daphne

MIND THE GAP!

Improving Intervention in Intimate Partner Violence against Older Women

It is never too late

Older Women as Victims of Intimate Partner Violence Information for Social Support Practitioners

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Göttingen February 2013

Downloadable (including in German) and further information at: www.ipvow.org

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Information for social support practitioners

Sandra Kotlenga Barbara Nägele

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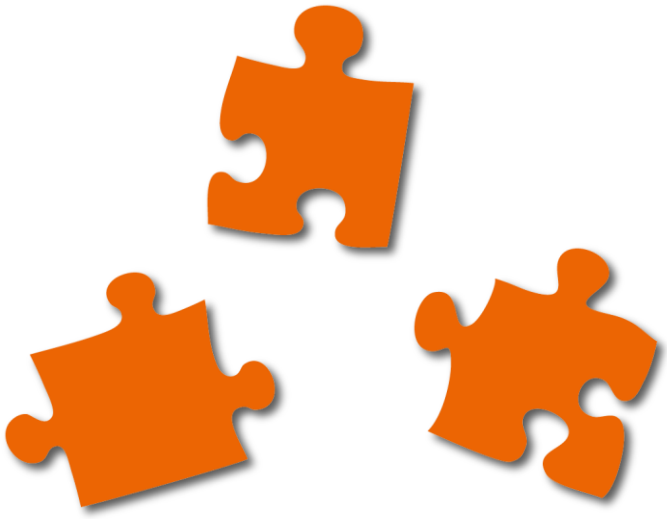


Introduction

> "Well, I would say that looking for someone outside the family to openly discuss things with, someone who listens to you, or someone whom you can pour your heart out to, whatever is bothering you and such. I think that you can get a lot off of your chest, it puts things in perspective again. You have verbalized it. I believe that many women are alone in their sorrow. ... I would advise them to gather up their courage and speak to someone. I would say that otherwise it is not possible to endure something like that for a long time without becoming ill."
> ***Ms Jansen, 67 years old***
>
> "Get away. That is the best thing you can do. When nothing else works. And that is what other women who leave say as well. I know a lot of women who have had a house with her husband. They left and they also say why should we stay and go to the dogs in a golden cage and be humiliated or things like that. So we just leave."
> ***Ms Kopp, 63 years old***[1]

This is how two women who experienced violence in their intimate partnership in old age and escaped from it answered the question as to what they would recommend to other older women who have experienced violence: to look for someone to talk to, to escape isolation and end the relationship. Women's shelters, women's counselling offices and intervention centres seek to support female victims of violence in this: they advise women, they support them in practical terms as well and offer them lodging. Older women have thus far only rarely made use of these services, however. That is why knowledge about age-specific issues has not been needed all that much to date in counselling work. But the situation is changing: specialists are witnessing a slow increase in the number of women seeking help and in many places a closer, targeted look is being taken at older women as well. At the same time it is clear that the needs of older women victimized by violence are in part the same as for younger women, but by the same token age-specific aspects influence the counselling process. This brochure examines age-specific aspects and provides information on how to deal with these. The brochure is thus intended to support specialists at facilities – both in their actual counselling work as well as in the further development of their services. At the same time, we are aware that satisfactory solutions are not available for all problematic situations in counselling work given existing financial and legal constraints. This brochure addresses violence in intimate partner relationships. We are aware, however, that violence also often occurs in mother-son relationships in old age as well. Much of the information in this brochure may also be useful with constellations like these.

Part 1 (A) of this Brochure presents the present level of knowledge with regard to intimate partner violence against older women. You will find information for dissemination and special notes on intimate partner violence in old age as well as information on how older women can make use of help.

Part 2 (B) contains information and tips for counselling work.
First aspects are listed which play a general role in counselling work with older women who are victims of intimate partner violence. The most important notes for counselling practice are presented on certain topics and situations where help is required (for example, need for

[1] Quote from Nägele, Böhm, Görgen, Kotlenga & Petermann, 2011, pp. 236 f.

nursing care and support, basic needs in old age). The addresses contained in the German version cannot be found here as they do not apply for other countries.

Part 3 (C) addresses the question as to how facilities which support women victimised by violence can better tailor their services and public-relations work to suit the needs of the target group of older women if they so desire. Information is also provided here on how the problem can be addressed in local networks on domestic violence.

This Brochure is based on the experience of many specialists who work with older women victimised by violence, especially staff members of women's shelters, women's counselling offices and intervention centres. They have reported on their experiences to us in several surveys and joint projects.[2] We have furthermore made use of the wealth of information material and hand-outs coming especially from Canada and the USA, but also from Germany on individual topics. Of greatest importance in the creation of this Brochure, however, was a working group which met in Hanover to address this topic in the autumn of 2011 and whose members commented on the drafts of the brochure before its publication. The working group was made up of staff members from women's shelters, counselling offices and intervention centres from Erfurt, Mannheim, Meiningen, Mettmann, Neustadt, Rostock and Warendorf, as well as staff members of the women's shelter coordination office (Frauenhauskoordinierung e.V.) and the Federal Association for Women's Counselling Offices and Women's Hotlines (Bundesverband für Frauenberatungsstellen und Frauennotrufe - bff). The women from this working group, who we would like to take this opportunity to expressly thank here, developed the idea which led to the structure of the Brochure and much of its content goes back to input from the working group. Of course the authors are responsible for any inadequacies in the end product.

The Brochure was developed within the framework of the project "Mind the Gap!" with support from the European Commission. It is available as a PDF file on the homepage of the project (www.ipvow.org). In addition to this and brochures for social services from other countries you will also find material addressing older women for public-relations work of facilities for the support of women victimized by violence (posters, postcards and flyers for specialists from social services, staff working in the area of care for older people and nursing care as print templates) and training materials and manuals for the police on the topic for different countries in the country languages (Polish, Portuguese, German, Hungarian) and English translations. We very much hope that this Brochure together with the other material will help close the gap existing between older women who are victims of violence and facilities for support of women victimized by violence on the one hand and these facilities and age-related services on the other.

[2] You will find information on these surveys at www.ipvow.org, as well as information on the project "Living Safely and Securely in Old Age" at www.silia.info

A Information on the phenomenon

The first part of this Brochure gives fundamental information on the phenomenon. It contains information on the scope of the phenomenon, on factors involved in the cases, and on how intimate partner violence against older women differs from intimate partner violence against younger women. Detailed information on the phenomenon is contained in the study "Intimate partner violence against older women" (Nägele, Böhm, Görgen, Kotlenga & Petermann 2011) and in the analysis of procedures contained in the files of the Hessian Public Prosecutor (both are available in English at www.ipvow.org).

1. Explanation of terms: what exactly do we mean by intimate partner violence against older women?

"Intimate partner violence against older women" is based on the following understanding of terms: intimate partnership is defined to be any form of intimate relationship – homosexual and heterosexual, married or unmarried, living together or apart. It involves intimate partner violence experienced by women over 60 years of age. By the same token this can also involve violence committed by former intimate partners. Intimate partner violence is a specific type of domestic violence which occurs when power and control are exercised within an intimate relationship. This is independent of age, origin, social and cultural background, physical / mental condition and lifestyle. Violence is understood to be a non-legitimate action (or failure to take action) intentionally employed in order to injure another person physically and/or psychologically against their will. This may comprise the use of physical force, causing pain and injuries as well as emotional/psychological and sexual abuse, sexual harassment, financial exploitation and intentional neglect (in particular when the victim depends on nursing care and/or the support of the partner). (see Band-Winterstein & Eisikovits, 2009, p.165)

2. Gender-specific perspective: why is the focus on women as victims?

Again and again practitioners are confronted with the objection that the focus on women as victims of intimate partner violence ignores intimate partner violence against men. This should be countered by the argument that in this focus it is precisely intimate partner violence against older women which is interesting, and this is often lost sight of when one examines all types of violence experienced in old age independently of gender. This generally places age-specific aspects at the heart of enquiry in the development of violence, psychological alterations, the need for nursing care and inability to cope in providing nursing care. By the same token, there are good reasons to adopt a gender-sensitive perspective on old age: one of the most important structuring factors in societal power relationships is the category of gender. Such central power relationships are not an abstract construct, however, but rather manifest themselves in the concrete reality of everyday life and hence in intimate partnerships and families. This is where such power relationships are undermined, negotiated, re-established and defended time and time again – even if this is associated with many disjunctures, ambivalences and ambiguities. It must moreover be taken into account that women who are now older have had experiences in their life histories with societally-based, gender-related power relationships, including those marked by dependency and

violence, in a particularly salient manner. They have experienced gender as a factor assigning social roles, while also impacting and structuring private lives more than younger women.

To be able to examine more closely the gender-specific dimensions of experiences of violence in old age described above this Brochure is limited to the group of older women as victims. It is not denied that older men also experience violence in their partnerships and that these victims also need help and support. On the contrary, special attention appears warranted here as well, as the percentage of men among all victims of intimate partner violence in families of their age group according to studies on unreported cases and criminal statistics kept by the police is significantly higher among persons over 60. With a lower number of cases on the whole, male victims accounted for 27.4% of all cases of intimate partner violence against persons age 60 plus registered by the police in the years 2006 to 2008, while their share among victims up to 60 years of age is considerably lower at 12.4% (Hessisches Landeskriminalamt, 2007, 2008, 2009; author's own calculations). This deserves mention and it is important to bring up this topic in other contexts as well.

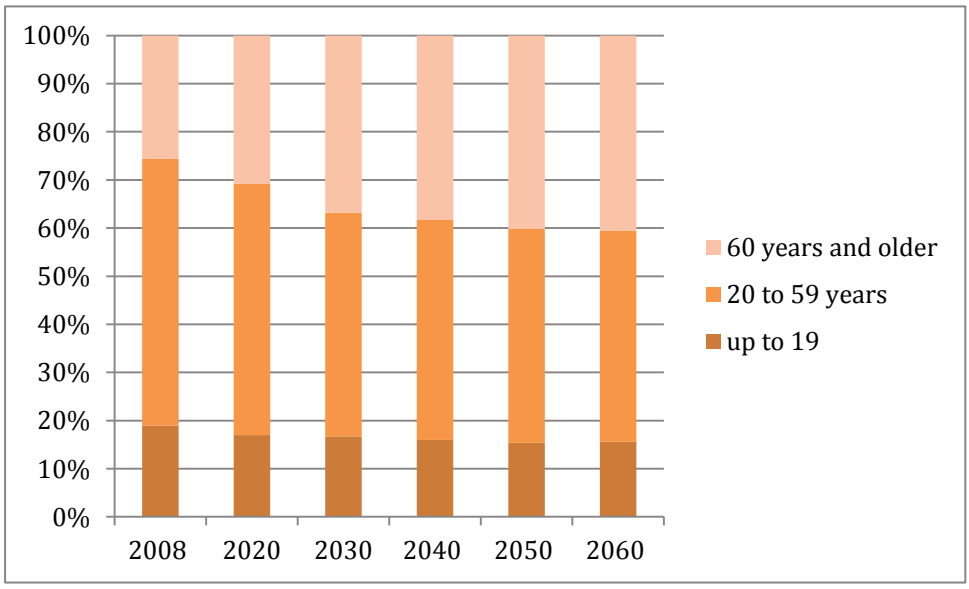
3. Frequency of the phenomenon: How many older women are affected?

3.1. Demographic change and percentage of older women living in intimate partnerships

With the growing number of older people the number of cases of intimate partner violence affecting older women will also increase; the age structure of users of services for victims of domestic violence will change. Cautious population development projections[3] state, that the proportion of persons age 60 and above of the total German population might increase from 26% in 2008 to 30% in 2020 up to 40% in 2050. This development is shown in the following graph 1.

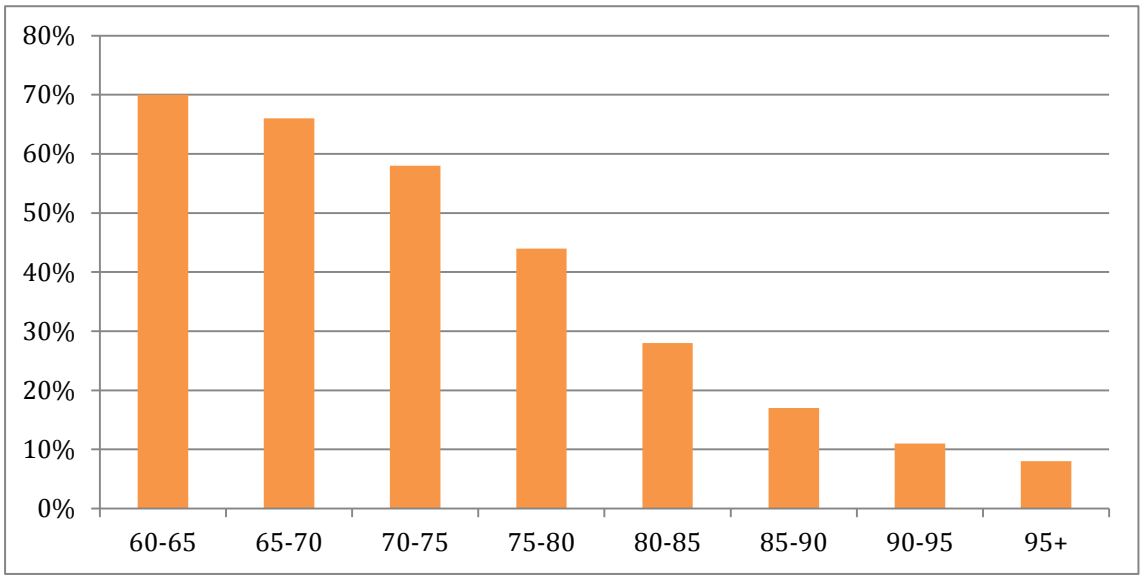
[3] This cautious prognosis is based on the assumption of a stable birth rate and mortality and a population growth of 100.000 persons per year due to migration from 2014 on. (Statistisches Bundesamt 2009)

Graph 1: Age distribution 2008 to 2060 according to the population projection (Statistisches Bundesamt 2009)



The question as to whether intimate partners are married or not in the current intimate partner relationship or whether they live together in a common household apparently does not play any major role with regard to the degree of physical and/or sexual violence within the partnership - according to findings of the study on the "life situation, security and health of women in Germany" (BMFSFJ - Federal Ministry of Research, Senior Citizens, Women and Youth , 2004; Schröttle 2008, p. 144) Because the dominant form of an intimate partnership in old age is a common household and in particular marriage, the number of women who are married and those who live together with their intimate partner allows one to estimate how many older women could potentially be affected by violence in their intimate partner relationships. According to the micro census, 44% of women over 60 were living alone in a household in 1998, barely three-fourths of them being widows. 46.3% per cent were living in a two-person household, whereby 87% of these cases involved marriage and 3% pairs living together out of wedlock. (Deutscher Bundestag, 2001, p.213) According to more recent data from Lower Saxony for 2011, even 51% of women over 60 were married there. The percentage of married women declines with age – mainly due to the different expectancy of life among men and women. The figure is 70% for women aged 60 to 65, 66% for 65 to 70-year-olds, and still 58% among 70 to 75-year-olds. The percentage was 44% among 75 to 80-year-olds, 28% among 80 to 85-year-olds, dropping to 17% among 85 to 90-year-olds, 11% among 90 to 95-year-olds and finally only 8% among over 95-year-olds. (Landesbetrieb für Statistik und Kommunikationstechnologie Niedersachsen, 2012, p. 8f.) Hence the "possibility" of becoming a victim of violence in intimate partnerships declines with increasing age.

Graph 2: percentage of married women broken down according to age groups, Lower Saxony 2011 (source: Landesbetrieb für Statistik und Kommunikationstechnologie Niedersachsen, 2012, pp. 8f)



3.2. Unreported cases: victimisation surveys

All victimisation surveys on intimate partnerships indicate a lower percentage of older women becoming victims of physical/sexual violence (but not only) than younger ones.

A study entitled "the living situation, security and health of women in Germany" conducted over the years 2002 to 2004 commissioned by the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth has provided fundamental data on women's experience with violence in Germany (BMFSFJ, 2004). The Interdisciplinary Centre for Research on Women and Gender (IFF) at the University of Bielefeld surveyed a representative number of 10,000 women living in Germany on the basis of a random community sample in cooperation with infas, Institut für angewandte Sozialwissenschaft (Institute for Applied Social Research). The secondary analysis of the data (Schröttle, 2008) shows that the incidence of physical or sexual violence committed by a current or former partner is significantly lower among older women than younger ones. 4.9% of women up to the age of 34 report such victimisation, 2.6% of women aged 35 to 44, 1.6% of women 45 to 59, but only 0.1% of women over 60.[4]

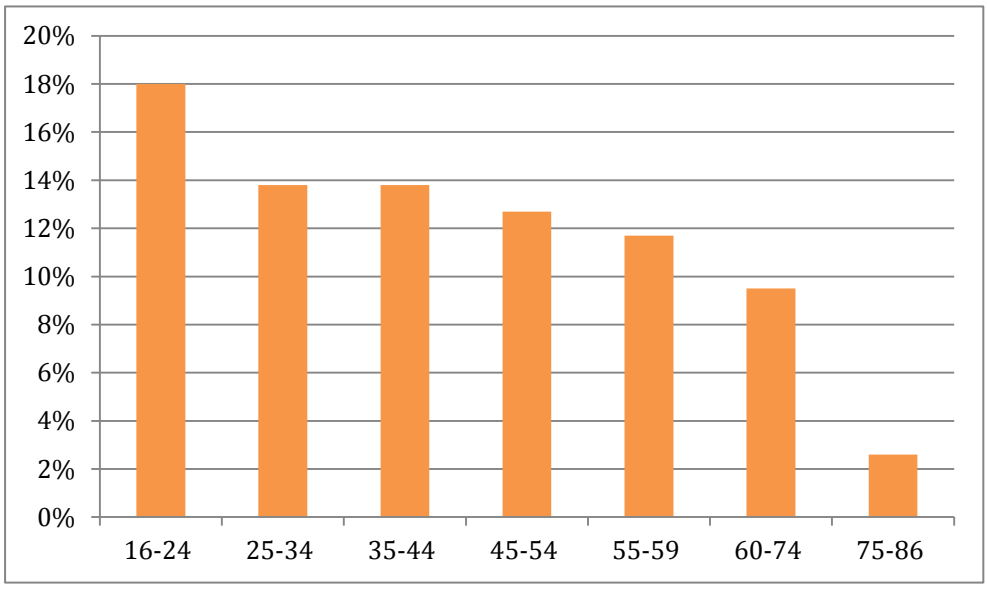
A decline in the prevalence of psychological violence, in contrast, only takes place among older age groups. Here the persons surveyed were asked to check off which statements accurately characterise the behaviour of their current partner.[5] If one only examines the very

[4] The author notes the limited reliability of the data as a result of the low number of cases. The trend is nevertheless very clear.

[5] The instrument is a slightly abbreviated, modified version of the Psychological Maltreatment Instrument used in U.S.-American studies. With the instrument on psychological violence, the interviewees were asked which of the statements accurately described their current intimate partner in whole or in part. Statements were then offered such as: "Is jealous and prevents my contacting other men/women", "says that I am ridiculous, dumb or incompetent", "ignores me, does not answer questions"; "checks up precisely how much money I spend on what"; "checks exactly where I go with

great salience of psychological violence,[6] statements checked off by the age group of women under 75 were evenly distributed – 6-7% of persons up to 75 are accordingly victims[7]. 3% of persons 75 and over report this kind of behaviour on the part of their intimate partner.

Graph 3. Experience of violence in the current intimate partnership (phys./sexual) (the case base is women currently living in partner relationships; Schröttle, 2008)



Types and the scale of older persons' experience of victimisation in the years 2004 to 2008 have been examined under the auspices of the Kriminologisches Forschungsinstitut Niedersachsen e.V. (KFN). A representative national survey of victimisation was conducted by infas, Institut für angewandte Sozialwissenschaft (Institute for Applied Social Research) for the older populated aged up to 85 within the framework of this study. 3,030 persons aged 40 to 85 selected in a random sample were surveyed verbally (in German). Drop-off forms were left behind for a somewhat smaller random sample in which among other things people were surveyed about victimisation at the hands of persons from the immediate social area of the persons surveyed. This study shows in general that experience of violence decreases in old age. Especially serious victimisation at the hands of adult members of households (sexual violence, serious physical violence, property crimes) was surveyed separately. 40 to 59-year-olds were victimised approximately five times more frequently in the said areas than persons 60 and older. With regard to physical violence, marital partners are the primary persons cited as perpetrators of physical violence for the higher age group, while the victims are women. (Görgen, Herbst & Rabold, 2010, pp. 162f.)

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whom, what I do, and when I come home"; "intimidates me when I am of a different opinion (e.g. by means of gestures, glances or yelling)", etc. The list of items is contained in the long version of the final report. (BMFSFJ 2004, pp. 249f.)

[6] i.e. at least four items / modes of behaviour regarding psychological violence were answered affirmatively

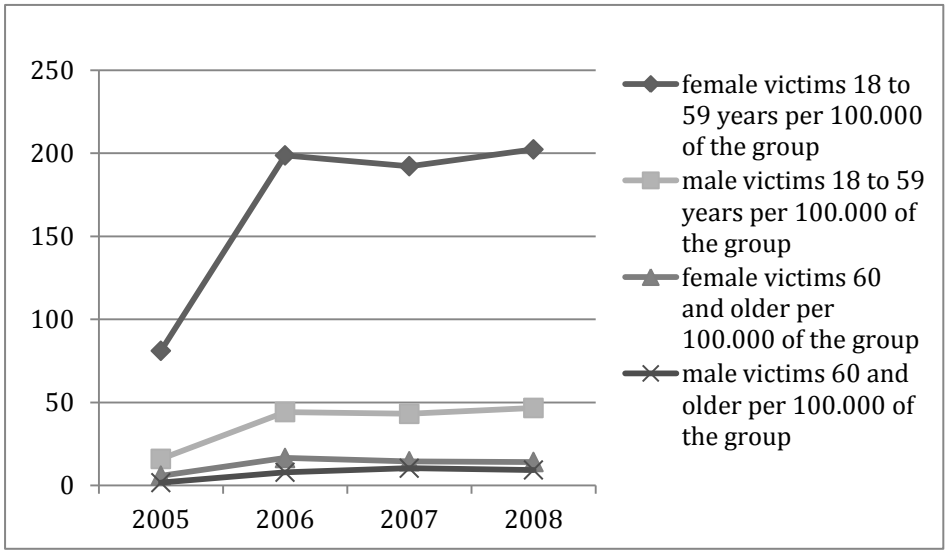
[7] The span derives from questions being asked at several points of the interview and in the questionnaire on experience of violence. The information here is not always consistent.

3.3. Reported cases: institutionally recorded cases

One cause of the low level of attention devoted to the topic by help organisations and law enforcement agencies is the limited number of older women who contact these as victims of intimate partner violence there. But there are quantitative differences between institutions.

Criminal statistics kept by the police available indicate that older women are also much more infrequently victims of offenses registered with the police at the hands of current or former intimate partners. The percentage of older victims among all female victims of intimate partner violence in the German Länder for which such figures are available (Hessen, Baden-Württemberg and Schleswig-Holstein) varied between 2.6% and 4.5% over the years 2006 to 2008. Graph 4 shows, that while in Baden-Württemberg in the years 2006 to 2008 from 100.000 inhabitants age 18 to 59 200 women became victims of intimate partner violence, the same proportion was for women age 60 and above 14. In numbers in Baden-Württemberg a total of 204 older women became victim of an act of intimate partner violence registered by the police. In comparison: a total of 7679 of all age groups was affected. In Hesse the absolute figures are also low: while there were on average 365 victims of intimate partner violence registered with the police for every 100,000 women aged between 18 and 50 in 2008, there were merely 20 victims per 100,000 persons among women 60 and over (Hessisches Landeskriminalamt, 2009; author's own calculations).

Graph 4: **Victims of criminal offenses in the context of intimate partner violence per 100,000 persons in the group, Baden-Württemberg, 2005-2008**



The proportion of older women of all female clients of services for victims of domestic violence is still small. While statistics on the number of inhabitants at 140 German women's shelters for 2008 indicate only 110 residents over 60 (1.6% of all adult residents), there were 317 clients over 60 for counselling and intervention centres (BISS offices) in the Land of Lower Saxony for 2007 (3.7% of all users[8]; see the overview provided in Nägele, Böhm, Görgen, Kotlenga & Petermann, 2011).

[8] Although this also includes other constellations of relationships, frequently mother/son relationships.

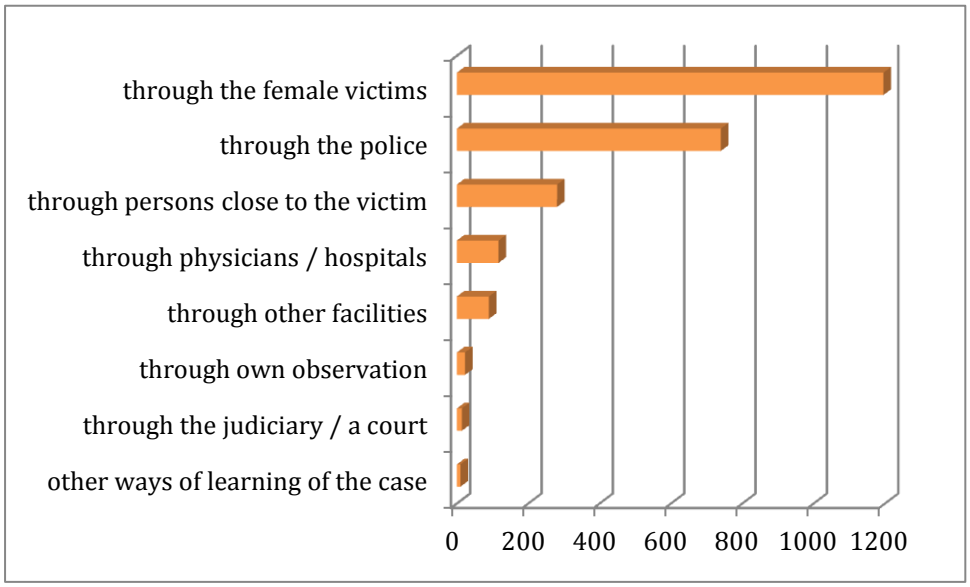
An institutional survey from 2009 sheds light on the question as to which institutions and facilities learn of cases of intimate partner violence against older women. (Nägele, Böhm, Görgen, Kotlenga & Petermann, 2011)[9] With minor exceptions, the facilities included in the assessment were only aware of few cases – 50% of all institutions stated that they had only dealt with 4 or less cases over the years 2006 to 2009. By comparison, the intervention centres became aware of most of the cases. Half of the intervention sites reported 17 or fewer cases, i.e. 50% reported more than 17 cases. Half of the women's counselling centres (for violence) reported 7 or fewer cases, half of the combined services more than 11 cases, and half of the women's shelters 4 or fewer cases for the said period of time. Nursing-care advice centres and clerics reported no knowledge of any cases, while nursing-care and medical facilities in the study, community social services, other counselling offices and services for senior citizens reported only limited knowledge. Awareness of cases among the 35 police officers surveyed differed greatly. While half of them stated that they were only aware of one or fewer cases over the said period of time, 7 police officers (20%) were aware of 6 or more cases.

The study revealed in some instances major differences in the awareness of cases at the same types of institutions. Staff of individual institutions reported time and again that – contrary to the general trend - they definitely had experienced such cases: a facility for aid to the homeless, a counselling office at a community housing facility, a nursing home, a social-psychiatric service, a psychiatric clinic and a psychosocial counselling office. Interviews subsequently conducted with experts at these facilities showed that a specific sensitisation to the topic based on (occupational) biographies on the part of the experts surveyed can contribute to such cases being perceived at a facility in the first place.

The survey showed the tremendous importance of the police force and of intervention centres in processing and reporting cases. It was the women themselves who contacted the help facility in approximately half of the cases reported, although third parties informed facilities in half of the cases, with the police being the main facility mentioned here – of course frequently in the context of formalised referral of cases to intervention centres. The fact that within the myriad of institutions it was intervention centres – which above all receive contact to women who are victims of IPV through the police – that have the most wide-ranging experience with cases underscores the key position of the police in work involving cases of intimate partner violence in old age.

[9] Firstly, all facilities offering support in the case of domestic violence in German territory were surveyed in the study; secondly, a broad spectrum of organisations and professions were written from the nursing-care, medical and psychosocial area as well as criminal prosecution offices. A total of 427 institutions returned filled-in questionnaires (a total response rate of 29.8%), of which 77.3% reported that they were aware of cases over the period 2006 to 2009. These institutions reported 4,196 cases.

Graph 5: Modalities in awareness of cases with victims assisted by the institution 2006-2008 (N=350 surveyed institutions, IPVoW Institutional Survey)



Nonetheless a study on public prosecutors files involving cases of intimate partner violence against older women, which was carried out within the Mind the Gap! project,[10] showed, that in only few cases in the files it was documented that the police had sent a fax to the intervention centre and that the women were asked for consent. Although guidelines and state policy see case referral from the police to the intervention centre as a key feature of the system of victim protection, almost none of the cases analysed was referred to the intervention centres.

3.4. Lack of investigation of unreported cases

There are indications that a considerable number of old women affected by domestic violence are not aware of the respective institutions offering help and/or do not make use of them. Thus the secondary evaluation by Monika Schröttle (2008) shows that in comparison to women in the middle age group, among older women there is a significantly lower percentage of women victimised by intimate partner violence in their partnership who are aware of help services (67–70%[11] of the 25 to 54-year-old women vs. 52–58 % of women 60 and older) and make use of them (11–14% of the 25 to 54-year-olds vs. 2–5% of women aged 55 to 74). These figures are even much lower for very old women and older women with migration backgrounds. (Schröttle, 2008, S. 191ff.)

Most important findings:

1. **The potential for victimisation in intimate partner relationships declines significantly with age as a result of changing household and family structures.**
2. **Experience of physical and sexual violence in intimate partnerships declines significantly with age.**

[10] The results are available on www.ipvow.org under the heading research reports / case file analysis. (Taefi, Nowak, Görgen, Kraus, & Nägele 2013).

[11] Persons were asked about their experience of violence at several points in the survey (interview, drop-off questionnaire). This produced different findings in part. The bandwidth described relates to this.

3. **The scale of victimisation with regard to psychological violence, on the other hand, remains stable to the mid-70s.**
4. **Institutions rarely experience cases of intimate partner violence among older people – including as a result of the lower number of cases.**
5. **Whether cases are perceived or not frequently depends on the sensitivity of experts to the topic of domestic violence.**
6. **intervention centres are the institutions which most frequently experience cases of intimate partner violence in old age.**
7. **The police is assigned a key function when it comes to institutions becoming aware of IPV cases.**
8. **Awareness and use of help on offer to victims of violence declines with age.**

4. Characteristics of cases: what is special about cases of intimate partner violence against older women?

It is hence not primarily the quantitative dimension of the problem which justifies a close look at the topic. The crucial point, rather, is characteristics of cases and special aspects relating to access to help and support as well as aspects characterising the existing help system.

4.1. Intimate partner violence in nursing-care relationships

The study "criminality and violence in the lives of older people" contains a series of cases of intimate partner violence in the context of domestic nursing-care relationships reported in qualitative interviews. It became apparent that the dynamics of violence with reference to nursing care and those in the context of many years of intimate partner violence may overlap and mutually reinforce each other (Nägele, Kotlenga, Görgen & Leykum, 2010, pp. 356 ff.). Thus in addition to cases in which violence is clearly due to the added strain on the person providing nursing care, continued intimate partner violence with women requiring as well as providing nursing care as victims constitutes an important group among the cases of intimate partner violence reported in domestic nursing-care relationships.[12] It became clear that in those cases in which the women providing care became victims, dominance relationships can be successfully preserved in spite of dependence on nursing care, i.e. that in spite of objectively changing power positions and dependencies women were afraid of their husbands who required nursing care.

4.2. Documented violent relationships – violence which crops up for the first time

Results of studies produced to date indicate that in intimate partner relations characterised by violence among older people, one especially finds cases in which older women are suppressed, humiliated and physically maltreated on a massive scale and in a systematic manner over long periods of time and that they only come to make use of help with difficulty (c.f. Nägele, Böhm, Görgen, Kotlenga & Petermann, 2011, Görgen, Newig, Nägele & Herbst, 2005). Many cases lead to psychological and physical problems (Thomas, Joshi, Wittenberg &

[12] In particular cases of (sexualised) violence by sons/sons in law and grandchildren against mothers, grandmothers and mothers in law which do not involve excessive strain due to nursing care also need to be analysed in the context of gender-specific power relations.

McCloskey, 2008). Even long violent relationships may change in old age. In part a decline in victimisation is reported, a shift to psychological violence, although other cases also describe an escalation of violence in relationships. In addition there are a series of intimate partnerships in which the partner only becomes violent in old age. There tends to be fewer cases of women entering into relationships in old age which subsequently become marked by violence.

4.3. Causal and influential factors in the development or escalation of violence in old age

Various age-related and non-age-related factors can contribute to violent relationships changing in old age or violence taking place for the first time. One critical life event cited again and again is retirement of the man; this eliminates free space for women (and men), with checks and controls multiplying, the male no longer receiving societal confirmation of his role, and frustration and aggression mounting along with the isolation of the couple. Serious changes in intimate partner relationships occur when men or women develop disorders and illnesses that have an effect on behaviour, emotions and personality (dementia, paranoid or bipolar disorders, changes in personality as a result of strokes or Parkinson's disease, etc.). Such changes can exacerbate relationships which are already characterised by violence, but they can also help trigger violence for the first time. Other important influential factors include processes of physical decline ranging all the way to the need for nursing care on the part of the husband and the wife; increasing need for help by the woman may intensify violence because she is no longer able to perform her function of taking care of the household, i.e. she no longer functions in line with the expectations of her husband, instead even requiring help herself; increasing need for help on the part of the male may also ratchet up violence because men take out their frustration over their loss of status, the loss of capabilities and dependence on nursing care from their wives. Finally, alcohol abuse also plays a role in violent relationships between older people in case after case. This is also frequently associated with excessive physical or sexual violence.

4.4. Factors specifically relating to generations

In addition to age-specific factors, a major role is also played by factors and experiential backgrounds of specific generations in experiencing and coping with violence. Of key importance is the psychologically important experience of clear power relationships between men and women in their life histories. Experience of violence has been commonplace for many women who are older now in gender-specific power relationships, but not only these. Many of them experienced violence as a sort of biographical constant growing up with their parents (against children, against women), in school, while undergoing training, at their jobs and in intimate partner relationships. Some reported several relationships marked by violence as adults, and some even that their daughters or sons are once again involved in violent relationship. Post-war Germany and dramatic experiences with violence, poverty, flight and displacement and the loss of family and loved ones are an important element of this generation. An early lesson which many women learned during this period is that they have to endure hardship and carry on in order to begin something new. The notion of marriage in this generation is moreover that of a life-long obligation which cannot be reneged much more than is the case with younger women. Responsibility is a key part of their lives; they were responsible for taking care of family members in their families. For many this was an important part of their identity and remains so today. But the experiences

of women over 60 today are of course very heterogeneous. Thus there are significant differences between women with and without migration backgrounds in this respect, between women from western and eastern Germany, women in the third or fourth life phase, women with different social, financial and educational backgrounds, etc. While as a result of their continuous working experience in most cases in East Germany, eastern German women were usually more financially independent than western German women, they at the same time experienced domestic violence in East Germany not being recognised, as it was assumed that this cannot exist in a purportedly egalitarian society, while separation was difficult because of constraints on dwelling space, whereas in western Germany many women in this generation assumed the classic role of running the household and as a result living in massive financial dependency on their husbands. A portion of women who now belong to the "young old" have had contact with the women's movement, however, and many women have experienced enormous social change in their lives. Every new generation of older women has had its own distinct life experiences. Women who are now over 60 have had a completely different life than women who are now over 80.

4.5. Special vulnerability

Age-specific processes of decline usually lead to increased vulnerability to injury and a decreased ability to defend oneself or find help. By the same token, a greater need for help and assistance in old age is often associated with external specialists receiving access to the family system for the first time – and problems with violence can no longer be concealed. This thus creates possibilities for intervention and it is above all specialists working in the fields of aid for older people, nursing care and medicine who can play an important role if they have a raised awareness and intervene in an appropriate manner to improve the living situation of women.

4.6. Impediments to making use of help

In addition to deficitary knowledge of programmes, there are special motivational and emotional barriers to older people taking advantage of aid and filing charges.[13] One key factor is that they shy away from medium and long-term separation from the perpetrator, which for them has negative connotations. Changes in the living situation are scarcely conceivable for many older women, even though they long for an end to the violence. Most of these women desire nothing more fervently than for their husbands to change their behaviour.

- The fact that people leave their accustomed space less often in old age (facility, apartment, house, garden, city district) and withdrawal into ever-smaller areas plays a role here. The loss of this living environment arouses fear if it becomes necessary to move out or sell the common dwelling as a result of separation. This is all the more distressing as dwelling property is experienced as a tangible life achievement by the generation of now older people. This generation is also afraid of losing its children's inheritance.

[13] The factors listed here were identified in the study "intimate partner violence against older women"(Nägele, Böhm, Görgen, Kotlenga & Petermann, 2011). Many of these factors are also prevalent in other studies. (z.B. Scott, McKie, Morton, Seddon & Wasoff, 2004; Dunlop, Beaulaurier, Seff, Newman, Malik & Fuster, 2005)

- Financial factors are moreover frequently major obstacles especially for older women. They fear a worsening of their living standard and often do not know that they may have pension claims or social assistance.
- Many women, although they want a stop to the violence in their lives, are nevertheless at the same time afraid of losing the intimacy and closeness of their partner relationship, which they have become accustomed to after many years and with whom they are linked by a common history.
- IPV victims in need of nursing care and help dread the idea of having to move to an in-patient care facility. Many of them would prefer to be cared for by their husbands. Vice versa, the need of the man maltreating them for nursing care and the responsibility associated with this has the effect of forging much stronger ties. Nevertheless, concerns for the perpetrator of violence may be decisive in deciding to remain in a relationship in relationships involving nursing care, however.
- Victims frequently cite a deep-felt feeling of shame and embarrassment and the feeling that they themselves are responsible for the violence they have experienced and that they have not been able to end the relationship.
- On top of this, there is the fear of reprisals by the person committing the violence.
- An additional reason for not making use of help is the assumption that the aid and assistance on offer will not be in tune with the individuals' need for help.
- On top of all this, many older women lack the energy and prospects to venture a new beginning because their lives are drawing to a close, as a result of low self-esteem and not least depression as well.
- A feeling of powerlessness, hopelessness and isolation play a major role in these persons not taking advantage of help,
- on top of this all is the desire to avoid jeopardising the reputation of the family.

Some of the factors listed are also of relevance to younger women, especially when they have been living in violent relationships for many years.

4.7. It is possible to make a new beginning

Even if there are major obstacles to separation, many specialists have experienced successful separations on the part of older women again and again. The reason for this in these cases is in part experience of violence taking on potentially fatal dimensions, but also an increase in frailty and vulnerability in old age as well as a decline in the ability to cope with the violence and its effects. Surveyed persons also report that some women in view of the approaching end of their lives see the final opportunity to separate, "now or never", "not the golden anniversary to top it all off" with their husband, "a desire to see the sun once again" and "to finally have peace and quiet". (c.f. Nägele, Böhm, Görgen, Kotlenga & Petermann, 2011). A successful new beginning is possible; but women only rarely take over the common dwelling or the common house. They frequently do not want to fight for it, and prefer a new beginning in a small apartment, in some cases assisted living, in others in nursing homes as well.

4.8. Importance of adult children

Generally speaking the persons surveyed described adult children as key persons – they are able to support separation of their parents (and do so frequently), but they can also help prevent it. Not infrequently they themselves were victims of violence at the hands of the father as children, and as adults are still emotionally caught up in it all and are after all

personally affected by the consequences of separation, for example when care of the father is no longer provided for, or when separation and/or placement in a nursing home would lead to sale of the parents' property or they would even be involved in financing the care themselves.

The most important findings:

1. **Older women usually experience violence during relationships lasting many years. In most cases these have already been characterised by violence for a long time. In part, however, relationships change in old age, with violence occurring for age-specific reasons.**
2. **Even cases of violence in nursing care may involve many long years of intimate partner violence; conditions prevailing in nursing care may even exacerbate an existing violent relationship. Specific age and generation-related factors play an important role in experiences of violence by older women.**
3. **Counselling and advice facilities report that older victims separate less often than younger ones. The obstacles are greater for older women.**
4. **Grown children may be an important source of support for older victims of intimate partner violence, but at times they may have an ambivalent or rejectionist attitude towards such.**

5. Appropriateness of the system for protecting against violence: are existing help services and intervention possibilities suited for older women?

If older women or persons from their social environment decide to seek help and support after all, they are confronted by a help structure which is not specially geared to them. Experts working in the field of help and care for senior citizens have a limited general awareness or no awareness at all and experts from the field of medicine only a partial awareness of the topic of domestic violence, while few experts perceive domestic violence in old age as an independent problem in and of itself. By the same token, facilities working in the area of protection against violence are not explicitly focused on the target group of older women and in particular are sometimes called upon to act on a scale which exceeds their possibilities (extensive need for advice and assistance). The lack of sensitivity and the frequent lack of knowledge regarding the dynamics of domestic violence as well as intervention and support possibilities relating to these among experts in the area of care and aid to senior citizens portends the danger of an incorrect assessment of the causes of violence and potential for victimisation and, as a result, the intervention strategy derived, as a result of an inaccurate assessment of the situation. Frequently it is attempted to relieve the perpetrator of the violence along the lines of an interpretation of "violence as a reaction to excessive stress" – an approach which in cases in which violence is based on ingrained conflict and power structures is not capable of preventing further victimisation. Moreover, this often leads to other possibilities of ending a situation of victimisation being overlooked (c.f. Nägele, Kotlenga, Görgen & Leykum, 2010, S. 468f.).

Generally speaking, crisis intervention in cases involving intimate partner violence in old age such as that offered by intervention centres in a proactive manner following police missions

is not sufficient in order to clarify and improve the situation. Older female victims of IPV frequently do not make use of initial counselling and advice. Here long-term support and reach-out aid is necessary to shed light on the prospects of both intimate partners and not to simply rely on short-term changes. intervention centres frequently lack the resources for such cases. At the same time there is no clearly prescribed responsibility for such cases within the structure of local institutions, i.e. in contrast to violence against children, in which the statutory social service takes action, it is not clear what agency is in charge in cases of IPV involving older people. General responsibility is repeatedly assigned to the local government and its social services because of the general obligation to provide public care and a guarantee obligation in this regard, but by far not all local governments also see things this way and act accordingly. Concentration on services for young people and financial constraints faced by local governments cause problems connected with ageing to be afforded less attention. Another problem is that if an intimate partner requires nursing care the application procedure and decision on who is to bear the costs are often tedious and take a long time to resolve. There are recurring examples of how efforts to achieve separation over the short to medium term fail for these reasons.

B Counselling and support of older female victims of violence

Part A offered information on why cases in which older women are victimised by IPV are often of a special nature. In the following we explore what all this means in the way of requirements for individual counselling and support work.

First of all, general information is given on counselling and support work with older women. In the following chapter, special life situations and needs are discussed along with possible methods of implementation. Possibilities for obtaining additional information are listed at the end of each and every chapter.

1. General information on the counselling and advice process

1.1 Key topics and aspects: an overview

Experience of the present-day generation of senior citizens, importance of this in the counselling process

Counsellors and advisors should be keenly aware that with all the differences between biographies from women from the current generation of senior citizens, a majority of them have lived their lives taking for granted the following things that they have experienced and been confronted with:

- There are many cases in which older women suffered from sexualized violence and traumatization during the war and post-war era. These experiences have generally never been analysed and have been repressed in society and individually for decades.
- Many present-date senior citizens have lived in a legal and personal situation of complete dependency on men and the certainty of being subject to their will and desire as far back as in their childhood and adolescence.
- In West Germany, they came to know and take for granted a gender relationship
  - in which the role of wives in marriage was laid down by law and men had the right to intervene against their wives engaging in gainful work down till 1977,
  - in which rape in marriage was considered a private matter and was not penalised by law (until 1997),
  - in which women could be divorced, held culpable and have no claim to support if they failed to perform their "marital obligations".
- In East Germany, a certain type of gender relationship became taken for granted: Although equality of men and women was a formal state objective, in actual practice women performed the housework and raised the children in addition to working full time, while at the same time there was still a traditional understanding of the role of men. Possibilities to address the topic of violence in intimate partner relations were also limited in East Germany, as the gender issue was considered to be "solved" and intimate partner violence was for this reason treated as a private problem there just like it was in West Germany.
- The societal norm of not allowing outsiders to know anything about private/family matters dictated behaviour for many decades. The use of help in the form of counselling and therapy was generally stigmatised for a long time; people with psychological problems

were considered to be "crazy". People were supposed to cope with problems by themselves. The establishment and use of aid services for different problem situations only got underway in West Germany in the 1970s, with an expansion of aid to victims of violence at the national level commencing in the 1980s. This only happened in the new German Länder after reunification.

Given all this, counsellors should assume that victims of IPV from the present-day generation of senior citizens

- often do not see themselves as victims of violence, or they have an understanding of violence which is limited to physical abuse,
- are very ashamed when they have to speak about what they believe to be private matters and share their experience with "strangers",
- might be making use of outside help or have contact with aid services for the first time.

Key topics in support work

With older women who have been victimised by intimate partner violence, the following aspects should be taken into account as well as possible factors in specific support work ("subjects in mind") in order to support changes or help protect victimised persons.

- Burdens associated with physical and intellectual decline of both intimate partners may lead to violence escalating more and more frequently.
- In old age it is always more difficult to endure or compensate for humiliation and denigration, physical and sexual abuse, force and controls. The risk of injury grows, while the ability to defend oneself declines. This needs to be taken into account in the development of possible means of protection.
- In many cases, older women (or their partners as well) need support in connection with illness, nursing care and functional limitations, or they depend on help and aid along these lines in their everyday lives. In many cases, these kinds of needs are only recognised when intervention takes place.
- Many older women have been emotionally, socially and financially dependent on their intimate partner for decades; it is particularly difficult for them to escape this, especially because prospects for a new beginning are limited as a result of the short time of life left to them.
- Women often have the de facto responsibility for caring for a partner who, although violent, nevertheless requires their support, or they feel responsible for caring for him.
- Children are an important "topic" and a decisive factor in counselling work. They may prevent changes as well as be helpful in supporting them.
- Remaining in one's familiar environment and continuing to enjoy the living standard which has been attained is also an important matter for older women.
- Property-related matters (share of assets, the house) need to be resolved more frequently than is the case with younger women.

Requirements applying to the counselling and advice process

Support and counselling of older women is frequently marked by the following requirements: it is

- more time-consuming on the whole,
- requires longer, repeated phases of counselling and advice,
- more frequently requires inclusion of (several) third parties to transfer the case to or coordinate required help,

- Requires more reach-out contact to victims of IPV and third parties,
- And requires more practical support to cope with separation and removal or to facilitate the use of legal and government aid (support).

1.2 What does this mean for communication in counselling?

Appropriate mode of communication

Older women are not a homogeneous group. How and what is to be addressed with them in counselling and advice work depends of course on individual capabilities, situations and problems of these women. It is nevertheless often pointed out with regard to older women that in comparison to younger women a different approach and another type of communication may be necessary in order to gain their trust and confidence and make possible understanding. Nevertheless, it is also true that many of the tips and notes on communication in the following may also be useful in counselling and advising younger female victims of violence.

For counsellors it is important to know the following:

- Especially for older women, the **relief provided by a talk** may be especially important; for this, however, they need the space and time to tell "their" life story, even if these reports are only marginally related to the counselling.
- It may be necessary to speak more slowly and in shorter sentences, to opt for a **slower approach** in general in the discussion and to limit the conveyance of information as much as possible.
- One should also reflect on the **use of terms.** Some counsellors avoid the term "violence", for example, instead referring to "controls", "being put under pressure", "he wants to control everything", "to touch you in a rough manner", "treat you poorly". Another term should tend to be used instead of the term "victim". It is important to make clear that psychological violence and controls are unacceptable and wrong regardless of what these experiences are called.

Be attentive for "messages between the lines"

Older women often have major hang-ups or are ashamed about discussing what they have experienced; experiences involving violence and abuse are often communicated "between the lines" or with unclear terms such as "blow his stack", "yelling", "being nasty", etc. It is important to be attentive and notice these subtle messages and then follow up on them with questions, but in a careful manner.
Some women put out contradictory messages: they attribute the current behaviour of their intimate partner, for example, to age ("it did not used to be that way"), but at other times state that there had previously been "temper tantrums" – for example towards the children. Some older women have actually experienced violence at the hands of their intimate partner for the first time in old age in connection with changes attributable to aging and illnesses. For other older women who have experienced many years of violence, however, reference to age-related changes in their husband constitute a possibility to talk about experiences involving violence for the first time. Counsellors should be aware that in spite of current age-related changes, the relationship might possibly be marked by a long history of violence.

Addressing experiences involving violence from a biographical perspective

It is also a good idea to also move the focus of discussion with older women to violence experienced in the past. For many women currently victimised by intimate partner violence, this experience is part of a biographical continuity of violence and should be addressed in this context as well. For some, analysis of current violence can be broached by first addressing violence experienced in the past.

Addressing sexualised violence

For many older women, addressing sexualized violence poses a **special difficulty.** First of all because they are **ashamed and embarrassed**, and secondly as a result of "taking for granted" being sexually available for decades and experiencing this as a form of abuse, without, however, viewing it as unlawful. Many victimised women hope that the threat of sexual violence will at some point cease in old age. This is often based on the societal notion that men stimulated by the attractiveness of women "cannot" help "giving free reign to their legitimate drives" (**rape myths**). Older women find it difficult to speak about ongoing sexual abuse because of another societal norm summed up in a nutshell as "young and beautiful". The fear that no one will believe something which seems so unbelievable, or the fear of being made fun of or even being considered mentally unstable is very great. Sometimes older women only have limited knowledge of physical and sexual things and allow themselves to be intimidated by their intimate partner ("he just needs that"), while often they cannot find any words to describe what has happened to them. (See chapter 2.3 Illnesses and aggression, the topic of illnesses and sexual violence).

It may be useful for the counsellor to **state examples** of what different forms of intimate relationship violence there are and also name **forms of sexual abuse** which some women experience. In this manner, the affected person can be provided the opportunity to confirm what is said as (not) applicable or even go into more detail. For some older women, the description of sexualised violence/sexually abusive behaviour can be shocking, whereas for others the counsellor calling it by name may be a relief because they no longer have to address or mention "it". At any rate, it is important to be very careful and prudent in dealing with **borderlines in the discussion,** which are set in a nonverbal manner, and leave this up to women themselves to decide.

It is important especially with older women to point out that psychologically or physically forced sexual actions can also be **deemed to constitute rape or sexual duress in marriage since 1997**. This is also new to many older women. It underscores that violations of sexual self-determination in an intimate partnership are not a "vested right", nor are they a "private matter".

Signal effect of protection against violence

In cases in which older women are affected by intimate partner violence, tools and instruments laid down in the violence protection act often do not work (**limits of protection against violence)**, for example, because the victim and/or perpetrator are dependent on nursing care and support and dependent upon each other. In other cases as well, older women take advantage of the opportunity offered under the Act on Protection against Violence even less than younger women. As a result of the experience older women have had, information on the Act on Protection against Violence nevertheless has an **important signal effect for older women** regardless of whether this instrument is used or not. Knowledge of the Act on Protection against Violence and also the knowledge that help is available send out a signal to the persons affected: 1. They are not themselves responsible for the violent deeds, but rather the perpetrator. 2. Violence in a relationship is not a private matter, but rather a criminal act for which the intimate partner can be banned from the dwelling and subjected to sanctions. This is also linked to the **message that "you are not alone"** (in the twofold meaning of the word). First of all, it makes clear that many other women experience something similar (one in every four women experience violence at the hands of their intimate partner at some point in their lives, while one in every seven experience sexual violence). Secondly, support and help offers for victimised women are (hence) available.
State and societal sanctions against this type of violence and knowledge about the help available can support many women in interpreting what they experience as unlawful. This encourages many women to make use of help and strengthens their will and desire to change.

1.3 What requirements arise for practical support work?

Taking into account/including a large number of potential third actors

- If there is a need for support in connection with health and functional limitations or disorders, but also to clear up issues relating to meeting basic existential needs and the establishment of a support network, there are potentially a **large number of relevant third actors** that should be included in the work on the case.
- In clearing up issues involving how to meet basic existential needs and basic care support, potential claims to benefits from a **large number of social insurance branches** should also be taken into account/reviewed, as should pension claims from marriages, many of which have lasted many years.
- In the case of older victims of intimate partner violence, **networked cooperation** is often necessary on a greater scale in order to find solutions. In many cases, it may be useful or even necessary to include the following actors and facilities: physicians, out-patient services, counselling services for senior citizens, nursing-care support offices, assisted living, physiotherapy, court-appointed/voluntary guardians, social services at health offices, socio-psychiatric services, family courts for arranging legal guardianship, open work with senior citizens ...
- Many older people victimised by intimate partner violence are already in regular **contact** with **health-related and other areas of work bearing relevance to senior citizens** that can be included or even must be included in the support.

- It may be a good idea to meet in advance with persons from certain institutions working in the area of senior citizens to make specific **agreements on procedures**, for example on transferring a case. Although this ties up resources, in specific cases it can also ease the situation.

  → on this, see also the recommendations in part C

- Especially for older victims of many years of intimate partner violence, support from their social environment is important in finding a way out of the violence in addition. Here the task is to enquire in a targeted manner about resources and support possibilities from the social, family and neighbourhood environment. Especially children often play a crucial role here – they may be both helpful as well as prevent necessary changes, however. It is easier to understand their behaviour when one takes into account that they have themselves frequently been affected in cases involving many years of intimate partner violence and that in some cases they have been trying unsuccessfully for a long time to get their mother to separate and have then withdrawn, resigned. They also have to bear the consequences of a change in the living situation of their parents.

"No husband any longer, no children any longer, no new beginning in working life, all that is left is growing old alone" – the lack of options, burdening both IPV victims and counsellors

The counselling process for older women is often different than with younger ones, and this also translates into particular burdens for supporters. The mood of younger women over the course of counselling has been characterised as **ups and downs with lots of changes**, which, however, frequently take a turn for the positive. Among older people, a "high" at the beginning and the initial relief after escaping from a relationship overshadowed by many years of violence often gives way to a more **sobering realisation**. The perceived and real loss of familiar surroundings, a negative "balance sheet" on one's life, the "realisation" that one has done it all wrong and on top of it all, in view of the remaining time in life, only limited options – all this constitutes a major burden on victims of IPV, who often suffer from **depression, lack of energy and hopelessness**. For counsellors as well, it is sometimes difficult to cope with the comparatively **negative momentum in cases**, to avoid being discouraged by the hopelessness and mourning of these persons or to accept one's own helplessness.

In view of the severity of the burden and strain on older women and the intensity of the work with them, it may be a good idea to **split up responsibility for the case within the facility** in order to be able to continue to encourage and support the victims of IPV. For counsellors it is moreover important to know that older women sometimes have unrealistically high hopes from an intervention (for example, a positive influence on their husband). It is important to **underscore** that it is an understandable desire for the partner to change his behaviour, but **that only she can change the situation**.

Biography and resource-based approach

The use **of biography-based methods of counselling** or brokering access **to group services** may be warranted especially for older people. Many women are embarrassed and ashamed that they have not been successful in having a happy marriage; in some cases they even feel responsible themselves for what has happened to them. Admitting that one's

life model has failed is doubly difficult in old age, when prospects for a new beginning are significantly less. The possibility to reflect on one's life, to draw a negative or even positive balance sheet, to summon up one's strength again, can be helpful in particular for older victims of IPV. The general message should also be conveyed to them that **change** in their life situation and **analysis supported by therapy** are still **possible** and a good idea in old age as well. This is particularly the case given the fact that many older women are prescribed psychoactive medication for psychosomatic disorders without being informed that there are other types of help available.
Older women have often already put up with many decades of a violent relationship while at the same time performing considerable feats (in the post-war and reconstruction phase, in family work or even in working life). Without putting into question the massive suffering they have experienced, it is a good idea in the counselling to address the **strengths** *also* reflected in their ability to put up with these challenges as a **resource and source of strength for change** and point out that this can help them run their own lives.

Develop and support the creation of free space in small steps

Older women separate even less often than younger women from their violent intimate partner and can usually not imagine **any fundamental change** in their lives. For this reason, dealing with older victims of IPV requires a greater degree **of acceptance and support for decisions** to remain in a domestic situation characterised by violence or, however, to constantly return to a violent partner (after repeated stays at women's shelters or other attempts at change).
Especially among older women, the task is often to encourage them to take **small steps** and to develop these together with the victim. As an alternative to separation, counselling of older women can focus on creating small areas of free space ("separate bedroom"), changed modes of behaviour in everyday life ("not cooking two meals every day"), possibilities for fleeing and obtaining protection when abuse occurs again or simply offering a **free space** for a chat to provide relief in the counselling. Given the fact that the person affected may have been experiencing violence for many decades without having spoken to anyone about it, this definitely means considerable changes.
Such an accepting counselling process may possibly cultivate and support a greater will for change. Acceptance of decisions made by the older victims of IPV, the fact that somebody listens to them and believes them can be an important and **first-time experience of respect and self-determination** in particular for older women.

Planning safety and security

Such a "small" step can be the joint development and preparation of a safety and security plan for emergencies, just like the ones already being used at many facilities for protection against violence. A safety and security plan can be **an important instrument especially among older women**. First of all, older women usually remain in the situation characterized by violence. Most older women who flee from their violent intimate partner moreover do this very hastily without preparation in situations where things have escalated to extreme levels. At the same time, older women are often dependent on aid devices in their everyday lives.
A health and safety plan should be developed jointly with the victim of IPV by having her make a list of priorities for things which are important or should be directly available in the event of another incident of violent abuse. Especially for older women, in addition to the

safety precautions taken, this may be an effective instrument **in becoming active themselves, gaining control over their lives and developing self-assurance**.
A safety and security plan comprises first of all objects which need to be ready in the event of an emergency and if possible should be kept at a safe and secure location. These could include, for example: medication or prescriptions, articles of clothing, health insurance card, bank card, cell phone, important documents, aids (for difficulties involved in financing and buying aids, see chapter 2.5). A safety and security plan may also include arrangements with friends, neighbours, etc., for help to be provided in a threatening situation or if the woman runs away. (a code word can be agreed upon to communicate an acute need for help)

Developing future options in a familiar setting

Remaining in their accustomed environment and continuing to enjoy a living standard they have obtained with their intimate partner are often important to older women. In developing possibilities to live separately, local reference points, accustomed routines and familiar things should therefore be taken into account. In contrast to the case with many younger women, this is also often possible for older women, as stalking takes place less often in these cases when women separate from their violent intimate partners.

Supporting the development of leisure time activities, creating possibilities for activities and communication

As described in the foregoing, many older women to not want to or are not able to give up their familiar environment. Their own self-image is often intimately intertwined with their taking care of home and family; moving out/separation would confront many of them with the loss of their life task. By the same token, women in the current generation of senior citizens frequently have not had any "leisure time" pursuits or perhaps even social contacts. In offering counselling on how to develop new options, one should therefore focus on the development of new patterns of activity and possibilities for social interaction. In developing alternative goals and prospects, it may be a good idea to familiarise oneself with local services provided by local communities or churches in their free help for older people, leisure time activities for senior citizens or also voluntary services in order to be able to broker these in a targeted manner.
Older women in particular like to also make use of follow-up services in their own facility in order to be able to keep up contacts in a familiar environment. Many women's shelters report that older women often assume certain tasks at and in the house and also work in a women's shelter after having stayed there.

Follow-up services/open meetings

It is above all important to offer older women another contact possibility, including targeted follow-up services, e.g. in the form of an open meeting in one's own facility. Easy-access follow-up services make it possible to keep contact with the facility in a familiar environment, to keep up social contacts and to keep the door open for help and support.

Long-term assistance and support

Potentially a large number of relevant third actors need to be included in the case, especially in cases where there is a need of support as a result of health and functional limitations, but also to clear up issues relating to

meeting basic existential needs. This requires someone to perform a sort of case management and to also **assist the victim of IPV over the long term** as well; the question of long-term "responsibility for the case" often arises. Depending upon needs, different actors may be possible here (see below Chapter 2.1 Need for basic care and support).
If there are no specific needs and the issue at hand is especially **support in practical matters** over the long term, for example following a separation (e.g. help in applying for benefits), then local counselling for senior citizens, the national association Weißer Ring / aid for victims of violence (for support and assistance in emergency situations in the wake of violence, the spectrum of activities and contacts >> see chapter 2.5), social and welfare associations or church programs offering assistance in a community can be involved.

Follow-up contacts and offers of help following one-time contacts

One difficulty in the support of older women is often that information on their being victimized by violence is only "communicated" once following a police call or after contact is initiated to an intervention centre, but the woman herself does not make use of any additional services. **Counselling contact often remains a one-time affair.** The reason for this is that older women do not want to make use of help because they are not willing to see change and do not want to make use of help. Many of them believe that they can only make use of help if they also separate. Given this, **easy-access, follow-up and long-term contact programs** are particularly important to older women in order to let them know that the door is open for help and support. It needs to be determined on a case-by-case basis whether and who in addition to facilities for protection against violence can assume responsibility for such follow-up contacts. It is conceivable, for example, that the "special local police" or "contact area police officers" (working in the special precinct service of the regular police), who are assigned the task of taking preventive, reach-out action at the local level, or perhaps also Weißer Ring, which works on a voluntary basis, or churches' visiting services, contact these persons.

Include third parties and assist in transitions

As was already discussed at the outset, additional actors often need to be included in supporting older victims of intimate partner violence. Older people tend to shy away from making use of help and support, however, and a long process of trust-building is necessary before they can accept it. In passing these people on to other facilities, it is therefore especially important in the case of older women to accompany the transition in a "hands-on" manner in order to prevent a rupture in the chain of support (through a new facility). This means, for example, a reach-out initiation of contact to other facilities as well as a personal "handover" in order to build trust and confidence. When it is foreseeable that other actors have to be brought on board (nursing-care support office, for example), it may be a good idea to **jointly plan the initial contact from the outset.** Arrangements should be made with other facilities to this end.

➡ on this see part C

2 Possibilities for dealing with age-specific and special problems in the counselling process

2.1 Violence in the context of a need for care and support

What characterizes cases of intimate partner violence in connection with domestic care of family members?

Cases of intimate partner violence also occur in connection with domestic nursing care. In such cases, **violent domestic and nursing care-related dynamics** may overlap or mutually reinforce each other. With increasing need for help, people often come into contact with specialists from the areas of health, nursing care and help for older people. It may be the case that **intimate partner violence is perceived by outsiders for the first time** in this manner. Thus an opportunity arises for victims of many years of violence to receive help from outside and allow this without having to disclose their own victimization in many years of violence right off. You may become involved in such cases. As a specialist, you may be confronted with various constellations:

- **The partner perpetrating violence needs nursing care***:* Older women are possibly responsible for caring for their partner, who controls and threatens them, verbally abuses them, insults, beats, kicks or throws objects at them. This often involves the continuation of a long period of dominance and violence in a relationship. In spite of (or as a result of) a greater dependency on the woman, men who require nursing care and are ill and fragile may also commit massive violence. Some of them maintain their long-standing "regimen" by means of emotional pressure, threats and massive controlling behaviour without exercising physical violence. Sometimes the perpetrator also displays an altered aggressive behaviour as a result of illness while there is a long-standing dynamic of violence in the partnership which is then reinforced by the illness. In other cases, violence begins for the first time as a result of an illness (see the chapter on illness and aggression). All these constellations have in common that the woman affected by violence is often kept from doing something about the situation due to her feelings of responsibility.

- **The male partner committing violence provides his wife with nursing care:** Some women depend on their male partner to provide them nursing care. They experience violence in this relationship and want the violence to end. They fear being admitted to in-patient care even more, however, and are therefore afraid of any change. It is a positive development in such cases when specialists from the area of nursing care are involved. You should be aware that in particular people from the nursing-care field often assume that the strain and stress caused by the nursing care is the (sole) cause of violence. This may be the case, but it is not always so. This often involves the continuation of many years of violence in the relationship that is exacerbated by the nursing care situation and the strain involved.

- **The woman requiring nursing care is neglected***:* The targeted neglect of people requiring nursing care, which means insufficient care in the form of food, hygiene, clothing, possibly associated with social isolation and allowing dwellings to become filthy and untidy may also be a

form of an expression of intimate partner violence as well as excessive strain and stress due to nursing care.

Why can you in your capacity as a specialist from the area of protection against violence play an important role?

In contact with specialists from the area of nursing care and work with senior citizens, it must first of all be kept in mind that they are not always sufficiently informed about the topic of intimate partner violence and there is a danger of incorrect interpretation. It is frequently assumed at first that the violence is solely due to the nursing care or an illness. Domestic violence which has occurred for many years often remains undiscovered.
It is therefore very positive if you as an expert from the area of protection against violence are involved by specialists working in the area of nursing care and senior citizens. With your specific knowledge from the field of protection against violence, you can help clear up the situation and determine the reasons for the violence in a comprehensive manner while avoiding overly hasty explanations of the violence. You can also play an important role in helping develop solutions which above all help protect the victim against more violence.

➡ Use the flyer from the information package tailored to specialists from the field of nursing care to sensitize this target group.

Limits of protection against violence

Especially in cases in which nursing care or medical care and assistance of victims or perpetrators is necessary, measures in the area of protection against violence (temporary banning orders / lodging in a women's shelter) run up against constraints. Here the primary task is to find (other) **possibilities to care for** the victim in order to achieve protection.
If the wife has been responsible for caring for her violent intimate partner so far, **solutions for the abuser** must also be part of the equation. If need be, contact should also be initiated with him or other actors (for example, nursing care support offices) in order to develop alternative care solutions. This ultimately always involves support for the person victimized by violence.

➡ For specific information on general care in the area of living and nursing care, see the end of this chapter

Interpret correctly – help in an appropriate manner

A correct interpretation of the violence helps develop the right help needed by the person affected.

- If the violence is **primarily due to nursing care/illness or neglect and abuse** resulting from lack of knowledge (nursing care mistake), information, counselling and relief may reduce the danger of a new outbreak of violence. One should consider services offered in the area of nursing-care counselling (nursing care insurance schemes/nursing care support offices), the use of out-patient nursing care, voluntary visiting services and family-member groups or even the use of day or short-term nursing-care services. The crucial issue is whether the risk situation can actually be effectively improved by such interventions. In addition, medical and psychiatric professions (see chapter 2.3 Psychological illnesses) may have to be involved in order to clear up diagnoses, but also to determine the need for basic care.

- If a case involves **many years of intimate partner violence**, and the female does not indicate a will to undergo change, then it may be a good idea to encourage her to make use of external services, but above all to establish checks and controls in order to break through the isolation somewhat. It may also be necessary, however, to support a separation between the person affected by the violence and the perpetrator. Above and beyond the development of protection and securing basic care, it is especially important for the victim of IPV to receive help in coping with the violence experienced.

What needs to be kept in mind in developing protection models?

- From the perspective of protecting against violence, a **temporary or permanent separation** of victims and perpetrators may be warranted (for long-term in-patient lodging, short-term care in the case of "preventive care", see the notes in this chapter on basic care and living quarters). In your contacts with specialists from the care area, you must be aware that efforts are often made to preserve the domestic care arrangements if possible and to look for possibilities of relief. If the violence is not due to the strain of providing care, however, such relief services (for family members) will not have any impact - aside from the checks and controls which are therewith established. At the same time, the option of separation should also be explored at intervals with the victim of IPV in cases where violence is due to the strain caused by providing nursing care as well. It is very difficult for a woman providing care to give up this responsibility. She may experience relief when she is encouraged by outsiders not to put up with everything.

- In developing solutions, **the risk potential must be assessed** against the background of the dynamics underlying the violence down to the present, with the emphasis being placed on avoiding risks in the future. This is where you with your special experience play a particularly important role. It should be kept in mind that for older women and in particular women requiring nursing care, vulnerability, exposure and the limited capability to put up resistance constitute a high potential risk level. There is a special responsibility towards victims requiring support who are not able (any longer) to articulate their desires. Especially in cases like these, it may be better to initiate institutional care instead of risky domestic care in a situation marked by violence.

- In some cases it may also be a good idea instead of spatial separation to establish **effective control and protection measures**. Thus, the involvement of out-patient nursing care, the use of day-care services or arranging for a visiting service may not only provide relief - they also have a check-and-control function, thereby contributing to a reduction in risk. The objective should not be relief and support of the perpetrator here, however. It is important that he be signalled that his behaviour has been noted and is not accepted.

- In many cases it is difficult to convince the persons involved that they should be put in a home or make use of professional care services, inter alia because they may have to help pay for it. Drawing basic benefits eases the use of such services in many cases, as the costs are borne by the local community.

- Generally speaking, the existing **social and family environment** should be involved in clearing up the situation regarding basic care and needs. Above all children may play a key role in developing solutions and almost always have to be involved in clearing up

financial and basic-care matters. They may also effectively block intervention, however, because they believe that it would have negative (financial) consequences for them or because they do not see any need for change.

- At any rate it is important to respect the desires of the woman affected and to devise solutions together with her. If the woman is no longer able to make rational decisions, it is then important to arrange external legal guardianship.

2.2 Dementia / psychological illnesses

In a significant number of cases of intimate partner violence against older women in which specialists from the area of protection against violence, but also the police and judicial authorities are involved, the people affected or even the perpetrators display symptoms of dementia or psychological illnesses. If staff working in the field of protection against violence learn of such cases, there is often already a description of the situation demonstrating a connection between these illnesses and the violence without there being any medical evidence. For this reason, it is important to be very careful about overly hasty "diagnoses" of dementia or psychological illnesses.

Information box on dementia[14]

Cognitive decline may have a significant effect on the health and well-being of older women seeking help and who want to escape situations involving violence as well as their ability to make rational decisions. That is why it is of crucial importance for specialists from the field of protection against violence to have some understanding of the symptoms of dementia as well as help services available. Dementia is the most frequent cause of need for nursing care.

What is dementia?

Dementia usually signifies a general loss of mental and cognitive functions and displays a host of symptoms. There are different causes.

- **Alzheimer's**

The most well-known and frequent form of dementia is Alzheimer's; two-thirds of people suffering from dementia have this illness.

The following are considered to be warning indications of dementia:

- Loss of memory
- Difficulties in performing familiar tasks
- Language problems
- Disorientation regarding place and time
- Weakened powers of assessment and prioritisation
- Problems with abstract thinking
- Forgetting where one placed things
- Significant mood swings and changes in behaviour
- Changes in personality
- Apathy

- **Other types of dementia**

[14] This information box has been adopted in slightly modified form from a Canadian Brochure (Hightower & Smitz, 2006).

A series of other dementia-related illnesses may trigger similar symptoms such as Alzheimer's like, for example, vascular dementia (blood circulation disorders in the brain, often in connection with a stroke), Pick's Disease (also known as frontotemporal dementia, which may be associated with highly aggressive behaviour), Creutzfeldt Jakob's or Lewy body dementia. Like Alzheimer's, these forms of dementia are progressive - with the exception of vascular dementia.

- **Slight cognitive disorders**

Another slight cognitive disorder is so-called old-age forgetfulness. This designates a cognitive decline which is abnormal, but does not meet the criteria for diagnosing dementia. Often certain changes in cognitive functions are noticed, but these do not have a significant impact on actual tasks performed and in many cases no more decline takes place after a certain point.

- **"Healable" dementia-like conditions**

Not everyone who displays warning signs suffers from unhealable, progressive dementia. Indeed, some such symptoms occur in connection with treatable illnesses such as depression, infection, metabolic disorders, consumption of medication or problems setting the right dosage, irregularities or also intolerance to medications, or even thyroid illnesses.

Dementia and trauma: There are indications that psychological trauma can increase the danger of dementia developing at a later time.

What needs to be kept in mind?

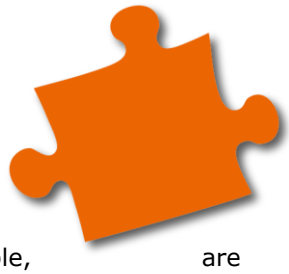
- **Believe confused women:** Older women may repeatedly experience people not believing them as a result of their confused / psychologically disturbed / paranoid behaviour. Also or even especially such women may be victims of IPV, however, including when their reports are perhaps difficult for counsellors to understand. Dementia-related symptoms and psychiatric illnesses may also be a consequence of many years experiencing violence. There are also indications that the development of dementia may among other things be a reaction ("inner withdrawal") to trauma.
- **Confusion is not tantamount to dementia**: When older women seek out a facility for protection against violence, it should be kept in mind that disorientation / confusion is not necessarily a symptom of permanent dementia. Instead, it may often be a reaction to a psychological shock and inability to cope with a situation.
- **Symptoms of dementia in connection with taking of medication:** Confusion / cognitive disturbances may also emanate from disorders / interruptions in the taking of mediation (for example, after fleeing one's home, or when perpetrators of violence prevent their intimate partners from taking medication).
- **Addiction and dementia-related symptoms:** In particular, many older women who suffer from violence are dependent on medication. When they prescribe medication for psychosomatic ailments, physicians frequently often fail to set the right dosage for psychoactive medication; they also frequently do not offer other types of aid, e.g. psychotherapy (trauma therapy, psychosomatics). For this reason, older women have in many cases been taking medication for several decades. Alcohol is also a widespread problem, tolerance of quantities of alcohol tends to decline with age. Many specialists believe that long-term alcohol abuse and even dependence on medication (e.g. benzodiazepine) encourages or triggers symptoms of dementia. Negative developments become more pronounced when taking growing amounts of medication is combined with alcohol consumption.

- **Involvement of physicians***:* In cases in which you detect symptoms of possible psychological or dementia-related illnesses or even suspect an addiction-related illness, it may be a good idea to contact the physician providing treatment in order to initiate proper diagnosis or clear up questions relating to treatment to date / medication. Among other things, you need to determine whether possible cognitive or psychological illnesses are of a permanent or temporary nature and whether the right help and options can be provided taking the physician's diagnosis into account.

2.3 Aggression and illnesses

- In many cases, women experience aggressive / **violent behaviour for the first time in connection with an illness** of their intimate partner. Different illnesses may trigger or cause aggressive behaviour or reduce controls on affective behaviour. These include, for example, neurological, psychiatric or even cognitive disorders / illnesses. Increased aggressiveness is described, for example, in connection with Parkinson's Disease, strokes, but also dementia-related illnesses. With dementia-related illnesses, in particular frontotemporal dementia, so-called Pick's Disease, highly uninhibited or often even physically aggressive behaviour is witnessed. Often aggressive / violent behaviour emanates as an indirect reaction to illness or a nursing-care situation, due to frustration and anger about the loss or limits on communication as well as deficits in other means of expression. Last but not least, aggression may constitute a reaction to anxiety and panic (disorientation).
- In cases in which the perpetrator displays altered aggressive behaviour as the result of an illness, this may nevertheless involve a continuation of **a relationship characterised by dominance and violence for many years.** Current changes in behaviour due to illnesses may reinforce already existing violence.

Illness and sexualised violence



Some victims of IPV suffer in old age from increasingly aggressive/ abusive or violent sexual behaviour on the part of their intimate partner which comes about in connection with the illness or is strengthened by it. A sexual behaviour which is altered in this manner can be due to growing **loss of inhibitions** (through dementia, for instance). Some medications also influence sexual behaviour - some drugs used to treat Parkinson's patients, for example, are often sexually stimulating, but also at the same time contribute to disorders in sexual function. **Disorders in sexual "function"** such as problems with obtaining an erection or in dealing with such sometimes contribute to an **increase in sexualised violence**. In many cases the intimate partner committing the violence seeks greater stimulation in order to attain sexual satisfaction, insisting on sexual practices which violate the borderlines of the woman involved on a massive scale. **Stimulants** (Viagra) can play an important role here, as they help males compensate for this functional disorder. Some women for this reason experience a rise in sexual violence compared to the past and are confronted with new demands ("he never wanted that before"), but at the same time they are often very **ashamed** to talk about it.

What should be kept in mind in developing options for protection?

- You should note that in many cases increased aggressiveness accompanying an illness on the part of the perpetrator offers the victim of IPV the possibility / a **legitimate reason** to **allow help** or to reveal that she is a victim of violence for the first time without having to say that she has been suffering from violence for many years.
- The possibility that **someone may be a victim of many years of intimate partner violence** and the help needed to address this experience with violence should generally speaking always be "taken into account" when clearing up how basic needs are to be met in the future.
- For persons victimised by acute intimate partner violence, it makes a tremendous **difference** whether this involves the continuation or a first-time experience - both with respect to the experience of violence, their ability to bear up and with respect to their resources for developing appropriate options for protection and ways of dealing with it.
- If aggressive behaviour comes about for the first time **in connection with illnesses**, the victim of violence may possibly be supported in finding **ways of coping and dealing** with the situation which reduce anxiety and hence aggressiveness and **protecting herself.** To this end some clinics offer joint therapies and nursing-care and family-member counselling and advice services or even self-help groups can be made use of. In these cases, the right medication for the patient can moreover help as well.
- If the case involves **continuing intimate partner violence** it is much more difficult for the victim to be able to develop effective mechanisms for protection and ways of behaviour which mitigate the aggression. There is a very high risk potential and an **alternative should be developed to the domestic care arrangement**.

→ see also chapter 2.1 on nursing-care and support needs

2.4 Physical disabilities / physical handicaps

Use of facilities for protection against violence free of any barriers

- A large portion of women with disabilities are over the age of 60, while at the same time a high percentage of older women have a disability. For many older women with handicaps, the question of whether to make use of advice and aid arises more frequently due to **limited mobility** - for instance, when it is not possible to use public transportation. When a woman with limited mobility wants to go to a **women's shelter** and does not have any possibility to come to the agreed-upon meeting place, this raises the question of who is responsible for transport. In many of the German Länder, the jurisdiction of the police is laid down in guidelines on how to proceed in cases of domestic violence. If transport is rejected, it may be a good idea to draw attention to such guidelines (if they are available).
- There are **no** universally applicable arrangements for the **assumption of costs** by an institution in the case of **travel** to a women's shelter or to a counselling and intervention centre by taxi. In cases like these, it may be a good idea to contact Weißer Ring in order to enquire about the possibility of a one-off grant. (see below)

Demand and secure freedom from barriers over the long term

Over the long term possibilities (argumentative and political) may open up to lay down binding arrangements for the assumption of costs wherever this is necessary through the **UN Convention on the Rights of Persons with Disabilities**. One point linking into this is offered by § 16 - Freedom from Exploitation and Abuse. Weibernetz e.V. and the German Council for Persons with Disabilities view this, for example, to constitute an argument with which to obtain acceptance for guarantees of access to help and counselling services free of any barriers. Among other things, it is noted that every **local community** must develop action plans for **implementation** of the UN Convention on the Rights of Persons with Disabilities. This would be a good possibility at the local level to place the **topic of freedom from barriers** on the agenda in the area of protection against violence as well. You will find information on this inter alia in the guidelines on initial contact with women with disabilities. (see below)

Guidelines for initial contact with female victims of IPV who are disabled

Over the last few years, facilities working in the area of protection against violence have increasingly addressed issues relating to counselling and support for women with disabilities. In particular older women are often affected by functional limitations that have an influence on the availability and possible support.
The Federal German Association of Women's Counselling Offices and Emergency Hotlines (Bundesverband Frauenberatungsstellen und Frauennotrufe – Frauen gegen Gewalt e.V. - bff), Women's Shelter Coordination (Frauenhauskoordinierung e.V.), Weibernetz e.V. and the Federal Network of Women, Lesbians and Girls with Disabilities have developed guidelines for initial contact with women victimised by violence. The guidelines provide suggestions on what aspects urgently need to be kept in mind with certain types of disabilities. These guidelines are intended for staff at women's shelters, Women's counselling offices and

intervention centres in order to facilitate counselling work with women who have disabilities and are victimised by violence.

At the same time, these guidelines draw attention to numerous structural deficits and strategies which are politically possible in demanding and receiving the right to access to help and support by victims of violence.

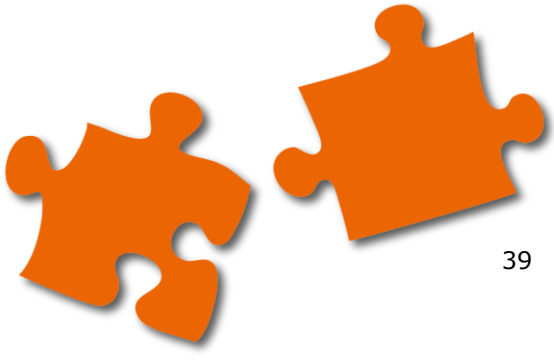
From the guidelines

In addition to questions common in an initial meeting, there are also questions which especially relate to physical disabilities:

- Determine whether there are any barriers, e.g. steps in the reception area. For persons confined to wheelchairs: width of doors
- Is assistance available? If so, are the assistants female? Are the assistants trusted?
- Is she in contact with the perpetrator?
- Is assistance needed?
- Has an aid device been damaged?
- Is there a physician in whom the woman has special trust or who is especially familiar with her disability?
- Are there possibly any additional illnesses?

Topic of financing / financial compensation for aid devices

- **Supplying people with technical aids and healing aids** may pose a key problem with many older women in a manifold sense. Older women who have experienced many years of violence at the hands of their intimate partners frequently have an undiscovered need for nursing-care services (on this see nursing-care and support needs) as well as a supply of aid devices (hearing aids, artificial limbs and joints, wheelchairs, etc.). It may be the case that such undiscovered needs only become apparent through a police mission or become evident after the woman visits an intervention centre / women's shelter. These needs must then be addressed.
- Another topic is the **loss of aid devices** through destruction, the violent intimate partner keeping these from the woman or in the wake of the woman fleeing her home. A large percentage of older women escape to women's shelters "head over heels" without any preparation for such. In these cases the question arises as to the (re-)procurement and financing of appropriate objects.
- The **financing** of services in the area of aid device (re-)procurement is often a **problem** because health insurance schemes or social services do not pay for these.



C Above and beyond individual cases - what can we do to better reach older women victimised by violence and support them in an effective manner?

Ideas and proposals are offered for measures in the following which are in principle capable of facilitating access of older women to help and to improve the support provided. First of all proposals are forwarded for the modification of one's own services and public-relations work. Secondly, the issue of what can be done in the area of networking and cooperation is addressed.
Some of the measures can only be implemented when additional resources are available, while it may be possible to carry out others with existing resources or with another form of distribution. The measures listed here go back to reports on the experience of many staff at women's shelters, women's counselling and intervention centres, while some experiences have taken place within the framework of the project "Living Safely and Securely in Old Age". Experience from other countries has also been taken into account. Most of these measures have already been tried out successfully.
A note at the outset: It may be a good idea in a team to take the time to subject one's own strategies and services to an "age check" - for instance in a workshop - and analyse systematically whether the services on offer, the way that target groups are addressed and networking activities are also appropriate and useful for older women, where there are deficits and a need for adjustment and what solutions could look like.

1. Adjustment and modification of one's own services

1.1 Adjustment and modification of counselling and support services

A **modification of counselling and support services to meet the needs of older women** is in many cases a question of resources. There are the following possibilities:

- There has always been positive experience with supervised **group services for older women**.[15] An exchange of opinion and comparison of experience can encourage women to talk about experiences with violence; the mutual support possible in a group can make a contribution to coping while analysing the experience, confirming one's feelings of having been wrongly treated and helping gain strength and autonomy. A separation is not a precondition for participation. In the case of German-language services, it is often also useful to offer such services at women's counselling and advice offices or women's shelters, perhaps even at church or community facilities. For migrants, exchange and self-help groups in the relevant languages can be offered at migration-related counselling and educational facilities. Especially for this group, support from a group offers major advantages. Good experience has been gained with groups expressly addressing the topic of violence, but it may also be a good idea to offer a broader spectrum of topics which,

[15] For example, within the framework of the Action Programme entitled "Living Safely and Securely in Old Age" (Silia), which was funded by the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, by facilities in Hamburg www.dhpol.de/de/medien/downloads/hochschule/13/SiliA-Abschlussbericht.pdf, for more details on this see p. 71; for facilities with such services: www.bifff.de/sites/winterhude/programm_winterhude.htm; www.amnestyforwomen.de/deutsch/projekte-1/silia/

however, provide space for the topic of violence. In publicising such possibilities to these groups, the most successful approach is to directly approach women who might profit from them (e.g. in counselling).

- A certain percentage of older women have derived their self-image over many years from caring for their husband, family and home, and many have not learned how to spend leisure time. In some cases women do not have any viable social network (any longer). After a separation, then, they lose their "life task" and social context - both are difficult to compensate for. Here **follow-up assistance programmes** from one's own facility and services may help to facilitate **a meaningful use of leisure time** during and after the actual counselling process (for example, taking on tasks at the women's shelter, making common use of leisure time programmes) and make possible long-term **links to the facility**. This could be achieved in the form of discussion groups and open meetings such as, for example, eating breakfast together with former residents.

- **Self-assertiveness courses** may be a useful and attractive service for older women. Such courses can be carried out by your facility itself, or they can be suggested. There are Wendo trainers in almost every region who can be consulted with here.[16]

- Access to women's shelters **free of barriers and appropriate modifications of buildings and furnishings** at women's shelters should also be assured (e.g. no bunk beds, integrated sanitary facilities, single rooms, possibilities to be alone and quiet areas). If renovation or new construction projects are pending, anyway, such aspects can be taken into account. Institutions that assume such costs should be requested to fund these measures while citing the UN Convention on the Rights of Persons with Disabilities. The Federal Association for Women's Counselling Offices and Women's Hotlines (Bundesverband für Frauenberatungsstellen und Frauennotrufe - bff) has issued a manual entitled "Barrier-free Counselling Offices for Women and Girls", which offers numerous tips on barrier-free renovation and remodelling.
  https://www.frauen-gegen-gewalt.de/veroeffentlichungen.html#Informationen_FB.

- Rapid changes in living situations tend to be the exception among older women. Many of them need more time, more support, more commitment and more reach-out counselling in one set of hands than younger women. If this is possible, a **modification and adaptation of the counselling services** to meet the needs of older women should be carried out and include long-term counselling, home visits, and possibly the establishment of decentralised counselling services in the living environment of victims of IPV or at places which are frequently visited.

- Many older women have special needs for support which cannot be met by all women's shelters and in part may also conflict with the principle of the ability to care for oneself as a precondition for living in a shelter. It is a good idea to carefully analyse one's own strategy to determine whether, in what scope and under what conditions **lodging, out-patient care and support for women requiring care** would be possible for older women. This includes thinking about whether it can be made possible to **take in women with psychological illnesses and addiction problems** at women's shelters.

[16] There is a programme like this at AURA in Nuremberg, for example. www.aura-nuernberg.de

1.2 Public-relations work / presentation of services to the public / sensitisation

With the target group of older women (victimised by violence)

- An **explicit targeting** of older women in public-relations work and portrayal of facilities to the outside world sends out a signal that they are welcome as users. This is especially important because many older women do not even consider the possibility that existing services may be appropriate and helpful for them.[17] It may be a good idea to expressly include the target group in general material (for example, think about the age of women shown in photographs), but material can also be developed only for the target group.

- In public-relations work it may be a good idea to **address the topic of intimate partner violence in a proactive manner** in public-relations work, for instance in lectures, articles in the press or other material used in PR work in order to facilitate identification and the topic at hand for women who are currently victimised by IPV - i.e. what they are experiencing is defined as violence for them.

- For other older women, however, access can be provided by **addressing them through other topics**, for example ageing-related topics (such as depression, development of intimate relations in old age, changes in biographies) and counselling on general topics. It may be easier for these women to first seek out counselling and advice on more harmless topics, and then broaching their experience with violence at a pace which they determine themselves and this at a time when the overall conditions fit with their situation. One can also address older women as multipliers with such open services - i.e. older women who make use of such services once again know other women and can pass on their knowledge. Such events and services with broader topics may be staged in cooperation with facilities which are frequently made use of by older people.

- If older women are to be made aware of services, it is necessary to disseminate this information at **places frequented by older people** and to select **media which older women are familiar with**. Posters, postcards and flyers can be hung up at savings and loan banks, at physicians' practices, at chemists, in churches, at educational facilities, senior citizens' meeting places, physical therapists, foot care, perhaps even at haircutters, etc. A request to make such material available may be linked to information on a facility's own services and an exchange, perhaps even cooperation arrangements (see next section). Media that older women frequently use include radio, local newspapers, weekly newspapers; but new media is also being increasingly used by older women (the Internet).

[17] Print templates for posters and postcards which you provide with your own contact details can be downloaded at www.ipvow.org/de/material-fuer-oeffentlichkeitsarbeit. At www.ipvow.org/de/broschuere-fuer-aeltere-frauen you will find an Austrian Brochure which addresses older women. It can be easily adapted to German conditions.

With the target group of specialists at facilities that have frequent contact to older people

- Older women affected by intimate partner violence who do not have any access to the aid system can best be reached by **multipliers** who as a result of their work have special access to older people. These include nursing-care professions, volunteers and professionals working in the area of help for older people and members of health professions (e.g. physicians, physical therapists). Educational and counselling facilities in the area of integration often have direct or indirect access to older migrants. **Sensitisation, information and training measures** may make a contribution to these professional groups becoming better able to recognise cases of intimate partner violence and receiving information on how to deal with such cases.

- One special challenge is sensitising specialists from the field of medicine, nursing care for older people and open help for older people to the topic. Especially in the area of nursing care for old people, there is a widespread attitude that intimate partner violence no longer occurs in old age and that violence in nursing care of older people is caused by stress and strain and that different ways of providing relief are helpful. For this reason it may be a good idea to encourage **integration of the topic of domestic violence** (including in old age) into respective **vocational training programmes** (e.g. for nursing care staff); in addition, open continuous and current information and continuing education services can be offered, as many persons without any special training are employed in the nursing-care field. Such a programme can and should be offered in cooperation with recognised educational institutions. Especially in the case of continuing training and information events in the area of nursing care, it may be a good idea to link the topic of intimate partner violence in old age to the topic of abuse and neglect in nursing care (possibly covering this with external facilitators). This increases the interest of specialists while at the same time making it evident that intimate partner violence in old age and violence as a result of nursing-care strain are possibly overlapping, but mainly different phenomena. The topic of violence at the hands of adult sons should also be covered.

- Older migrants use facilities for support extremely rarely in the case of domestic violence. In these cases, access appears to be particularly difficult. **Continuing training of multipliers** in the area of **language and integration courses** for migrants on the topic of domestic violence in general and in old age as well as existing help and support possibilities are a good idea because course teachers are often important contacts for older victims of violence or family and friends of these victims as a result of long-term contact.

2. Cooperation and networking

Why? – with whom? – how?

Work in networked structures may be particularly important to work with older women affected by intimate partner violence, especially in complex individual cases in which many problems play a role. In work with older people, a host of facilities that also play a role for younger women are important cooperation partners, such as, for example, physicians, hospitals, social service offices, housing offices, residency companies, courts and the police. The contacts differ in some cases, however. Among physicians, for example, the most important contacts for older people are internists, while in hospitals, these are, along with medical personel for older people requiring nursing care, hospital social workers who organise the transition to domestic care. At social service offices these are the specialists in charge of basic needs and nursing-care services and at local courts it is the courts appointing legal guardians that have to deal with issues involving older people. But above and beyond these, there are also facilities, however, providing support in the case of domestic violence which have scarcely had anything to do with, but which perform crucial tasks for, older people: These are in particular out-patient nursing-care services, nursing-care counselling offices (such as, for example, nursing-care support offices, nursing-care insurance schemes, support services for help in everyday life (meals on wheels, shopping services, visiting services), local community counselling for senior citizens and aid to senior citizens (also integrated in local community social services in part), social psychiatric services (or socio-medical service), churches, programmes offered by open help to older people and facilities providing assistance.

- It may be necessary in **individual cases** and only then also to negotiate over cooperation with these facilities. This is the actual practice at many facilities at present – if only because older women victimised by intimate partner violence have rarely sought help and support to date, agreements for "hypothetical future cases" would not appear to warrant the effort.

- It may significantly facilitate work in individual cases, however, if **agreements** and arrangements are already made, when facilities and specialists have already gotten to know each other and know which services they respectively offer, who they can contact and what the procedures are like at the facility. In some cases a single meeting suffices in order to be ready when actual cases occur (for example, with a health-insurance scheme or with the social services office with regard to certain services and with the nursing-care support office with regard to involvement in certain cases, etc.).

- And, finally, such a cooperation agreement – and this is the best-case scenario – can be an element in a **coordinated strategy** at the local level involving several key actors. Such strategies may jointly set out, for example, who is to be responsible for cases and domains of responsibility, hand-over procedures, agreements on financing and exchange of information, while the various actors can mutually agree upon resources in the network and look for solutions to deficits together. In view of the low number of cases, the establishment of continuous working structures such as, for example, a round table or a working group solely dedicated to this topic is no doubt unnecessary.

Approach the topic on the ground in a coordinated fashion!

A series of problems in providing basic care for older women victimised by violence cannot be solved by one facility. Multi-facility solutions are required for structural problems and deficits. It should be endeavoured to develop local intervention systems involving all relevant actors in which responsibility for cases is bindingly agreement upon, handover procedures have been clearly specified, long-term assistance of victims is possible and into which reach-out counselling has also been integrated. Networked cooperation between specialists from facilities for protection against violence, the police, aid to senior citizens and nursing care may moreover lead to greater attention being devoted to the problem. A process for developing such solutions may be proposed and steered by a higher-level association or government structure with possibilities to exert influence both in the area of protection against violence as well as in the areas of nursing care and assistance (e.g. by a local community commissioner for equality). This should be built upon already existing local network structures.

The following topics should be addressed in local networks:

- The question of "**responsibility for the case**". In many cases involving intimate partner violence, no solution is possible through short-term interventions. At the same time we know that intervention centres are the facilities which learn of cases involving IPV in old age most frequently. Because longer-term assistance is not possible for these types of facilities, it should be decided locally who is to assume this task and how a solid transition can be arranged. By the same token, it is important to keep in mind that there are not many cases, that in these cases many problems come together and that the situation for the victimised person is often highly risky. In these cases, a key factor is providing longer-term assistance from a facility, which assumes responsibility for the case in a reliable, comprehensive manner, but does not have to carry out all the assistance by itself. Indeed, it is not clear in the institutional structure of most local communities who is responsible for such cases. In some cases general / local community social services believe they are in charge, but this is far from being the case in all local communities – even if the technical literature affirms such responsibility. The citation in footnote[18] offers argumentation aids along these lines (even if they are no longer completely up to date).

  Long-term assistance is especially warranted in the case of intimate partnerships in which separation or greater use of help is not possible for the intimate partners at present and where at the same time the need for support is apparent (e.g. as a result of illness, need

[18] "General Social Services (Allgemeiner Sozialer Dienst - ASD) are social services offered by local communities that are needed in a social state in the area of "public care" in the meaning of Art. 74, no. 7 of the German "Basic Law" (Constitution). "Public care" under the Basic Law is more than mere "care for the poor", however (Richter 1979, pp. 42, 67). This term is understood to denote, rather, all public-law measures of a repressive and preventive nature serving the purpose of social accommodation or social help and support wherever there is a critical situation, such a situation is looming or even needs to be prevented, or where help to develop new options appears reasonable (see Schulte and Trenk-Hinterberger 1986, p. 32). Personal (individual) help is the main task of General Social Services – which have a blanket responsibility – and the social pedagogical specialists working at these. By the same token, the following categories are the most important: more holistic and uniform, more orientated towards life and the everyday world and closely tuned to citizens' needs (regarding approaches to work, see Schellhorn 1992, pp. 22 ff.; Bassarak 1992b, pp. 10 ff.)." (Proksch, 1994)

for nursing care); here it is important to maintain contact, to be available as a contact one can approach and to organise help and support when it is needed. New paths are being explored in such cases by the intervention centre SKFM in Mettmann, which has developed a strategy which provides among other things for cases with a need for long-term assistance to be bindingly taken on by other staff from the SKFM.[19] To avoid a rupture in processing cases, the transition is supported in a committed manner, i.e. the persons to whom the case is transferred are to assist the staff of the intervention centre as early as at the initial meeting. Other solutions are of course also conceivable – for instance involvement of nursing-care support offices or local counselling services for senior citizens. It is only at the local level that it can be determined and decided who is best suited for this.

- The question of availability and financing of short and medium-term **lodging possibilities** for victims (and perpetrators) requiring support or nursing care needs to be cleared up because there should be an opportunity at the site to make use of emergency beds, for example at senior citizens or nursing homes (e.g. through short-term nursing care) or hospitals quickly and without any hitches in cases of acute crisis. Arrangements with institutions funding these facilities are required; they should also be informed about any protective measures required, however (assuring confidentiality of addresses if necessary). Long-term accommodation possibilities can be contemplated in such a network.

- The question of who is to assume costs for special needs, which may arise as the result of a women's shelter or a counselling office being made use of (e.g. taxi trips funded with financial aid). Apportionment of funds in actual practice with respect to the **funding of basic care services / services** helping people with health disorders cope with everyday life is not based on any clear laws and regulations or case law handed down by the courts. In these cases, agreements can generally speaking only be made jointly and in coordination with other local facilities by the local community and other care providers (health insurance schemes / offices in charge of meeting basic needs) on what cases are to be funded.

Local "Round Tables on Domestic Violence" as possible forums for networking and arrangements on how to proceed

- Existing working groups such as, for example, the "Round Table on Domestic Violence" – which now exist in very many local communities with similar names, are available for cooperative ventures aimed at sensitising and networking along with making arrangements on how to proceed and requesting specialists in work with senior citizens / nursing care to attend individual events. Such events can take on the shape of a workshop with (or without) actual input on the topic, or be staged as a seminar or simply within the framework of a normal meeting date for the group. Special technical events, to which a general invitation can be put out, are also conceivable. The aim of such meetings should be to get to know other respective perspectives and approaches to such cases in a mutual

[19] SKFM Mettmann e.V. (o.J.): Nachhaltige Hilfen bei häuslicher Gewalt gegen Seniorinnen im Kreis Mettmann. In Ergänzung zum Konzept der Interventionsstelle Mettmann. Available at www.skfm-mettmann.de/files/pdf/Seniorinnenkonzept.pdf

exchange, to relate and compare know-how on the topic of domestic violence and older people, to identify deficits in the processing of cases and discuss modes of procedure in the future.

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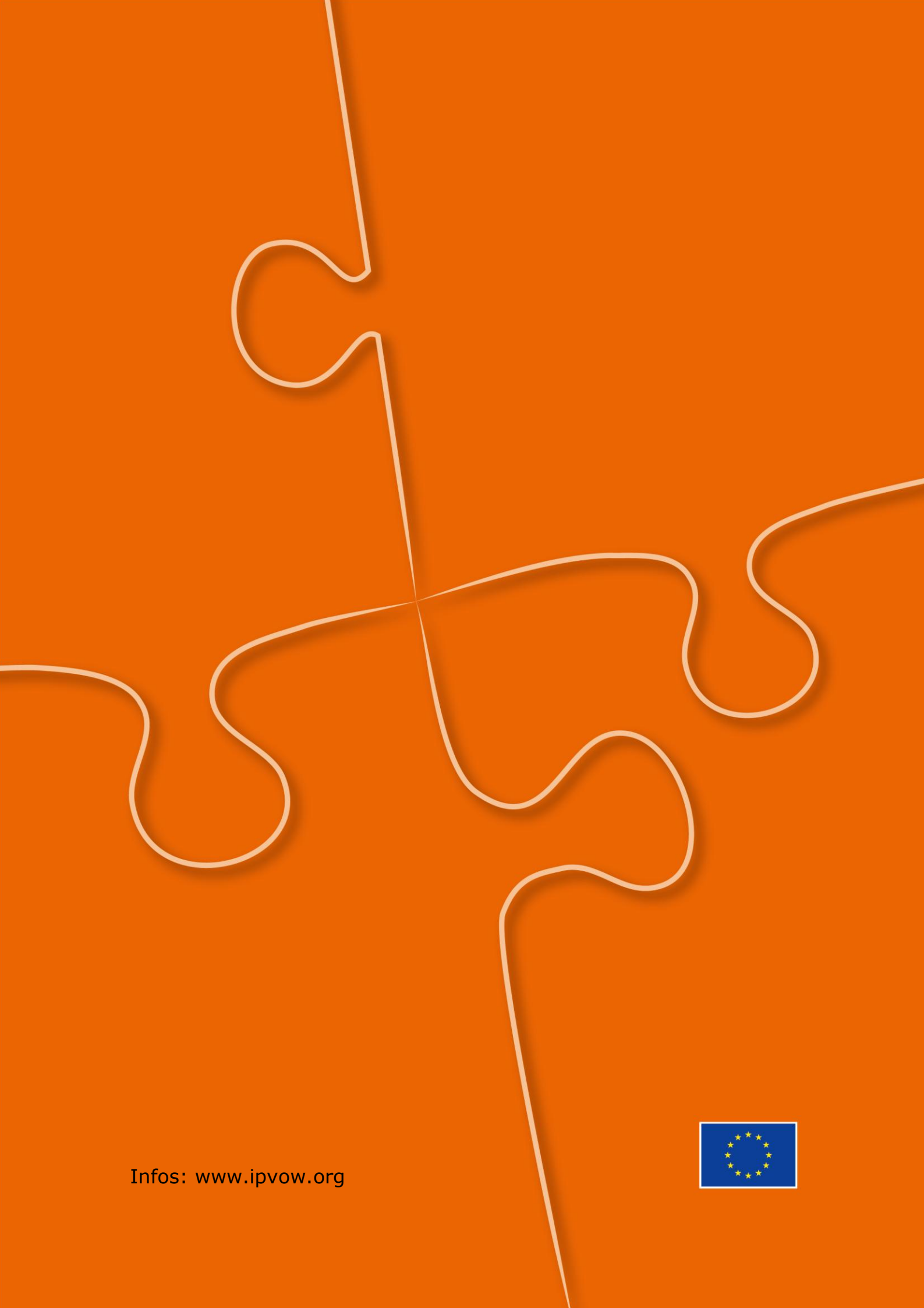

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