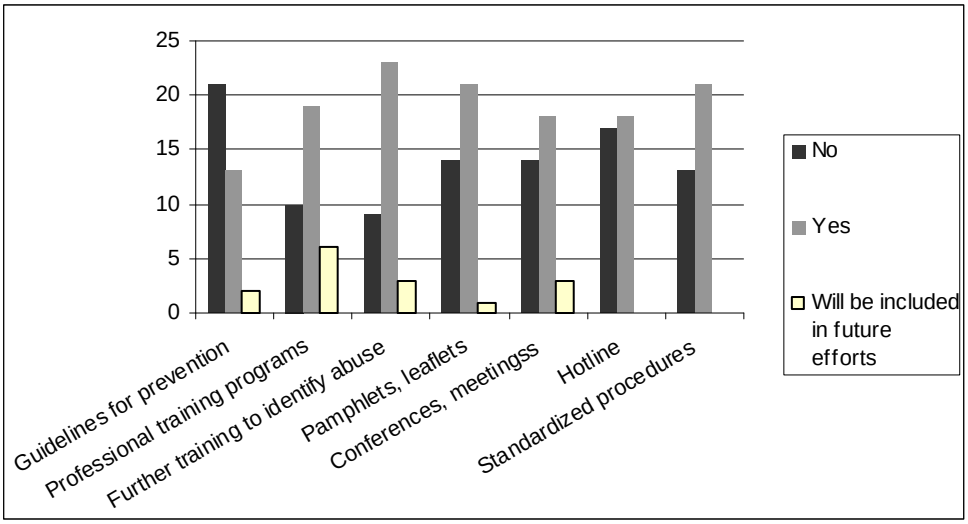
We noticed that 50% of the organisations that responded do not consider the capacity to cope with situations of abuse against older victims as a requisition for getting employed in health and social services (Fig. 8). However, cooperatives providing services tend to offer specific training for personnel, while associations (working with volunteers) trust in the experience of field-work made by volunteers (Fig. 9).

Figure 8 Is being trained for how to deal with abusive situations a requirement for gaining employment in your organisation?



Source: Questionnaire (Question n°2); N=38.

Figure 9 With respect to abusive situations in general which measures does your organisation provide?

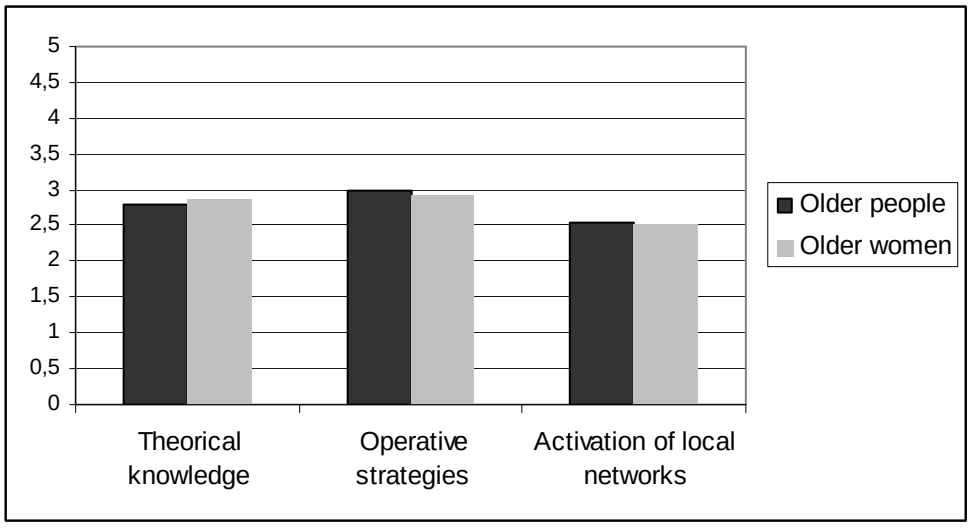


Source: Questionnaire (Question n°6); N=38.

6.3 Organisational coping strategies

According to the questionnaire, responding organisations do, on average, not feel too well prepared to deal with abuse and maltreatment (Figure 10). However, the organisational coping strategies obviously differ according to the type of service

Figure 10 In your opinion the organisation is adequately prepared to deal with abuse/violence/maltreatment?



Source: Questionnaire (Question n°7); N=38.

Anti-Violence Centres (CAV) usually proceed as follows:

- assessment of the seriousness of the problem,

- legal consultancy
- psychological support
- possible admittance to a women's shelter.
- When the situation becomes intolerable the CAV provides hospitality at a women's shelter with a secret address.

The CAV procedures do not change irrespective of the victim of violence being an older or younger woman, sometimes with positive results of intergenerational exchange:

> *"The older woman becomes a reference for who is living in the women's shelter. She is a reference also for the other younger women's children living in the women's shelter."* (SG6)

However, as older women generally suffer physical, psychological and economic abuse, rather than sexual violence, it is sometimes difficult to help older women adequately. Also the typology of the perpetrator often varies.

> *"… generally the coping strategy is related to the woman's history. However a specific procedure for older women doesn't exist."* (SG6)

> *"…an older woman has been beaten by her husband. She has been followed as she was a younger woman. At the end she had the same reaction of a younger woman. She had the same sense of liberation. She found a new life style, even if she was 70 years old."* (SG6)

SAVeR does not differentiate by gender when activating its services:

> *"… We don't apply a differentiation by gender. The procedure is exactly the same."* (SG7)

Also other organisations offer a range of similar and additional services for older people in general. No specific services for older women have been retrieved. The range of services includes the following activities:

- training courses for instance on the prevention of fraud (e.g. ACLI Trentino, Municipality of Orvieto)
- hotlines for first aid psychological support (e.g. TAM Friuli, SOS Anziani Pistoia)
- legal counselling, support and follow-up (e.g. Sportello "Offese da Reato", SOS Anziani Prato)
- short term accommodation (e.g. Municipality of Prato)
- the SOS anziani of the Municipality Prato (Tuscany) is currently setting up a shared procedure between different institutions such as the Province, the municipal department for social affairs, the local health agency, the public prosecutor's office, the police and the anti-violence center
- protected transport (e.g. Croce Giallo Azzurra – Turin)

6.4 Further support/strategies needed

Most interview partners stated that the phenomenon of violence against older people in families is still not acknowledged at all, and still a lot needs to be done to make the problems known to a broader public:

> *"I have this feeling. We are considering only the top of an iceberg. The public opinion doesn't have the adequate sensitivity to understand the importance of the phenomenon, the gravity of the phenomenon."* (SG7)

More information on the phenomenon is needed but also statistical data to support the "rumours":

> *"…first of all we don't have the access to statistical data about the consistency of the phenomenon. Some years ago I organized a workshop about this theme. I invited the subjects supposed to give information on elderly abuse. Police officials, GP, researchers…nobody was able to estimate the phenomenon."* (SG3)

Most of interviewed denounced the lack of material resources.

> *"It is very difficult to find locations where we can work in."* (SG3)

> *"We need screwdrivers and pincers! We need tools for those who are ready to give help."* (SG3)

An additional problem is the lack of trained personnel who would be able to provide support:

> *"Somebody able to manage the conflict. The violence usually stays behind a social conflict. Behind a disrupted social context. We need professionals able to activate a mediation. Able to analyze the social context. We need a lot of competences, impossible to embody in a single professional."* (SG3)

The institution of inadequate services is real:

> *"If for example, we install a hotline to collect the older people denounces and then we are not able to give appropriate answers … it would be completely inadequate. First of all we must be able to give answers. Then we can think how it is possible to help the persons."* (SG3)

From the questionnaires the perception of missing services targeted towards older women is nevertheless expressed by some organisations. The following proposals were made:

- more public awareness and information (e.g. TAM Friuli)
- more specific training (e.g. SOS Anziani Municipality of Pistoia, Municipality of Orvieto)
- more prevention (e.g. Croce Giallo Azzurra – Turin)
- sheltered housing (e.g. Sportello "Offese da Reato" Gruppo Abele)

- full implementation of mutually agreed procedures between institutions (SOS Anziani – Municipality of Prato – Tuscany)
- home help
- more resources (budget, staff)
- more collaboration of GPs and public institutions (e.g. Anti-Violence Centres)

7 Conclusions: Strategies for professionals to deal with domestic violence against older women

The aim of this report was to investigate on existing material, literature and initiatives in practice that deal with a phenomenon which has been widely neglected until now. Though a wide range of organisations and professionals could be retrieved that are potentially confronted with domestic violence against older women, it could be shown that even in this context there is a lack of preparedness for tackling the consequences of domestic violence and sometimes even of awareness concerning the phenomenon as such. The negligence of abuse of older people even by professionals and the fact that many prefer to close their eyes when confronted with doubts or suspicions is yet another facet of abuse.

Still, it is extremely difficult to make strong statements concerning the scope and the impact of domestic violence against older women – and the coping strategies of staff – due to lack of research and empirical data concerning this topic. Therefore this project's objectives are so important: to raise awareness and to initiate changing attitudes and actions in this field.

Undoubtedly, there are many different levels of violence that, however, very often remain unnoticed. As older people cannot protect themselves any more as they are in need of care, even if professionals start to intervene in abusive situations they are often confronted with the fact that adequate remedies are missing. The same is true for structures to prevent and identify violence against older people living at home. An additional problem that arose from our research is certainly the fact that, with perpetrators being their own relatives, victims are often reluctant to actively fight for their rights due to a traditional concept of family loyalty and/or the fact that the overburdening situation of family care is brought into play to defend the perpetrator.

In our patriarchal society women are still generally subject to many kinds of oppression, which puts older women even more at risk of becoming a victim of violence than her male counterparts. However, the type of abuse with which young and old women are confronted is very different. Our point is not to classify the seriousness of the different kinds of abuse but to draw attention to the fact that the existing organisations for supporting women are not always adequate for the kind of help older women are seeking. Most of the now existing "shelters for women" do not have appropriately trained professionals to deal with these types of abuse, also due to lack of gerontological knowledge.

Before designing strategies against abuse of older women, it is worthwhile to take into account the political, economic and cultural framework in which abuse and maltreatment is taking place individually and structurally.

It is certainly necessary to raise awareness and to train personnel but in a violent society, in particular against the slow, the weak and the excluded, it is difficult to find easy remedies. For instance, the provision of a counselling centre or a hot-line for victims is definitely a first step but: What if no adequate help can be provided, once victims have overcome their doubts and expressed their suffering?

The same is true for the creation of a network to connect organisations/associations that are already dealing with these issues at present. Such a network could help to solve doubts and uncertainties of staff and management – but again it would need to provide adequate support structures for the victims who will then be recognised in much larger numbers than today.

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Annexe List of interviewed persons

Nr.	Code	Profession – Place (Italian)	Profession – Place (English)
1	AS1	Assistente Sociale - Stienta	Social Worker – Stienta
2	AS2	Assistente Sociale – La Spezia	Social Worker – La Spezia
3	AS3	Assistente Sociale - Venezia	Social Worker - Venice
4	AS4	Assistente Sociale - Venezia	Social Worker - Venice
5	AS5	Assitente Sociale – Rovigo	Social Worker – Rovigo
6	AS6	Assistente Sociale - Mestre	Social Worker – Mestre/Venice
7	AS7	Volontaria Cooperativa Sociale - Milano	Voluntary Worker – Social Cooperative – Milan
8	AS8	Assistente Sociale - Treviso	Social Worker – Treviso
9	AS9	Assistente Sociale - Venezia	Social Worker – Venice
10	AS10	Assistente Sociale - Treviso	Social Worker – Treviso
11	SG1	Responsabile Sportello Tutela Anziani - Roma	Manager Support Centre for Older People – Rome
12	SG2	Responsabilè Ufficio terza età sicura - Genova	Manager, Office “Third Age in Security” – Genua
13	SG3	Responsabile SAVeR - Roma	Manager, SAVeR – Rome
14	SG4	Responsabile Centro Anti Violenza - Venezia	Manager “Anti-violence Centre” – Venice
15	SG5	Funzionario Sindacato CGIL	Union Representative, CGIL
16	SG6	Medico Ginecologo - Vicenza	Ginecologist – Vicenza
17	SG7	Medico Legale - Padova	Legal Doctor – Padua
18	SG8	Medico di base - Treviso	General Practitioner – Treviso
19	SG9	Medico Geriatra - Palermo	Geriatrist – Palermo
20	INF1	Infermiera – Padova	Home nurse – Padua
21	INF2	Infermiera - Treviso	Home nurse – Treviso