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

Breaking the Taboo

Overview of research phase - Poland

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November 2007

This project has been funded with support from the European Commission. This report reflects the views only of the author, and the Commission cannot be held responsible for any use which may be made of the information.

1 Introduction

Abuse can be viewed from a variety of perspectives, such as a social pathology, deviance, or as a result of societal disorganization following transformation processes.

“Breaking the Taboo” deals with a number of important problems. In order to improve the quality of life of an aging Polish population, action must be taken to intervene in any social pathology affecting older people. Certain areas connected with older age, including violence directed against older people, require more in-depth investigation, especially considering that this is a rather neglected field, even by gerontology researchers.

Violence directed against older people is a taboo topic in Poland. Not until recently has this issue entered into social consciousness and begun to be discussed along with such other topics as domestic violence and violence directed against children and women. Also, professionals caring for older people have not added much weight to this issue. There exists a lack of studies and publications examining violence directed against older people in general and against older women in particular. Health professionals do not possess the necessary tools which may allow for and/or streamline intervening in situations suspect for violence, beginning from identifying these situations, standardized intervention procedures, and finally preventing future incidence of family-based abuse directed against older people.

In the current model of family life, caring for older people is chiefly the responsibility of family members. This has lead to difficulty in identifying situations suspect for abuse against older people. Certain segments of the older population are isolated and marginalized. Very often, contact between older people and health-care workers takes place at the behest, or only in the presence of, family members. Older people are often not conscious of the fact that they are victims of abuse. The situation of older people in medical and long-term care facilities also constitutes a taboo topic.

Social workers who professionally look after older people possess the necessary tools to combat violence. However, these tools are not adapted to the needs of particular age groups. The need exists for developing a set of tools which may help identify and intervene in cases of domestic violence, incorporating the

characteristics of different victim groups. Currently, any such tools are usually applied only in two age groups—children/adolescents and adults—treating younger individuals and individuals in advanced age identically.

2 Methods

A literature review examining violence and violence in the family was completed as part of this program. Through the National Library, Polish books from 1976, publications in Polish magazines/journals from 1996, and Polish articles in newspapers and periodicals from 1996 were analyzed. International databases, such as Academic Search Premier, Science Direct, Springer Link, Google, and Google Scholar, were also included in this review. Variations on the following search terms were used: violence, violence in the family, older people, maltreatment, and, in the case of international publications, Poland. There were 108 entries included in this analysis, mainly from books dealing with the general issue of violence.

Next, a survey questionnaire was sent out to groups affiliated with the "Blue Line", a National Polish Center for People, Organizations, and Institutions Helping Victims of Abuse. Organizations dealing with education, help, and/or caring for older people were also included in the survey questionnaire. Contact information was acquired from the Blue Line database, which coordinates The Polish Nationwide Emergency for Victims of Domestic Violence (accessed online: http://www.porozumienie.niebieskalinia.pl/index.php?option=com_instytucje&Itemid=40) as well as from individual organizations and NGOs (accessed online: http://bazy.ngo.pl). Using e-mail, 420 questionnaires were posted along with information concerning this project. Contact information was also included, allowing participants the chance to acquire more information. Select participants were recruited for more in-depth interviews at a conference dealing with violence directed against older people (held in Białystok, Poland, 2007) and, using the snow-ball method, from a group of medical and social work professionals acquainted with this program. The number of interviews conducted with proffesionals is 19.

3 General background on violence against older people with a special focus on older women

3.1 Definition of used terms: Abuse/Maltreatment/Violence

Polish literature lacks a uniform terminology relating to abuse. The most widely described concept deals with maltreatment, signifying all forms of cruel, inhuman, or degrading forms of treatment or punishment, including corporal punishment, violating the physical or psychological integrity of the individual (Council of Europe Document nr. 7369/01 COR 3, 2005). Maltreatment also includes neglect and physical and moral abuse.

Violence is discussed in a Polish social context more in terms of aggression, which reflects all forms of behavior, the goal of which is to harm or inflict damage (Krahe, 2005). According to frustration theory, the inability to achieve a goal leads to frustration, which, through emotional stress, is the source of aggression. The concept of violence arises from aggression theory and is conceptualized in its destructive form. A number of researchers use the terms “violence” and “aggression” interchangeably. However, as the goal of aggression and violence is to, respectively, injure and influence the individual, these terms are not identical. Cultural norms concerning family life also significantly influence the problem of violence and aggression (Pospiszyl, 1994).

In the Polish dictionary, violence is defined as advantage in physical size used for illegal purposes against another individual; unlawfully imposed authority; rule (Dictionary of the Polish Language, 1993). While social consciousness lacks one, uniform definition of violence, with respect to violence directed against older people, this more reflects a lack of knowledge as to what constitutes violence in general (Gietka, 2007). For a number of individuals, violence is almost exclusively connected with physical aggression.

Pospiszyl (1994) draws attention to the fact that “violence” is often understood as including all forms of individual maltreatment, inclusive of neglect. In practice, different forms of abuse are usually differentiated based on the level of aggression exhibited by the perpetrator. Terms such as “violence”, “harm”, “hurting”, or “taking advantage of” are used to name more mild forms of perpetrator behavior. However,

terms such as “maltreatment”, “abuse”, or “rape” relate to more severe forms of behavior. Some researchers go so far as to separate “taking advantage of” from the term “violence”, often treating it on the same level as neglect, abuse, or maltreatment (Rudnicka-Drożak, 2006). Others see it as a redundant term, inclusive of violence and neglect (Halicka 1996).

In general, violence can include any act threatening individual freedom, forcing the individual to behave in a way contravening their will. According to Kądziela (1979), violence is a means to influence individuals, the result of which their current level of somatic and spiritual development lies below their potential level of development. The intentionality and purpose of such actions is underlined in another definition, according to which violence includes all non-accidental forms of behavior going beyond socially accepted models of conduct which threaten individual freedom or contribute to individual physical or psychological harm (Pospiszyl, 1994).

The Program to Combat Domestic Violence, conducted by the National Agency for Resolving Alcohol-related Problems, applies a definition of domestic violence, also called violence in the family, which includes all forms of violence where physical advantage is used against family members, threatening their rights and individual integrity, leading to suffering and harm (Sasal, 1998).

The “taking advantage of” concept includes all action or influence, the effect of which poses a threat to individual rights, civil rights, physical and psychological integrity, or general condition. This action or influence may be deliberate or the result of neglect, including in sexual relationships or financial transactions, to which the individual has not consented, is not able to express consent in light of local laws, or which is undertaken with the aim of taking advantage of a particular individual (ResAP Resolution, 2005).

Literature also discusses neglect, defined as not meeting the basic physical or psychological needs of the individual (Badura-Madej & Dobrzyńska-Mesterhazy, 2000). This may be of a deliberate (i.e., active neglect) or unintentional (i.e., passive neglect) character and is reflective of the inability to care for an older person (Rudnicka-Drożak, 2006).

3.2 Forms of violence

Literature examining psychological issues differentiates four main forms of violence: physical, psychological, sexual, and neglect (Bińczycka, 1997). Even so, there is no consensus among authors as to one, uniform differentiation.

Physical violence describes deliberate actions with the aim of causing physical harm or disability. Thusly, it describes any intentional behaviour which carries with it the risk of physical harm, regardless if this harm actually occurs. Sometimes this also includes the intentional use of physical force ending in injury (Rudnicka-Drożak, 2006).

Physical violence is differentiated into different forms, including punching, pushing, hitting, and bruising. Especially in cases of dependent and weak individuals, force feeding, restricting physical activity (e.g., improper positioning in bed or in a wheel chair), improper use of drugs, and corporal punishment can also be included as forms of physical violence.

Psychological violence is defined as the conscious act of causing psychological pain, hurt, eliciting anxiety, or pressuring an individual through threats or behavior of a similar type (Rudnicka-Drożak, 2006). It may take different forms, such as scaring someone with verbal threats or accusations, humiliation, defamation and degradation, blaming, using/eliciting guilt with the intent to manipulate, name calling, trying to convince the individual of a non-existent psychiatric illness, humiliating claims, and infantilizing the older person. Special forms of emotional abuse directed against older people include not respecting their will, isolation from family and friends, and punishment by not speaking to them (Badura-Madej & Dobrzyńska-Mesterhazy, 2000). Isolation takes on different forms, for example controlling one's contact with others, not allowing use of the telephone, forbidding leaving the house, etc. Psychological violence is often accompanied by other hurtful behavior directed against the older person.

Literature also describes material violence, often called material/financial abuse or taking advantage of someone materially/financially. However, a few authors (Badura-Madej & Dobrzyńska-Mesterhazy, 2000) bring up this issue in the context of psychological abuse. Material abuse is based on the unlawful or improper use of funds, property, or other valuable articles, such as cashing checks without the

individual's permission or signature, pressuring the signing of documents, stealing money, controlling expenses, or enforcing money allowances.

Generally speaking, sexual violence entails undesired sexual contact (Rudnicka-Drożak, 2006). This includes, among others, forcing sexual activity on an individual against their will, continuing sexual activity without the permission or awareness of the individual or when they may be afraid to decline. Such violence may be based on the use or threat of force as well as emotional blackmail, often coexisting with financial and psychological abuse.

Neglecting the basic needs of older persons is relatively easy as, more often than not, they require special care. With respect to older people, neglect includes not tending to their basic needs for clothing, nutrition, shelter, healthcare, accessing healthcare, hygiene, or social contact. At times, this may lead to complete abandonment of the older person by the close individual entrusted with their care (Badura-Madej & Dobrzyńska-Mesterhazy, 2000).

Self-neglect , or the lack of self-care, is also cited as a form of abuse. In such cases, the older person is then perpetrator of their own abuse (Twardowska-Rajewska, Rajewska-deMezer, 2005).

Another form of abuse is abandonment of an older individual. This may take the form of leaving them in a public place or institution (e.g., hospital), or throwing them out of their home.

Certain authors (Cichocka, 2001) mention the practice of forcing older people to beg on behalf of their family.

3.3 Prevalence, statistical data

Despite growing interest in studying violence, there still exists the lack of reliable data concerning this field. As Poland does not keep official statistics related to the ages of victims, police and judicial statistics are not reflective of the true extent of violence in Polish society (Rudnicka-Drożak, 2006). Court data reflect only a small part of this situation, as not all cases of domestic violence are brought before the judicial system.

A study by A. Ratajczak (1980) found that the number of convictions related to domestic violence in the 1970s was approximately 12-15% of all court convictions,

where cases of violence against a family member or partner constituted almost half of all family-related crimes. This situation continued over the following years.

Doubtless, the incidence of violence in society is growing. This fact is confirmed by data from law enforcement agencies concerning the number and type of crimes committed each year. Despite only slight growth in the general incidence of crime, confirmed by the number of completed court cases drawn up from 1990-1996, domestic violence cases exhibit a much stronger dynamic for growth. The general incidence of crime has grown by 2%, while domestic violence has grown by 86%. Excluding alimony cases, in 1996, there were 21019 cases of domestic violence, which is 62% (n=8055) greater than in 1990. Concerning domestic violence in general, the number of adult convictions has also grown by 61%. Excluding alimony cases, this number has grown by 26% (Report on the situation of Polish families, 1998).

Poland lacks any sociological studies concerning domestic violence which may better describe the magnitude of this issue (Pospiszyl 1994).

It is no wonder then that literature dealing with violence most often cite statistics from other countries, especially the USA. The “Blue Card” method used by Police and social workers does not consider the age of the victim. Thusly, positing the extent to which domestic violence involves older people is not fully possible using this method alone. Survey studies in a number of European countries have found that the total rate of elder abuse ranges from 3 to 11%, with differences between the type of abuse, the most frequent being psychological abuse.

One study examining 600 residents of Białystok (Poland) aged 60 years and over found that these individuals reported different forms of neglect and abuse. The most often encountered example of neglect by one’s family included not providing care, isolation from family matters, and, especially in the case of women, emotional neglect. The incidence of financial abuse (i.e., the free use of an older individual’s financial resources, managing their finances without permission, or even stealing) was not high (Halicka, 1996). Experiencing physical abuse was reported by about 4% of study participants aged in their 60s, 70s, and 80s. Psychological abuse against older people was reported more often and concerned 2-5% of men and 5-9% of women in different age groups (Halicka, 1994).

Badura-Madej and Dobrzyńska-Mesterhazy (2000) posit that older people are most often the victims of neglect (48.7%) and emotional (35.4%), financial (29.9%), and physical (25.7%) violence. A study undertaken among clients of the City Office for Social Assistance in Poznań found that victims of abuse reported most often suffering from material and psychological abuse (62.5%), physical abuse (57.5%), passive neglect (40%), and active neglect (30%) (Twardowska-Rajewska, Rajewska-de Mezer, 2005). Of note is that these results are not representative for the general population and relate only to a sample coming from pathological family environments, which report a number of addictions and very low socioeconomic status.

Among 65-year-old women in Kraków, 14.1% reported being victimized by physical or psychological violence. Women who experienced violence most often reported being the victims of verbal threats or degradation (67.3%), hitting and physical assault (60.0%), restricted freedom (20.0%), destroyed property (14.5%), or sexual assault (14.5%) (Tobiasz-Adamczyk, Brzyski, Bajka, 2003).

According to a survey by the Center for Studying Public Opinion (2005), 10% of individuals aged 65 years and over confirmed that disagreements, arguments, or crises occurred in their family at least once per month, if not more often. For women aged 65 years and over, 24% confirmed that their husbands curse, insult, or yell at them, whereas 22% of men reported experiencing similar behavior at the hands of their partner. Individuals who experienced degrading or embarrassing behavior at the hands of their partner included 17% of older women and 7% of older men. Victims of blackmail or threats included 11% of women and 4% of men. Experiencing pushing and pulling was reported by 8% of women and 2% of men. Also, women aged 65 years and over felt that their partner restricted contact with their family, friends, or acquaintances. Only 2% of men reported feeling similarly. One can expect more complete data concerning violence to be published as part of the 2006 National Program to Prevent Domestic Violence (Report of the National Program to Prevent Domestic Violence, 2007).

3.4 Cultural and historical background

Socio-demographic changes affected the current system of social values and lead to changes in the family model, where the role of older people is now significantly restricted (Borowik & Pędich, 2002). Changes in the structure and

functioning of the family lead to a gradual break-up of intergenerational ties. These processes, observed in western societies, also affected Polish culture. Following World War II, despite the large participation of women in the work force, changes in the structure and functioning of the family took place rather slowly in Poland. The economy and society was structured around the family, supported financially by both working parents. In the 1950s, Polish women made up 45-48% of the active work force. In the 1960s, 63% of all women aged 15 years and over were professionally active. This number grew to 58% in the 1980s.

Women would become professionally active most often because of economic need. Similar to the countryside, where women worked in agriculture, managed the household, and looked after the children, as in cities, the division of labor in most households was not symmetrical. This asymmetry existed regardless if both the woman and man were professionally active. Still, the patriarchal family remained relatively strong, due to a strong foundation in religious principles, especially among older social groups, and limited social functioning of the state (Warzywoda-Kruszyńska 2004).

Characteristic for ideal family functioning in Poland is the existence of intergenerational relations, based on a feeling of family ties. This exists despite a growing trend since the 1970s for material and residential independence as well as the tendency to develop greater autonomy between each generation. However, such autonomy is not always attainable. The typical living arrangement in Poland sees parents living with their adult, independent children and their families, not so much out of choice, but out of necessity arising from the systematic lack of apartments in the 1970s and 1980s. During the period of transformation, apartments were treated as a market commodity and a number of families had financial difficulty in securing their own homes (Potoczna, 2004). The older generation more often lived in larger countryside residences than in cities (Nowak-Sapota, 2006). Living together in, more often than not, overcrowded apartments may lead to stress, conflict, aggressive behavior, and, finally, violence. High unemployment (i.e., 15.7% of the Polish population, or 2.8 million individuals), addiction (i.e., most often alcohol-related in Polish society), and poverty are also contributing factors to the current situation (Twardowska-Rajewska, Rajewska-de Mezer, 2005).

In Poland, securing care and help for aging parents, including support especially in the event of illness, has traditionally been the responsibility of adult children. This duty is treated as somewhat of a debt for difficulties connected with upbringing and an internal responsibility arising from the concept of reciprocity (Potoczna, 2004). The form and extent of mutual support afforded by family members differs based on generation. Parents, more often and to a greater extent, offer material support to their adult children, including looking after their grandchildren (Potoczna, 2004). Yet, a portion feel obligated to offer this help more out of social pressure.

As a result of deteriorating neighborly relations, extended periods of time spent away from the home, and increasing feelings of separation and animosity in society, researchers observe continued isolation of the family from their immediate environment. This results in weakened family functioning in terms of control by extended family and the community. As a result of social changes which deviate from the traditional family model, raising children has become a domain for professionals, where a similar tendency can also be observed in terms of caring for aging parents. Notwithstanding this fact, entrusting institutions to care for aging family members is still met with strong resistance in many spheres of Polish society (Marody, Giza-Poleszczuk, 2004). Transferring care to institutions is a very difficult decision for Polish caregivers and is seldom undertaken (Bień & Doroszkiewicz, 2006).

The transition process which took place in Poland in the 1990s, in addition to the obvious positive changes, also caused large segments of society to fall into poverty, which lead to a lack of stability and social security in these segments (Misztalska, 1995). In this new reality, the percentage of people with a more negative outlook on their lives has grown (Bień & Pędich, 1995). This is most evident among older people who, because of their modest retirement pension, almost as a rule, live at a lower socioeconomic level than mainstream society.

Alcohol addiction is a big problem in Polish society and, despite efforts aimed at curbing this problem, there remains rather wide-spread social acceptance for consuming large amounts of alcohol. More than 70% of all cases of violence take place in the context of alcohol addiction or other addictive substances.

3.5 Public awareness of abuse against older people

Recent years have noted an increasing number of information campaigns aimed at preventing violence in society. The goal of these campaigns has been to increase awareness concerning the problem of violence, however, with primary focus directed mainly towards violence against women and children. To what degree and extent violence is directed against older people still remains to be established. It seems that general social consciousness concerning this issue continues to be rather low. This may result from the fact that professional literature, scientific studies, and media have tended to focus most of their attention on violence directed against women and children. Examples of public campaigns concentrated on the maltreatment of children and women include “Childhood without violence” or “Because the soup was too salty”. A program aimed at combating domestic violence in families with alcohol-related problems was realized in 1992-1998 (Mellibruda, 1998). This program simultaneously targeted families dealing with alcohol addiction while increasing social consciousness as to the relationship between violence and addiction. Then again, violence against older people tends to occur even in families without any addiction-related problems. As a topic, the maltreatment of older people was most often discussed in the context of residential care institutions catering to older people. Such discussion would take place in television and radio broadcasts concerning the maltreatment of older people by the personnel of these institutions.

According to a survey by the Institute for Studying Public Opinion (OBOP, 1997), one-third of Poles feel that domestic violence occurs rather often (i.e., that it affects 25-50% of families). A similar number feel that violence affects less than 25% of adults. According to 8% of respondents, domestic violence occurs in more than half of all families, whereas 16% of those surveyed feel that these are only sporadic cases. Individuals aged 60 years and over as well as pensioners and retirees tend to undervalue their estimate of violence. The need for mass media to devote more attention to the issue of violence was reported by 60% of respondents, who felt that publicizing cases of violence might help bring aid to victims.

Survey studies confirm growth in social consciousness condemning violence. However, despite this fact, the number of reported cases of violence has not decreased. Probably only a selection of cases are actually reported to the appropriate authorities (i.e., police, local prosecutor). Feeling that there should be

some sort of intervention in all cases of violence is reported by 90% of Poles, where 80% feel the burden of intervention rests with the Police (OBOP, 1997). Yet studies suggest that only one in six cases of violence directed against older people goes reported (Pospiszyl, 1999). Analyzing statistics kept by the “Blue Line” finds that only 1.2% of older aged victims of violence seek help through their family and friends and 14% seek help through social workers (Durda, 2006). This suggests that social workers may play a greater role in identifying and intervening in situations suspect for abuse against older people.

3.6 Policies against abuse /policy background

Laws constitute one of the most important policy instruments governing families. The penal code lists a variety of crimes which can be committed by families and caregivers, including the physical or moral abuse of a family member or helpless individual. Domestic violence is a felony according to art. 207§1 of the Polish Penal Code. In Poland, domestic violence ranks third in terms of general crime (Pospiszyl, 1994). The Family and Caregiver’s Code is also meant to serve the interests of those victimized by domestic violence. However, separate legislation governing family-related violence was for a long time absent.

As a result of national campaigns instituted in the early 1990s aimed at helping families deal with alcohol-related problems, the need arose to develop more than just therapy-based forms of aid for victims of domestic violence. The work of district Commissions for Combating Alcoholism was concentrated only on the problem of alcoholism itself and not on the illegality of perpetrating acts of violence against one’s family. Efforts aimed at enforcing the mandatory treatment of alcoholics did not directly deal with the issue of violence, which resulted in the “immunity” from prosecution of the responsible party and continued violence. According to the current laws for Promoting a Culture of Sobriety, local district government are responsible for protecting the families of alcoholics against violence.

In 1992, the Health Minister’s Spokesman for Resolving Alcoholism, as part of the State Agency to Resolve Alcohol-Related Problems, included working against domestic violence as one of the main goals of this program. The State Agency to Resolve Alcohol-Related Problems (PARPA) developed a program of Working Against Violence in Families Dealing with Alcoholism. As part of this program, several

conferences devoted to combating domestic violence were organized throughout the country, a Fund for Working Against Violence in the Family was created, and, in cooperation with the police, a “Blue Card” procedure was developed for intervening in cases of domestic violence. In 1995, through the initiative of the PARPA, a National Crisis Center for Victims of Domestic Violence was created. Run by the Institute of Health Psychology of the Polish Psychological Association, it works to prevent violence in the family at the request of international, national, and local district government agencies.

This program also resulted in the creation of the “Blue Line”, which is a National Polish Society of People, Institutions, and Organizations Helping Victims of Domestic Violence, as well as publication of a magazine similarly titled “Blue Line”, devoted to the problem of violence in the family. Education campaigns, special courses on domestic violence, and grants for organizations working to combat violence have been taking place since 1992.

The work of the PARPA, The Polish Nationwide Emergency for Victims of Domestic Violence, as well as other institutions and organizations, culminated in the passing of a special law devoted to preventing domestic violence. The public ordinance of July 29, 2005 is aimed at increasing the effectiveness of efforts aimed at preventing violence in the family as well as initiating and supporting efforts aimed at increasing social consciousness concerning the causes and effects of domestic violence.

This law states which national government agencies and local district government offices are responsible for realizing programs aimed at combating domestic violence. In particular, this is regulated by the public ordinance for social services from March 12, 2004 and the public ordinance for promoting a culture of sobriety and working against alcoholism from October 26, 1982.

National and local governments should cooperate with NGOs, churches, and religious organizations to offer help to those victimized by violence, stop the perpetrators of violence, and increase social consciousness concerning the causes and effects of violence in the family. National and local government representatives may also outsource these duties as foreseen by the public ordinance for social services from March 12, 2004 or the public ordinance for public service organizations and volunteering from April 24, 2003.

In order to create an environment better suited to preventing domestic violence, in September 2006, the Prime Minister's Office created the National Program to Prevent Domestic Violence. This program is directed to the victims of violence, including especially older people, and the witnesses and perpetrators of violence. This program is realized through national and local district government agencies, NGOs, churches, and other religious organizations.

This program outlined detailed actions to be taken in order to protect and offer assistance to the victims of violence, correctional interventions for the perpetrators of violence, and increasing social awareness concerning the causes and effects of violence in the family. The goal of this program is to decrease the incidence of domestic violence and offer more effective protection to victims. For the perpetrators of such violence, this program sets out to increase access to therapeutic support as well as increase the effectiveness of correctional interventions.

The National Program is overseen by a panel from various ministries, called into existence in March 2007. This panel is made up of representatives from the various agencies realizing this program, the Chief of Police, and head of the National Council for Radio and Television. However, it is currently too early to posit any results from this program due to short time it has been in existence (Report from the National Program to Prevent Domestic Violence, 2007).

In 1998, the Polish Police force incorporated the "Blue Card", an intervention procedure for victims of domestic violence. Since 2004, it is also used by social workers in modified form. This procedure allows for collecting data and otherwise documenting the occurrence of domestic violence, which may be used later in the course of legal proceedings. This procedure also allows victims the opportunity to receive legal counsel, information concerning support in abusive situations, motivation to report incidents of violence, and knowledge of where to look for help. It also streamlines the supervision of families at risk and allows for cooperation with other public services.

The "Blue Card" procedure is an example of good practice. The "Blue Card" program requires police officers to complete specially designed cards when they respond to domestic violence calls (home interventions). The Blue Cards are separate from the police reports that officers must complete to initiate an investigation. It is divided into two parts: one of them documents the incident and the

other contains information about local assistance centers and programs, and the officer gives this card to the victim. The law requires officers to contact the local Social Service Center and consult with social workers. Together the officers and social workers track whether the victims have contacted any support agencies, determine a date for a joint visit to the family residence, and develop a “help plan” for the family. The structure of the Blue card vests significant responsibility in individual officers to participate in the social service plan.

No special procedures exist concerning assistance specially tailored to the needs of older people (Badura-Madej, Dobrzyńska-Mesterhazy 2000).

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

4.1 Context of violence

Factors leading to frustration are listed as some of the causes of violence directed against older people, including dependency of the victim on the aggressor, illness, incompetence, or decreased control on the part of the victim resulting from the aging process (Pospiszyl, 1994). Twardowska-Rajewska and Rajewska-de Mezer (2005) draw attention to the decreasing health status of older people (i.e., depressed mood and tolerance for physical activity, worsened intellectual functioning) as another contributing factor to violence. Approximately 92% of older people living on their own require help with at least one household task and 77% of older people are not able to independently venture outside their homes. More than half of those studied manifested memory or behavior disturbances or were incapable of systematically taking their medication, whereas urinary incontinence was noted in every third individual (Czekanowski & Bień, 2006).It is widely accepted that older people should be ideally helped by their closest family. However, not always is the family in a condition to ensure a satisfactory level of help and care, especially in situations where round-the-clock specialist care is required (Potoczna, 2004). In Poland, almost half of all those aged over 65 years require help with at least one everyday, household activity (Bień, 2002a). No national Polish register exists of caregiving afforded by individual families, though more than 80% of disabled older people remain under the care of their family members. The needs of older people are almost completely secured by relative caregivers (Bień, 2006), yet no formal system

exists to support family-centered caregiving. Any national caregiving services are limited to supporting the individual under care. This includes offering a nursing stipend for those aged over 75 years, care services (e.g., household, nursing, or specialist), and tax write-offs for nursing care in homes for the disabled. Approximately 25% of relative caregivers have difficulty in finding temporary support in the care of an older person, whereas 10% do not see such a possibility existing at all. Additional responsibilites are also met by 53% of caregivers resident in the countryside and 31% of those resident in cities (Czekanowski, 2006). This increases the stress and burden felt by caregivers.

Assuming the responsibility of caring for an older person often leads to physical and psychological exhaustion by the caregiver (Bień, Wojszel, Wilmańska et al., 2001), of which violence is an often encoutnered consequence.

Often encountered disturbances in perception and consciousness, stupor, and behavioral problems coexist in the case of older people subject to neglect (Rudnicka-Drożak, 2006).

These same authors draw attention to the worsening social situation and poorer financial state of older people, which may result in increased dependency of the victim on the aggressor.

Cases of violence often occur in situations where there is increased dependency of the perpetrator on the victim due to psychiatric problems, substance addiction, or physical disability (Pospiszyl, 1994). Most crimes requiring police intervention, especially violent crime, take place under the influence of alcohol (Sasal, 1998). This relates especially to domestic violence, including that directed against older people. According to The Polish Nationwide Emergency for Victims of Domestic Violence, more than 40% of all reported cases are alcohol-related, whereas 7% of cases are related to psychiatric illness in the perpetrator or victim (Durda, 2006).

Shared, long-term living arrangements between the perpetrator and victim are one of the factors increasing the risk of violence. The perpetrators of violence are often blood relatives, most commonly adult children, spouses, grandchildren, or siblings. Select studies find that violent acts against older people are more often committed by spouses than children (Cichocka, 2001). The perpetrators of violence are most often family members which, according to different studies, account for 70-

75% of the perpetrators of violence. They are commonly males (i.e., husbands, sons-in-law, sons), live together with the victim, and have, or at one point had, trouble with their psychiatric health or alcohol dependency (Pospiszyl, 1994; Twardowska-Rajewska & Rajewska-de Mezer, 2005). It seems that women, more often than men, are party to the neglect of older people (Badura-Madej, Dobrzyńska-Mesterhazy, 2000). This may be connected to the fact that women more often assume caregiving roles.

It has been observed that abuse exists between partners mainly in later life (Halicka, 1995). Rudnicka-Drożak (2006) also include older age, low education, and dependency on others as risk factors for violence.

4.2 Influence of social and biographical factors

The social status of an older person changes with the moment they retire. The end of their professional careers leads older people to feel excluded from active social life and to interpret their social position as destabilized. Aging brings with it weakened physical and psychological strength and increased dependence on others. This consequently leads to feelings of security loss and fear (Twardowska-Rajewska, Rajewska-de Mezer, 2005). The everyday activity of older people is marked by routine and they are often socially isolated (Pospiszyl, 1994), helpless in the event of increasing disability, physical weakness, and, more often than not, make for attractive targets for criminals because of their accumulated wealth. This attractiveness and accessibility of older people is an additional risk factor for potential violent offenders.

Halicka (1995) found that the dependency of older people on caregivers is not the cause of their maltreatment. Rather, it is the emotional, financial, or residential dependency felt by abusive individuals.

Attention is drawn to the mutual dependency of the victim and perpetrator of domestic violence on a long standing model of household organization (Twardowska-Rajewska, Rajewska-deMezer, 2005) as well as the financial dependency of the perpetrator on the victim. Social workers underline that in Poland's current reality, older people, retirees, and pensioners, with secure and stable incomes, are often the primary earners in families, especially dysfunctional families affected by alcohol-related problems. It is worth noting that the victims of violence in childhood often use

violence against their aging parents, once themselves the perpetrators of similar abuses.

It seems that differences still exist between rural and urban settings in terms of the determinants of violence. Rural victims of violence are often worse educated and not aware of their rights or the possibilities which exist for seeking help (Rudnicka-Drożak & Latalski, 2006).

The age of the potential victim also acts as a risk factor for violence, as older people aged 80 years and over are two or three times more likely to be at risk of violence (Badura-Madej, Dobrzyńska-Mesterhazy 2000). This suspicion is confirmed by Rudnicka-Drożak and Latalski (2006) who found a greater risk for more severe forms of violence along with increasing age and decreased functioning of the older person.

4.3. Risks and consequences of violence

The risk of becoming the perpetrator of violence against an older person (i.e., the risk of entering into the role of aggressor) seems to be dependent on a variety of social determinants, family relations, alcohol dependency, and cultural and social norms. Being brought up in a family where violence is used as a means of problem solving increases the risk of subscribing to such behavior in adult life. It is often the case that individuals abused by their parents in childhood themselves become the perpetrators of violence against their older, defenseless parents who remain under their care. Cultural and social determinants include sanctioning the use of violence against weak individuals remaining in a relationship of dependency or acceptance of violence which occurs behind closed doors.

Older age and the health consequences of aging are the main risk factors for becoming a victim of abuse. Aging is connected with worsened somatic and psychological health and suffering from concomitant diseases and disability. The burden of caring for such an individual may lead to frustration and aggressive behavior. Additional factors increasing the risk for violence include when the caregiver and older person share the same residence as well as if there exists an element of dependency, be it financial or emotional, in the relationship. Aggression is often a response to fatalistic feelings harbored by adult children who remain

dependent on their aging parents. The social isolation of certain older people (i.e., little or no social contacts) may also increase the risk for experiencing violence.

More than anything, the consequences of abuse are health-related and connected with psychosomatic dysfunction. Physical and psychological suffering leads to worse physiologic functioning, problems with eating, malnutrition, dehydration, sleep disturbances, etc. The psychological effects include depression, anxiety states, phobia, and having the older person blame themselves for the current situation. The psychological pain and coming to grips with being victimized by one's own child may also lead certain groups of older people to attempt suicide. These victims often consciously withdrawal from social life, interpersonal contacts, and experience a low feeling of self-worth.

4.4. Gender Aspects

It seems that the source of domestic violence is the patriarchal family model itself, giving the husband the "right" to correct the behavior of his wife through the use of corporal punishment. Physical differences between women and men, the association to authority in the family, and cultural acceptance for using violence against women, are all factors accommodating male domination and aggression, in addition to allowing perpetrators to avoid accepting responsibility for their actions.

Studies undertaken among individuals involved in violence find that the victims of violence are most often older women, characterized by lower education and requiring care due to chronic disease or compounded disability (Rudnicka-Drożak, 2006; Twardowska-Rajewska, Rajewska-deMezer, 2005). Statistics from the "Blue Line" find that older women constitute 79% of all reported cases of abuse, whereas for women in all age groups, this percentage is higher and reaches 86% (Durda, 2006).

The perpetrator of violence against older people is usually a middle-aged male, relative of the victim (i.e., more often a son than spouse), not working (i.e., unemployed, pensioner, or retiree), with some level of dependency on their victim (i.e., financial, family, caregiving, or residential). In reality, it is suggested that women are much more often the perpetrators of violence against older people than that portrayed in the actual number of cases reported (i.e., 39% vs. 18%) (Durda, 2006). Women are most often the perpetrators of different forms of neglect against older

people (Badura-Madej, Dobrzyńska-Mesterhazy 2000). This may be due to the fact that women frequently serve as caregivers.

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

Violence directed against older people, though seldom recognized, is often encountered in practice by social workers and community nurses (Badura-Madej, Dobrzyńska-Mesterhazy 2000).

Professionals working with older people are generally aware that elder abuse exists. According to a study by Tobiasz-Adamczyk (2007) undertaken among healthcare and social workers, 9.8% had previously dealt with older aged victims of physical violence, while this number grew to 12.9% in cases of psychological violence. Among these workers, 43% also observed older aged victims of neglect and 18% had to deal with cases of abandonment, mainly in hospitals or other such institutions. Approximately 28% of study participants also observed financial abuse and 49% observed self-inflicted neglect by the older people themselves.

Older people fall victim to different forms of violence:

> I encounter victims of elder abuse on a daily basis (...) It is difficult to say which form in most prevalent, still I encounter all forms of abuse, regardless of age (4M)

Especially evident is the susceptibility of older people to financial abuse and neglect. This fact is reported by both social and healthcare workers, professionally active in urban as well as rural settings:

> Compared to younger people, older individuals are characteristically more often the victims of financial abuse. However, they can also fall victim to psychological, physical, and sexual violence. Neglect is more prevalent among immobile, less mobile, infirm, and dependent individuals, as well as those having difficulty with moving about. In most of these cases we can talk about neglect (4M)

> Violence directed against older people presents in two basic forms: financial abuse as well as neglect and abandonment (1H).
>
> A major form of abuse is fraudulent use of older person's financial resources (6M)

The most often encountered scenario usually finds an older woman financially supporting her son, who is most often unemployed and/or dependent on alcohol. In certain instances, the older person's pension remain their sole source of income:

> Here in Nowa Huta [a district in Kraków], there are a lot of dysfunctional families dealing with unemployment. Often a family's sole source of income is the grandmother's pension or the money left by her late husband. Once this money is collected from the grandmother, she is pushed aside (5M).
>
> An older woman financially supports her 62-year-old son. While this woman receives a sizable pension from the Department of Social Insurance, her son remains without any source of income. Though he was earlier receiving a disability pension, the Department of Social Insurance eventually concluded that he was able-bodied enough to work. However, he refuses to work, citing that he cares for his mother, which is not entirely true (5H).
>
> An older, well educated woman, who earlier worked as a pediatrician, lived with her adult son. She was overprotective and arranged for him to receive a disability pension. Himself unemployed, the son would sometimes take his mother's money, leaving her without any means. This gave rise to a variety of conflicts. An overbearing motherly instinct, cemented over the years, lead to a dysfunctional mother-son relationship (2M).

Cases of neglect often arise out of feeling that the state should care after the needs of disabled older people:

> A seriously ill, bedridden, 76-year-old woman with diabetes, hypertension, and muscular atrophy sporadically leaves her home only in the company of a Red Cross caregiver. She is confined to a wheelchair. Despite having a number of children, none wish to offer her any help (7H).

Cases of neglect and abandonment occur in situations where older people live alone, with the family neither providing any care nor reporting such cases to the appropriate social welfare authorities. As adequate care is costly, this happens due to financial constraints or believing that the older person will be able to take care of themselves.

> We mainly encounter cases where children live outside of our country and are unable to care for their parents (4H).

Cases also exist where families open declare that they will care for an aging family member, when in reality they do not provide the promised care or the care they do provide is unsatisfactory:

> An older lady lived alone in an apartmentment block. According to information from the Social Welfare Agency, she was looked after by her grandson and his girlfriend. They would, in fact, check up on her every now and then, mostly when there was a report she was being neglected. Only when neighbors would report she was being neglected would her grandson appear and claim that he was looking after his grandmother, discounting any need for hiring a professional caregiver. This older lady had a relatively high income, which made involving a caregiver from social services that much more difficult. The grandson claimed that her income was large enough to satisfy him as the individual looking after his grandmother (4M).

> A couple of retirees live with their unemployed son. One is bedridden, while the other is mobile, but only in the confines of their apartment. The daughter, who lives in the USA, attempted to find a place for her parents in an old people's home. Both parents have relatively high retirement pensions. However, the son would not allow this and would withdraw the application papers following his sister's departure. The suscpicion exists that the son financially abuses his parents. These are only our suspicions, based on how the house is made-up, but especially on the new electronic equipment acquired by the unemployed son. It seems he takes his parents' money, which makes it convenient for him to have them at home, giving him access to their pensions (M5).

Psychological violence is another often encountered form of violence. It is frequently accompanied by other forms of violence, especially physical or sexuality. ,

> We hav ea few older ladies who, during their environmental interview, complain that they are treated poorly, that they never hear a kind word (6H).

> Psychological violence often accompanies physical violence. I can not imagine that somebody beats another person without yelling “You something-or-other…” (5M).

> There is a large number of older women who have trouble with the increased sex drive of their husbands. Recent years note an increase in the number of such cases. Oftentimes it is not limited to “marital rape” but also psychological and/or physical violence which begins following denial of sexual encounter. The lady may not have a desire to talk, but her husband feels a strong desire to encourage her, while her rejection leads to an aggressive, brutal response (4M).

The husband is frequently the perpetrator of sexual violence against older women, who are oftentimes also infirm or disabled:

> There was this one case of a disabled woman whose husband was unhindered in continuing to have sex with her whenever he felt the urge (5M).

One doctor highlights how violence directed against older people is not at all a rare phenomenon:

> Violence directed against older people happens quite often (…) it most often affects dysfunctional families which also have to deal with alcoholism. It may also affect individuals looking to inherent a residence from their parents or other relatives. Violent experiences involve both physical aggression as well as psychological aggression, which is encountered significantly more often (1M).

However, the issue of violence is not limited only to dysfunctional families with alcohol-related problems.

> Violence often affects families which, at first glace, seem to be immune to such problems. It is not limited only to families dealing with alcoholism, despite the widely held belief that it precisely should affect only those types of families (7M).

5.2 Recognizing domestic violence against older women

Recognizing situations of abuse against older people is not an easy task. Attention must be drawn to the different symptoms of elder abuse, as presented by healthcare workers in the analyzed literature (Rudnicka-Drożak, 2006), as well as that presented by the caregivers of older people. Older people place great trust in health care workers, with whom they have the opportunity to engage in regular contact. This means health care workers have the possibility to recognize any injuries or potential signs of neglect (e.g., malnutrition, dehydration) during physical examinations. Beyond their immediate family, community nurses or family physicians are often the only individuals with whom older people have contact. However, citing lack of time (i.e., needed to expose, confirm, and resolve the problem) and other professional responsibilities, health care workers often keep to themselves their observations and suspicions of elder abuse (Twardowska-Rajewska, Rajewska-de Mezer, 2005). There is also little desire to intrude in the lives of others or a lack of certainty that the older person is adequately portraying the reality of their situation:

> Older people often say that they are being mistreated, however it is not always known if their are telling the truth. These are often individuals suffering from atherosclerosis. We seldom choose to involve ourselves in family affairs, often of a financial nature. In theory, we should involve ourselves, but we don't want it to concern us (3H).

> Older people rarely talk about it willingly because, on the one hand, they are afraid of their families and, on the other hand, they are ashamed of their situation. Though nurses are rather adept at recognizing situations suspect for violence, they, however, lack any mandate by which they could force the family to change how they treat the older person (1H).

The attitude of the victims towards reporting abuse plays a significant role, as does social awareness as to what can be defined as violence. In in-depth interviews,

respondents cited the problem of very poor social awareness. Despite a number of media campaigns, with no uncertainty as to the message, individuals reading such posters and billboards would often interpret them in a manner far from that desired.

> The "Because the soup was too salty"[1] campaign was interpreted as a commercial for consumers by two random individuals discussing the billboard at a bus stop. One of them was quoted as saying "What a horrible commercial for salt!"

Studies show that aging parents/victims of violence often keep silent. An analysis of telephone calls made from 2003-2006 to the "Blue Line" finds that only 1.2% of those victimized by their own children turn to family or friends for help and 14% turn to social workers. Among older people, barely one-third of all reports come from the victims themselves, whereas 68% of cases are reported by those who witness elder abuse (Durda, 2006), of which 45% are not related to the victim (Gietka, 2007). Identifying situations suspect for violence may be possible with help from other family member as well as children not living with their aging parents:

> Suspicion concerning a situation suspect for violence directed against an older person is often expressed by extended family members. They undertake steps to stopping the situation (2H).

Information received from other, often not related, individuals may also prove valuable. This includes neighbors or individuals who, as a result of their office, maintain regular contact with members of a community:

> We receive reports from neighbors, district government representatives, and mayors (4H).

[1] A social campaign designed to prevent domestic violence directed against women. The billboard showed, among others, a woman with a black-eye and the running title "Because the soup was too salty" meant to imply the reason why she was hit by her spouse.

> We often get signals from neighbors that something is amiss, that an older person is falling victim to physical neglect (10H).

As part of Blue Card procedures, Police and social workers often exchange information in cases of domestic violence. When cases are reported to the Police by the victim or other witnesses (e.g., neighbors), passing information along to social workers is a standard procedure.

> I received information from the neighborhood police officer, as she requested that Blue Card information be collected (9H).

Other institutions and organizations dealing with violence may also signal cases suspect for elder abuse.

> I received information from a crisis center that an older woman from our district, who participates in a support group at this center, is the victim of domestic violence (12H).

Effectively identifying abusive situations is oftentimes the result of keen observation and active involvement by social workers who look after older people or the disabled:

> I became suspicious when the daughter continuously avoided meeting me (7H).

> I asked why does the woman live in a basement, where there is no running water or heating. I asked why does she walk around dirty and smelling foul (6H).

> This situation was related to me by the caregiver as well as in home visits. While taking an older woman to the toilet, the caregiver noticed that in her billfold there were pieces of fabric cut to the size of banknotes. The son was systematically stealing his mother's money. At first, this was very well hidden. During the interview I observed that all utilities in the house were turned off and began asking "Why is it so cold? Why is it so dark?" (5H).

It seems that social workers get more information concerning family-related violence and, as part of their established procedures, usually give the matter the

attention it is due (Twardowska-Rajewska, Rajewska-deMezer, 2005). It has been established that, in cases suspect for violence, older people look to social workers for help ten times more often than to their own families or group of friends (Durda, 2006). However, the real challenge involves educating older people that no one has the right to subject them to violence or aggression:

> It is very difficult to explain to a victim that they do not have to be completely subject to the will of their children—the perpetrators of violence—and they also have rights. Educating the older person is even a greater challenge than identifying and separating the assailant from the victim (2H).

Abused aging parents experience pity and despair, which may result from a feeling of blame (i.e., "I am responsible, because this is how they were raised.") Another reason battered older people feel they should keep silent is fear of ending up in a residential care facility. This is an often used form of blackmail should the victim express any desire to report their abuse. It is also rooted in the context of Polish society and Polish religious conviction that only unloved parents end up in residential care facilities. Going to such a facility is a traumatic event for the older person who was sent there by their own family, most often children.

Ignorance as to the issue of elder abuse is also another significant reason why some older people choose to keep silent. The author of an article on this topic wrote that "older mothers do not know what violence is. They wonder if spitting into someone's plate would qualify as such." (Gietka, 2007). Very often, the victims of violence are not even aware that they are being victimized by emotional, verbal, or financial abuse. Frequently they go so far as to rationalize the behavior of their child/the aggressor, especially in cases where they are also the sole caregiver.

5.3 Coping strategies

Strategies aimed at stopping or preventing violence require the participation of numerous social institutions. A good example is the cooperation and participation of different institutions in "Blue Card" procedures. This includes representatives from the Police, social welfare centers, commissions to resolve alcohol-related problems, local

district centers for family services, crisis intervention centers, pedagogic consultants, addiction treatment clinics, family court, parole officers, addiction support groups, crisis hotlines, and consultancy and information centers for victims of domestic violence. Though procedure is used by Centers for Social Welfare, it is not always applied:

> We can use Blue Card procedures in cases of physical or psychological violence. However, it seems that in some situations it may be too harsh or too strong. Instead I contact Center directors, discuss cases with my coworkers, and contact the directors and caregivers at Red Cross offices (7H).

Social workers react immediately in situations suspect for abuse: they visit the older person's home, they speak with the older person, they conduct family interviews (assuming they did not have contact with the family earlier), and finally they attempt to institute changes using a variety of possibilies:

> When talking to her, I asked if there was anyway I could help, to possibly speak with her husband (…) As the woman did not exhibit any self-esteem, I focused my efforts on her. She began to take care of herself, to leave the house, and make better use of her time, instead of just spending it with neighbors, which did not much differ from her own home environment. I referred her to institutional day care, in addition to continuing her addiction therapy (6H).

> After speaking with her, I asked for a family specialist to intervene. The specialist suggested different forms of assistance, such as moving her to a shelter or institutional care, where she could function in peace (9H).

After orienting themselves, the social worker may develop a plan of action most appropriate to a particular situation. In cases where the family is not able to properly care for the older person, the Center for Social Welfare may suggest care or specialist services:

> When we intervene with care services, the professional caregiver may supervise those who live with the older person or completely assume caregiving responsibilties (10H)

Even in the case of smaller centers, where demand outstrips supply, social workers somehow try to manage:

> We don't have any set procedures or established programs. We have our caregivers, fulltime employees at the District Center for Social Welfare, sometimes we hire temporary caregivers, or take advantage of neighborly help (all secured by the Center). The problem is that in winter months we are unable to secure care services for all those who request it. In these cases, we engage neighbors or other trustworthy individuals (4H).

On the other hand, healthcare workers complain that they lack any standardized procedures, where cases are violence are simply referred to their superiors:

> Unfortunately, lacking are clear regulations and procedures as to how one should proceed in cases of violence directed against older people. Personnel usually react by referring the matter to their superiors (2H).

> Upstairs we have psychiatry and toxicology departments for perpetrators. We have a toll free hotline for victims. We usually try to solve small matters on our own, whereas more drastic cases are referred to the director and the physician makes a note in their file (3H).

With the aim of releasing emotional tension and trying to find the best solution to matter at hand, most professionals who deal with cases of violence share their observations with coworkers and, in more serious cases, with their superiors. Younger workers with less professional experience often take get help from their more experienced colleague and make home visits in pairs. This is an especially important form of support for younger, less experienced workers:

My problem is the first visit to an unknown environment. I usually get support by going with a coworker (12H).

In the event of Blue Card interventions, social workers make home visits in the company of a neighborhood police office. Most institutions (i.e., governmental and nongovernmental) have the possibility to visit a psychologist (both for the work as well as the individual under care), be supervised, or consult a lawyer:

We get support in branch offices through supervision. Additionally, we work as teams, making problem solving that much easier. We also take advantage of other institution (e.g., Center for Crisis Interventions, Center for Individuals Affected by Violence). We also try to work with NGOs (8H).

At the Center, we receive continuous training for dealing with victims of violence and we have access to a psychologist-consultant, with whom I can discuss a particular case or, when I feel I will not be able to handle a case, make the intervention together. At times, the psychologist may take over a case (6H).

At the Foundation, an employee can count on help from the psychologist and coordinator (should a worker become exhausted). We work as a team and such problems are always referred to the coordinator. The Foundation's lawyer is used by those under their care as well as workers (e.g., housing matter, divorces, alimony) (2M).

NGOs are at a disadvantage for directly intervening in situations suspect for violence. However, in such cases, they may refer the matter to a more appropriate agency, such as the Police or Center for Social Services:

The possibilites for acting are very limited. A caregiver may explain certain things, but they may never interfere in family situations. We have such experiences and generally the situation ends poorly, with blame falling on the caretaker. We may also professionally refer such cases to a social workers at the Municipal Center for Social Services (6M).

> We are not empowered to undertake specific actions or interventions. All irregularities are reported to a social worker at the Municipal Center for Social Services, which takes the matter under consideration in their community interview (…) We can not intervene in families (2M).

Despite all problems and issues, most important is the professional's attitude and internal conviction as to the propriety and sense of their efforts in changing the situation of a victim of elder abuse:

> Years of professional experience let a person say „I can do this". It is most important to believe that something can be done, that a situation can be changed (6H).

5.4 Further support/ strategies needed

In so far as social workers and Police have an algorithm to follow in cases suspect for domestic violence, healthcare workers do not.

> There are no clear regulations or procedures which should be followed in cases of violence directed against older people (1H).

It then makes sense to recruit healthcare workers into resolving the problem of violence (Twardowska-Rajewska, Rajewska-de Mezer, 2005) and expand the "Blue Card" to include healthcare workers or develop different procedures for them to follow in cases suspect for abuse.

Another problem reported by healthcare workers is the sometimes less than enthusiastic response by the Police.

> In cases of physical assault, the matter is reported to the Police. In cases of psychological abuse, verbal assault, or other forms of violence not connected with bodily harm, there is unfortunately no legal basis for reporting such matters to the Police. Or, in the absence of any evidence that such a situation ever took place, the Police may not even accept such reports (1M).

Attention is drawn to the need for educating professionals who have contact with the victims of domestic violence, raising the level of social awareness, and greater participation by witnesses to such events.

> Professionals entrusted with preventing violence should be better educated and competent as to the role of different institutions. More often than not, in training programs organized by the Police, reservations are expressed concerning the sense surrounding “Blue Card” procedures. However, knowing these procedures is vital to defining the possibilities for and extent of police interventions. Though it currently leaves much to be desired, raising social awareness is key. This should involve dissolving stereotypes and social indifference and reporting all cases suspect for abuse, not being afraid to give testimony in cases where witness accounts may be of value. (7M).

Professionals cite the trouble with having a large number of individuals under their care, which makes identifying and monitoring family situations more difficult:

> There is no time for a human touch, entering a home environment without any real reason, just to look around and see what is happening. We visit once a month in the course of our professional obligations, but this is too little. Once a week and unannounced would begin to yield an effect (11H).

Smaller cities and the countryside as decisively worse off in terms of supporting social workers in the field. Generally this involves a lack of supervision which may be helpful in identifying crisis situation, psychologists on duty mostly work with individuals under their care, and not with workers. A small number of workers with a large number of individuals under their care, spread over a large area, does not support a mutual exchange of experiences.

The need for additional training is recognized by all professionals, without regard to professional preparation. The need exists for different types of schooling:

> We are relatively well prepared in terms of domestic violence. However, in cases of violence directed against older people, we lack certain information. Additional training would come in handy (4H).

> For social workers could benefit from learning how to deal with stress, work, emotions, exhaustion (12H).

Compared to social workers who, as part of their specialist training, are at least theoretically prepared for dealing with violence directed against older people, healthcare workers does not cover such topics in their course of their professional education. In postgraduate training they are more focused on issues related to the clinical care of older people. Those dealing with older people report encountering psychological problems in the older people themselves or in their caregivers:

> Alcoholism and psychiatric illnesses are universal problems in older people. Having an ill individual under their care increases the burden of the social worker (5M).

In many cases, this problem could be solved with a psychiatrist whom would be available locally and go on home visits with the social worker.

> A strict procedure exists if we see that the health of an older person has worsened: we submit a written request to FAN-MED for a psychiatric consultation, scheduling a visit with the social worker, oftentimes the older person doesn't open the door, which means the physician will not make a second attempt. It is good if the physician can see the older person and confirm that they need treatment. In these cases we drive them to the hospital (5M).

> Sometimes we need to make an urgent consulation or support, so we could use a fulltime psychiatrist at the Center. However, at present, this is only wishful thinking (6H).

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

Preventing violence directed against older people should be multidirectional and based not only on the cooperation of different services and organizations working together as part of the “Blue Card”, but should also include healthcare workers. The poor participation of this sector in identifying and combating violence has already been noted (Twardowska-Rajewska, Rajewska-de Mezer, 2005; Rudnicka-Drożak, 2006). There exists the need for raising the awareness and preparation of this group to identify situations suspect for abuse. This could best be done through speaking training and courses already at the level of professional education.

It would also be worthwhile to better educate older people themselves. This could be done in the context of mass media, senior clubs and associations, Third Age Universities, self-help groups, and, finally, encouraging the active participation of older people through self-help and community education programs (Twardowska-Rajewska, Rajewska-de Mezer, 2005).

It seems that education and conveying information through the use of media might play a significant role in preventing violence against older people. This includes education at a societal level: increasing awareness of the problem, breaking taboos, and changing negative stereotypes about older people. Increasing social awareness concerning the existence of domestic violence directed against older people should go hand-in-hand with streamlining the work of healthcare and social work professionals to combat violence.

6.1 Experience with domestic violence against older women

In recent years, the number of household police visits related to domestic violence has systematically grown yearly (Table 1):

Table 1. Police hauseholds interventions

	2000	2001	2002	2003	2004	2005	2006
Total household interventions	479.602	482.007	559.387	593.727	610.941	608.751	620.662

Inclusive of those related to domestic violence	86.146	86.545	96.449	85.512	92.495	96.773	96.099

Source: http://www.policja.pl/portal/pol/4/318/Przemoc_w_rodzinie.html

The number of victims of domestic violence also grows yearly (Table 2), though not incorporating the age of victim into statistics makes specifying their age impossible.

Table 2. Victims of domestic violence (based on Blue Card)

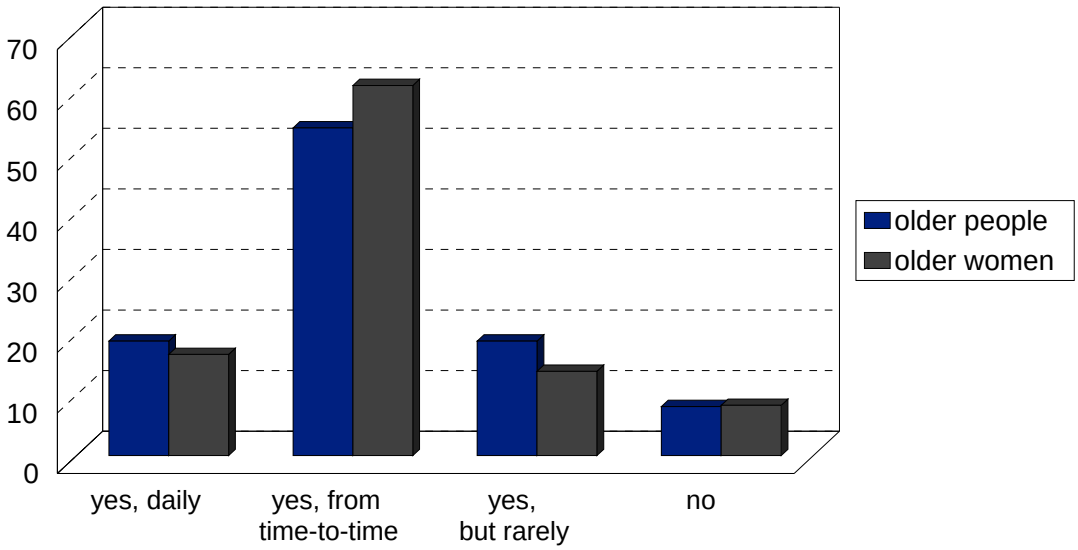
	1999	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**
Number of victims (in general)	96.955	116.644	113.793	127.515	137.299	150.266	156.788	157.854
Women	55.214	67.678	66.991	74.366	80.185	88.388	91.374	91.032
Men	4.239	5.606	5.589	7.121	7.527	9.214	10.387	10.313
Children (age <13)	23.929	27.820	26.305	30.073	32.525	35.137	37.227	38.233
Minors (age 13-18)	13.546	15.540	14.908	15.955	17.062	17.527	17.800	18.276

Source: http://www.policja.pl/portal/pol/4/318/Przemoc_w_rodzinie.html

In 2006, approximately 68% of interventions for domestic violence took place in cities. Though only 38% of such interventions took place in rural settings, this number is growing (Report concerning the state of criminal prevention and assignments realized in this regard by Police units in 2006, 2007).

A survey study found that the vast majority of organizations offering social and medical care to older or disabled individuals deal with the issue of violence from time-to-time. Few organizations cite violence as an everyday or rare occurrence. Such organizations are similar in number, while organizations which cite never encountering violence directed against older people, or older women in particular, are most rare (Figure 1).

Figure 1. Does violence directed against older people/ older women pose a challenge to to the work done by your organization ?



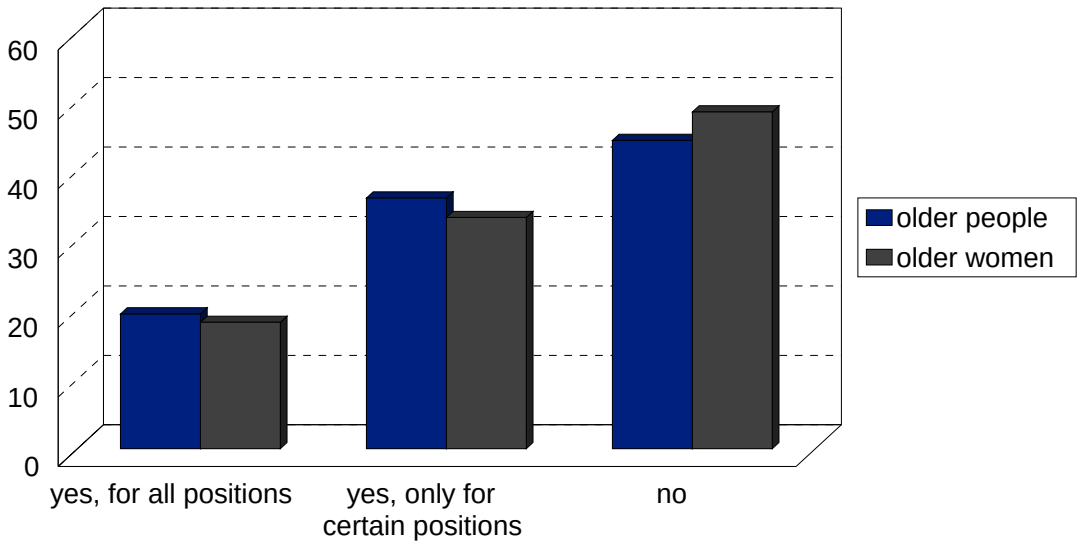
6.2 Recognizing domestic violence against older women

Identifying and effectively intervening in situations of domestic violence is difficult without prior preparation. Unfortunately, almost half of all organizations taking part in this study employed workers not adequately educated for dealing with cases of violence (Figure 2). Professional nursing or medical education lacks any training in terms of domestic violence. Even when such training is available, healthcare workers seldom participate. On the other hand, domestic violence is included in the curriculum of social workers, and violence directed against older people is included as part of specialist education. Though professional development courses are organized by a number of Centers, there exists the need for increasing the variety and number of courses:

> We consider each course to be valuable. If anything is organized, be it by the Regional Center for Social Services or the Director of our Center, everyone signs up. Unfortunately, even though everyone wants to participate, not everyone can due to a restricted number of places (3M).

> During specialist training we encountered the problem of violence directed against older people. Since we lack any theoretical advancement, we could use additional training here at work (4H).

Figure 2. Is being trained for how to deal with abusive situations a requiremant for gaining employment in your organization?



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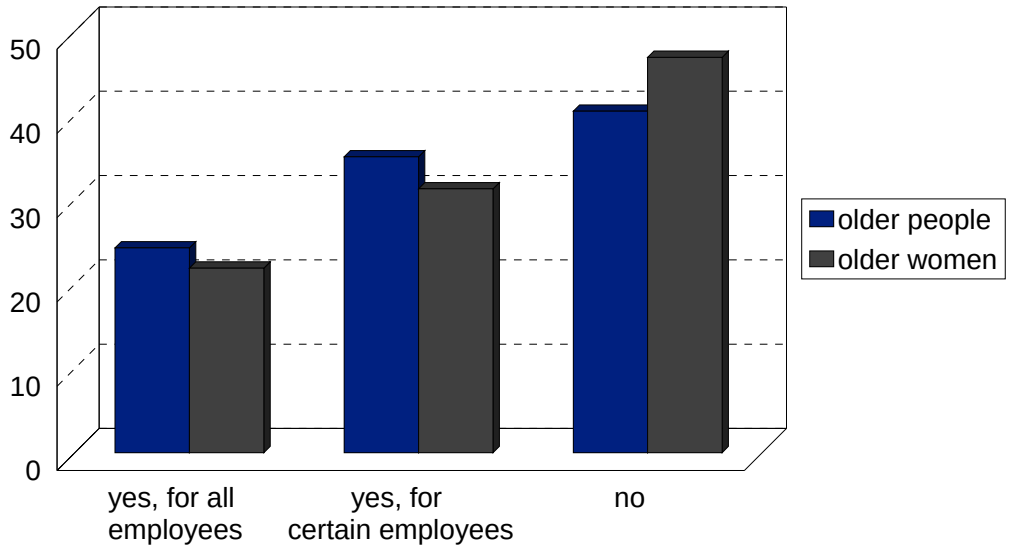
Various institutions and social agencies are involved in preventing domestic violence in Poland. These include the Police, local prosecutor, social welfare agencies, healthcare services, local district offices, and NGOs.

Survey studies find that approximately 40% of organization do not provide their workers with training or courses concerning preventing violence (Figure 3). Almost 70% of those surveyed reported not having developed any internal program

Figure 3. Does your organization provide internal training and/ or education programmes to teach employees how to deal with abusive situations against

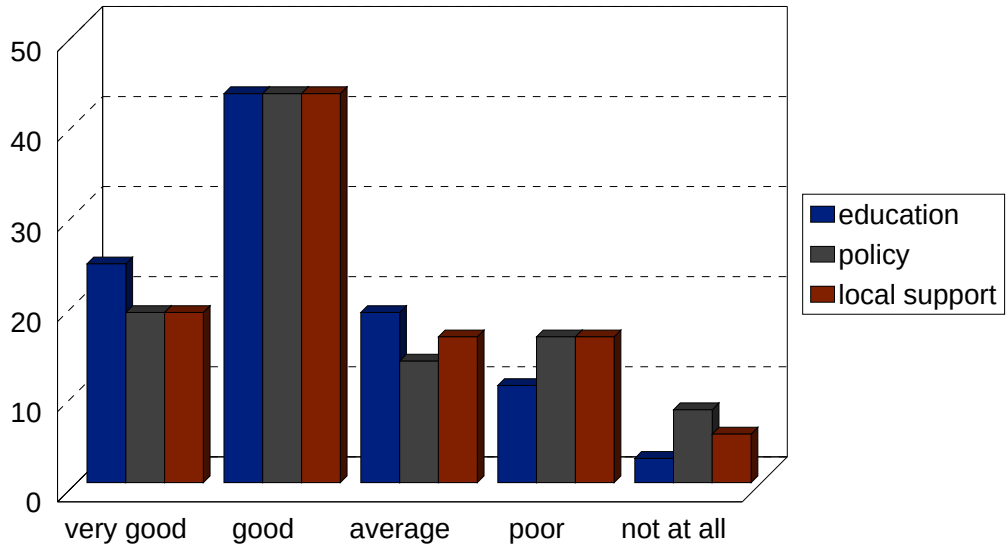


for combating violence directed against older people.

6.3 Organisational coping strategies

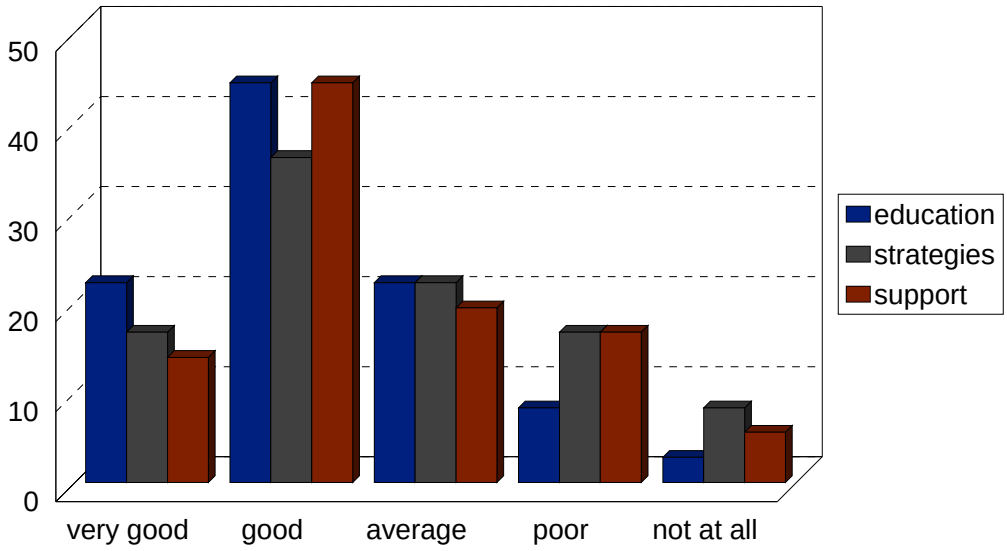
The organizations surveyed feel that they are satisfactorily prepared for combating violence both in terms of education, policy, and community support (Figures 5 and 6).

Figure 5. Do you feel that your organization is adequately prepared to deal with situations of abuse against older people?



Yet they feel less prepared in terms of policy and support from the community than with education. The Institute of Health Psychology publishes a bi-monthy journal, *The Blue Line*, devoted to the issue of interpersonal violence. This publications serves as a valuable source of information concerning the different forms of violence, legal options, coping with stress, etc. A selection of these articles are available online.

Figure 6. Do you feel that your organization is adequately prepared to deal with situations of abuse against older women



More than anything, this is because of poor cooperation between community nurses and physicians, both in terms of information about dysfunctional families as well intervention possibilities:

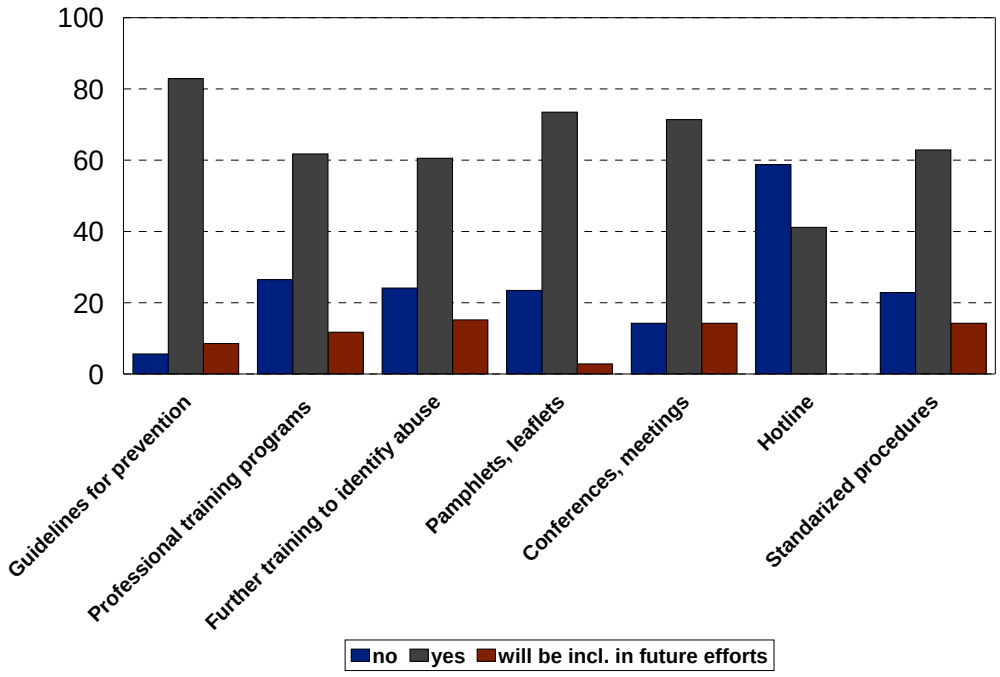
> Cooperation with the healthcare sector is rather poor. I was irritated by one situation where an older woman got out of bed without her son and hurt her tibia. The injury was rather serious and, as is well known, such wounds take a long time to heal in older people. Additionally, the was unkept. Hygiene was neglected in that house. I was calling around for a doctor for two days. When I finally made contact, the doctor and I agreed to arrive at the same time. Despite our agreement, she had arrived ahead of me (5H).

> Hospitals usually call ahead that an older woman, who lives alone, is about to get discharged. The hospitals ask if we know of any centers (...) We have a better level of cooperation with hospitals than with community nurses (M3).

> We once had an intervention where a worker waited from 8 in the morning to 9 in the evening for a physican to drive a patient to the psychiatric hospital (3M).

Training courses make it easier to identify cases suspect for violence and supply knowledge concerning intervention possibilities in domestic violence cases, the mandate of particular institutions, changes to legislation, and possibilities for action. More than half of the organizations taking part in this study used different types of training programs, ensuring their workers the possibility to participate in conferences, apply standardized procedures, etc. Workers and those under care have access to a variety of pamphlets and information concerning institutions one may turn to for help. A smaller number of institutions offer help in the form of a telephone hotline.

Figure 7. Which services does your organization provide to deal with situations of abuse/violence/maltreatment against older people / older women?



6.4 Further support/strategies needed

A number of organizations cooperate in the primary and secondary prevention of violence. This especially concerns the Polish and other social welfare agencies which work together as part of the Blue Card procedures (Figure 8). This cooperation is generally rated as positive. Other organizations which engage in cooperation include courts, local prosecutors, and parole officers. In limited cases, this also

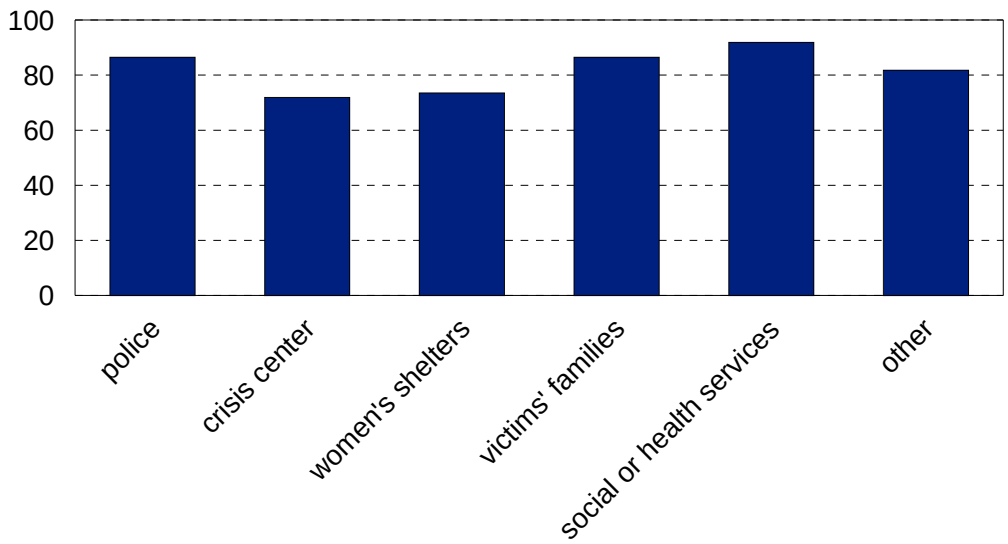
includes the local law enforcement agencies (e.g., City Guard), residence administrators, and NGOs, especially those devoted to supporting and encouraging an active lifestyle among older people. In cases where the perpetrator is someone with an alcohol problem, cooperation is engaged with local commissions for resolving alcohol-related problems, functioning at the level of local district governments.

Part of the problem lies in the minimal involvement of healthcare workers in reacting to cases of domestic violence. Also, there is an unsatisfactory exchange of information between healthcare workers and workers from other institutions in the interest of adding options for dealing with cases suspect for violence:

> Very rarely do we receive calls from community nurses about older people needing help, not just in the context of violence (M3).

> A community nurse seemingly makes regular visits. However, they do not always come and certain tasks (e.g., feeding) should be done by a professional. The caregiver is not always able to perform these tasks (5H).

Figure 8. Do you cooperate with other organizations when you recognize violence against older people?



The need exists to create more institutions which may support both the worker dealing with cases of violence as well as the victims themselves. This need is most evident in rural settings, which lack institutions which may provide care for older people in need or support them in living an active lifestyle:

> ...despite everything, there is a shortage of institutions which may support us in our work. There are also few courses which could prepare us for working in such situations (3M)

> we neither has a senior day centre nor any senior clubs... (4M)

> I wish there were more organizations working for the benefit of older people (7H)

In Poland, in cases of domestic violence, rarely is the victim separated from the perpetrator. Most often the perpetrator remains at home with the family and the victim but seek shelter elsewhere. Legislative changes are necessary to protect the victim.

> It seems more important to have the possibility to isolate the perpetrator, move them to a special facility where they may receive therapy and psychological help. In reality, it is the victim that gets isolated (11H).

> Legislative changes are needed to be able to remove the perpetrator from the home and refer them for toxicology or psychiatric treatment (8H).

Social conciousness concerning violence also needs to change. Society needs to be sensitized that such situations can in fact be remedied:

> We must combat social indifference and report problems when we see them, not worrying about having to testify in particular cases (7M).

> Communities and neighborhoods must become sensitized as to who they should call when reporting cases suspect for violence (4H).

> Especially useful are promotional campaigns and the example of others who went through similar situations, to show the positives. Letting the victim know that they are not alone, that others went through similar situations, and that such cases can be positively resolved (10H).

Specialist training concerning violence directed against older people is a requirement for employment in 20% of organizations, whereas 38% require such training only for certain positions. More than 40% of organizations do not hire properly trained personnel and, unfortunately, in 70% of these, workers are not properly educated concerning how to proceed in abusive situations. It would then seem worthwhile to specially train those who are not otherwise properly educated. It is promising that the employees themselves see the need for added training. Very good preparation in terms of education is reported by 25% of organizations, another 46% rate their preparation as good. Average preparation is reported by 17% and 8.6% rate their preparation in terms of education as weak.

Poor or lacking preparation in terms of action strategies was reported by 24% of respondents. This possibly shows the value of incorporating such strategies where they may be lacking or even diversifying already existing strategies.

A similar number of organizations rate their level of cooperation and support from the local community as either poor or bad. Almost 18% rate this level as average. Therefore the need exists for strengthening ties with local communities which may increase understanding and support in the work of these organizations.

7 Conclusions: Strategies for professionals to deal with domestic violence against older women (2-4 pages)

1. Social campaigns increasing awareness of the problem of violence directed against older people

It seems that action must be taken at changing the level of social consciousness. This can be done through social campaigning, education, open social discourse concerning violence, different forms of violence, consequences, etc. The problem of domestic violence directed against older people should be more widely

discussed. Data from the Center for Studying Public Opinion confirm the effectiveness of social campaigns in Poland. For example, one campaign aimed at decreasing violence directed against children actually led to a decrease in cases.

Especially important is education directed to the older people themselves, who, as mentioned earlier, do not yet possess enough information concerning this issue. As a result, they often fall victim to violence without even knowing.

A social campaign should be designed and implemented, the aim of which would be to inform the public about victim rights and to which institutions victims of violence can turn for help and support. In this context, adequate channels of communication are very important, so that such information may have a chance of reaching older people (e.g., religious media, churches). A good example of this in practice is the "Older Gentleman, Older Lady" program, working as part of the Blue Line. Before beginning any information campaign, a survey concerning media access is performed among older residents to gauge which forms of media are most often and most willingly accessed. Based on this data, information campaigns relating to elder abuse and the advertising of different crisis hotlines, which began to be accessed by victims, were undertaken in media readily accessible by older people.

Also of significant value are campaigns aimed at promoting the important role played by witnesses to violence and increasing their feelings of responsibility for the welfare of the victim. This is especially valuable, considering more than two-thirds of all elder abuse cases are reported by witnesses/third-parties (Durda, 2006). The role of the witness is important, since older people are somewhat reluctant to report cases of abuse or are unable because of, for example, poor health or restricted mobility.

2. Integrating the work of professional caregivers

Family physicians possess the greatest amount of knowledge concerning the overall sociomedical problems faced by patients under their continuous care, in relation to their place of resident (Bień, 2002b). Community nurses are also responsible for evaluating the environment of those under their care in an effort to see to their nursing-caring needs, this also includes coordinating the work of other nursing centers, family physicians, social welfare institutions, etc. Unfortunately, actions directed towards coordinating care and identifying problems are, in large part, neglected (Bień & Doroszkiewicz, 2006). It seems that health sector workers should

be included in the processes of identifying violence-related problems and taught how to undertake effective interventions, or at least informing competent authorities.

It is necessary to create interdisciplinary teams (e.g., Police officer, nurse, social worker)—a coalition of sorts—to oversee intervention cases and more effectively combat domestic violence. Experiences from programs aimed at preventing violence in families find that interventions by different institutions, whose mandates sometimes overlap, do not always involve a free exchange of information between these institutions (Report from the National Program for Preventing Domestic Violence, 2007). Oftentimes this exchange is not fluid, ineffective, or does not occur at all.

Effort should also be directed towards increasing the awareness of local authorities and professional working to combat domestic violence as legal regulations and different possibilities of action.

Legislative changes are also necessary to better prevent violence, especially in terms of better protecting the victim from the perpetrator and more effective application of already existing laws. Especially important is the need to isolate the victim from the perpetrator, particularly when the victim shares the same residence as the perpetrator. At the current moment, from when the abusive situation is reported to when a court verdict is announced, what becomes of the perpetrator remains to be better regulated. The actual number of evictions is rather low, due to little space where the perpetrator may be relocated.

Started in September 2006, the National Program to Prevent Domestic Violence should be continued. It is founded on good principles and seems to have a chance of achieve a positive affect in combating violence directed against older people. However, it is necessary to increasing financing in the realization of programs tailored to the needs of local communities.

3. Supporting family-centered care giving and developing care services

Undertaking the responsibilities of care giving often leads to physical and psychological exhaustion (Bień, Wojszel, Wilmańska et al., 2001). The accessibility of care-nursing services in the residences of older people acts as an added measure of support for family caregivers. In the public healthcare sector, such services are financed or cofinanced by health insurance or welfare agencies. At a regional-

government level, welfare services are provided by Centers for Social Services, while at a municipal level, such services are provided by Centers for Family Assistance. NGOs and volunteer organizations ensure the provision of services chiefly in larger cities (Bień & Doroszkiewicz, 2006). Centers for Social Services often outsource different forms of assistance to foundations and associations, whereas private caregiving services in Poland are developing without any practical oversight. A percentage of Polish families already make use of private services. However, there still exists a general deficit in the availability of care services, mainly extramedical. This shortage is due to high costs, distance from care centers, and bureaucracy (Bień & Doroszkiewicz, 2006). A portion of families consciously choose not to take advantage of institutional support, if only temporarily, due to not being aware of the availability of such services as well as not wanting to be associated with using welfare services, commonly linked with institutional support for dysfunctional families.
A lack of infrastructure is particularly evident on the countryside, especially in terms of services which may relieve the burden of families caring for older people as well as ensuring care for older people living alone (e.g., day centers, senior clubs). In small towns, younger people are leaving in search of work and older people are left alone. Consequently there is a shortage of centers which may offer support to older people for independent living or ensure proper care (e.g., institutional) for older people not capable of living independently.

8 References

Badura-Madej, W. & Dobrzyńska-Mesterhazy, A. (2000). *Domestic violence. Crisis interventions and psychotherapy* [*Przemoc w rodzinie. Interwencja kryzysowa i psychoterapia*]. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego.

Bień, B. & Pędich, W. (1995). Wpływ transformacji społeczno-politycznej w Polsce na jakość życia ludzi starych. Influence of socio-political transformation in Poland on the quality of life of the elderly. *Gerontologia Polska, 3(3-4),* 21-32.

Bień, B., Wojszel, Z. B., Wilmańska, J. et al. (2001). *Old age protected. The caregivers of disabled older people in Poland. A comparative study between city and*

countryside environments [Starość pod ochroną. Opiekunowie rodzinni niesprawnych osób starych w Polsce. Porównawcze studium środowiska miejskiego i wiejskiego]. Kraków: Oficyna Wydawnicza Text.

Bień, B. (2002a). The health status and functioning of older people. [Stan zdrowia i sprawność ludzi starszych.] In: Synak, B. (ed) *Polish elderly [Polska starość*] (35-77). Wydawnictwo Uniwersytetu Gdańskiego: Gdańsk.

Bień, B, (2002b) The family physician „geriatrics on the front line". [Lekarz rodzinny „geriatrą pierwszej linii"], *Polska Medycyna Rodzinna, 4 (2),* 171-176.

Bień, B. (2006), Family caregiving for the elderly in Poland. Wydawnictwo Trans Humana, Białystok

Bień, B., Doroszkiewicz, H. (2006). Long-term geriatric care: home-based or institutional? [Opieka długoterminowa w geriatrii: dom czy zakład opieki?] Przewodnik Lekarski (10): 48 – 57

Bińczycka, J. (1997), *Upbringing between freedom and violence. [Między swobodą a przemocą w wychowaniu*.] Kraków: IMPULS.

Borowik J. & Pędich W. (2002), Autorytet ludzi starych w rodzinach wiejslich Białostocczyzny. The family and social authority of senior citizens in the rural areas of the Białystok region. *Gerontologia Polska, 10(3),* 149-153.

CBOS (2005), Domestic violence and conflicts. [*Przemoc i konflikty w domu*.] Retrieved November 22, 2007, from http://www.cbos.pl/SPISKOM.POL/2005/K_027_05.PDF

Cichocka, M. (2001), The issue and types of violence directed against older people. [Zjawisko i formy przemocy wobec ludzi starych.] In M. Binczycka-Anholcer (ed), *Agresja i przemoc a zdrowie psychiczne* (213-218). Poznań: Polskie Towarzystwo Higieny Psychicznej.

Czekaj, K., Gorlach, K., Lesniak, M. (1998), The labrinth of contemporary society. [Labirynty współczesnego społeczeństwa], Katowice: Wydawnictwo Śląsk.

Czekanowski, P. (2006), Family carers of elderly people. In: Bień, B. (ed). Family caregiving for the elderly in Poland. Wydawnictwo Trans Humana, Białystok, 85-111.

Czekanowski, P., Bień, B. (2006), Older people and their needs of care. In: Bień, B. (ed). Family caregiving for the elderly in Poland. Wydawnictwo Trans Humana, Białystok, 66-84.

Dokument Rady EU nr 7369/01 COR 3, 2005, Retrieved November 23, 2007, from www.consilium.europa.eu/uedocs/cmsUpload/7369PL.pdf

Drabowicz, T. (2006), Digital inequality and old age. [Nierówności cyfrowe a starość.] In J.T. Kowaleski, P. Szukalski (eds), Old age and aging as an individual and collective experience. [Starość i starzenie się jako doświadczenie jednostek i zbiorowości ludzkich.] Łódź: Zakład Demografii UŁ.

Durda, R. (2006), Victimized in old age. An analysis of data from the „Blue Line" [Krzywdzeni na starość. Analiza danych telefonu „Niebieskiej Linii".] *Niebieska Linia, 6.* Retrieved November 18, 2007, from http://www.pismo.niebieskalinia.pl/index.php?id=355

Halicka, M. (1994), The negative aspects of older age. A community study in Białystok. [Negatywne aspekty życia w starości. Badanie środowiskowe w Białymstoku.] *Zeszyty Problemowe Polskiego Towarzystwa Gerontologicznego, 4(2),* 92-95.

Halicka, M. (1995), Elder Abuse and Neglect In Poland. *The Journal of Elder Abuse & Neglect, 6(3-4),* 157-169.

Halicka, M. (1996), Człowiek starszy jako ofiara nadużyć. Old men as abuse victim. *Gerontologia Polska, 4(2),* XXXVI-XL.

Kądziela, J. (1979), Studies on peace. Theory and practice. [*Badania nad pokojem. Teoria i jej zastosowania*.] Warszawa: OdiS.

Marody, M., Giza-Poleszczuk, A. (2004), Shifting social ties. [*Przemiany więzi społecznych*,] Warszawa: Wydawnictwo Naukowe Scholar.

Misztalska, A. (1995), Transition system and collective wellbeing. [Transformacja systemu a samopoczucie zbiorowe.] *Kultura i połeczeństwo, 39,* 44.

Nowak-Sapota, W. (2006), Spatial differences in the structure of households run by older people. [Przestrzenne zróżnicowanie struktur gospodarstw domowych osób w starszym wieku.] In: J.T. Kowalewski, P. Szukalski (eds.) *Old age and agng as an individual and collective experience. [Starość i starzenie się jako doświadczenie jednostek i zbiorowosci ludzkich*.] Łódź: Wydawnictwo Uniwersytetu Łódzkiego

OBOP (1997), Concerning the „Stop domestic violence" campaign. [*O kampanii „Powstrzymać przemoc domową".]* Retrieved November 21, 2007 from http://www.tns-global.pl/archive-report/id/127

Potoczna, M. (2004), Collective help, shared residences, and intergenerational responsibility. [Wzajemna pomoc, wspólne zamieszkiwanie i odpowiedzialność międzypokoleniowa.] In W. Warzywoda-Kruszyńska & P. Szukalski, *The family in a changing Polish society. [Rodzina w zmieniającym się społeczeństwie polskim.]* Łódź: Wydawnictwo Uniwersytetu Łódzkiego.

Pospiszyl, I. (1994), *Violence in the family. [Przemoc w rodzinie.]* Warszawa: Wydawnictwa Szkolne i Pedagogiczne Spółka Akcyjna.

Pospiszyl, I. (1999), *Together against violence. [Razem przeciw przemocy.]* Warszawa: Żak.

Raport o stanie prewencji kryminalnej i zadaniach realizowanych w tym zakresie przez jednostki organizacyjne Policji w 2006 roku (2007) [Report concerning the state of criminal prevention and assignments realized in this regard by Police units in 2006], Warszawa, Komenda Główna Policji, retrieved November 20, 2007, from http://www.policja.pl/download.php?s=1&id=7898

Raport o sytuacji polskich rodzin (1998), [*Report on the situation of Polish families],* Warszawa, Kancelaria Prezesa Rady Ministrów, Biuro Pełnomocnika Rządu do Spraw Rodziny.

Ratajczak, A. (1980), *Crimes against families, caregivers, and adolesents. [Przestępstwa przeciwko rodzinie, opiece i młodzieży.]* Warszawa: Wydawnictwo Prawnicze.

Rezolucja ResAP,(2005), retrieved November 23, 2007 from http://www.coe.org.pl/re_dokumenty/ResAP(2005)1.doc

Rudnicka-Drożak, E. (2006), *Violence directed against older people as a health right. Constructing instruments to study primary healthcare needs. [Zjawisko przemocy wobec osób starszych jako forma zagrożenia zdrowia. Konstrukcja narzędzia badawczego dla potrzeb podstawowej opieki zdrowotnej.]* Lublin

Rudnicka-Drożak, E., Latalski, M. (2006), Violence directed against older people aged over 65 years resident in rural areas of the Lubelski voivodeship, compared to urban areas. [Zjawisko przemocy wobec osób starszych powyżej 65 r.ż. mieszkańców rejonów wiejskich woj. lubelskiego w porównaniu do rejonów miejskich.] *Problemy Higieny i Epidemiologii, 87,* sup.

Sasal, H.D. (1998), *Blue cards. A guide to Police intervention procedures in cases of domestic violence. [Niebieskie Karty. Przewodnik do procedury interwencji Policji wobec przemocy w rodzinie.]* Warszawa: Państwowa Agencja Rozwiązywania Problemów Alkoholowych.

Sprawozdanie z realizacji Krajowego Programu Przeciwdziałania Przemocy w Rodzinie w okresie od 25 września 2006 roku do 31 grudnia 2006 roku (2007). *Report from the National Program for Preventing Domestic Violence*. Retrieved November 20, 2007, from http://www.feminoteka.pl/downloads/sprawozdanie_z_realizacji_programu.pdf

Tobiasz-Adamczyk, B., Brzyski, P., Bajka, J.(2003), Social determinants of quality of life among women at the start of older age. A comparative study. [*Społeczne warunkowania jakości życia kobiet u progu wieku starszego. Badania porównawcze*.] Kraków: Wydawnictwo UJ.

Tobiasz-Adamczyk, B. (2007), The perception of elder abuse in the work experience of health professionals. *European Jounal of Public Health, 17,* 321.

Twardowska-Rajewska, J. & Rajewska-deMezer, J. (2005), Abuses against seniors in their families. [Nadużycia wobec seniorów w ich rodzinach.] In M. Binczycka-Anholcer (ed), Violence and aggression as a public health problem. [*Przemoc i agresja jako problem zdrowia pyblicznego.]* Warszawa: Polskie Towarzystwo Higieny Psychicznej.

Warzywoda-Kruszyńska, W. (2004), The family in a time of change. [Rodzina w procesie zmian*.]* In W. Warzywoda-Kruszyńska & P. Szukalski, *The family in a changing Polish society. [Rodzina w zmieniającym się społeczeństwie polskim.]* Łódź: Wydawnictwo Uniwersytetu Łódzkiego.

Wiak, R. (2005), *Crime prevention in Poland. Personal Communication.* London.

Annex 1. List of interviewed persons

No	Code	Profession	Place
1	1H	Geriatric nurse	Kraków
2	2H	Physician, long-care physician	Kraków
3	3H	Nurse	Kraków
4	4H	Social worker	Communal Center for Social Services, Rejowiec
5	5H	Social worker - specialist	Municipal Center for Social Services, Kraków - Podgórze
6	6H	Social worker	Municipal Center for Social Services, Kraków - Podgórze
7	7H	Social worker	Municipal Center for Social Services, Kraków - Podgórze
8	8H	Psychologist specialised in family services	Municipal Center for Social Services, Kraków
9	9H	Social worker	Municipal Center for Social Services, Kraków
10	10H	Social worker	Municipal Center for Social Services, Kraków
11	11H	Social worker - specialist	Municipal Center for Social Services, Kraków – Nowa Huta
12	12H	Social worker	Municipal Center for Social Services, Kraków – Nowa Huta
13	1M	Physician, specialist of long-care	Kraków – Nowa Huta
14	2M	Manager of care services, nurse	Kraków
15	3M	Team Manager	Municipal Center for Social Services, Kraków – Nowa Huta
16	4M	Psychologist	National Crisis Center for Victims of Domestic Violence, Warszawa
17	5M	Team Manager	Municipal Center for Social Services, Kraków
18	6M	Manager of care services, psychologist	Kraków
19	7M	Police officer	Voivodship Police Headquarters Białystok

Annex 2. Profiles of the hands-on workers in the sector of community health and social care in Poland

Community nurse	**Home helper / carer**	**Social worker**
• Responsibility for medical care and organising medical aid • Responsibility for health education and health promotion	• Responsibility for personal hygiene • Supporting household activities (cleaning, shopping, etc.) • Supporting food intake • Responsibility for medical aid	• Supporting communication and social activities • Helping in hiring home helper/carer if necessary