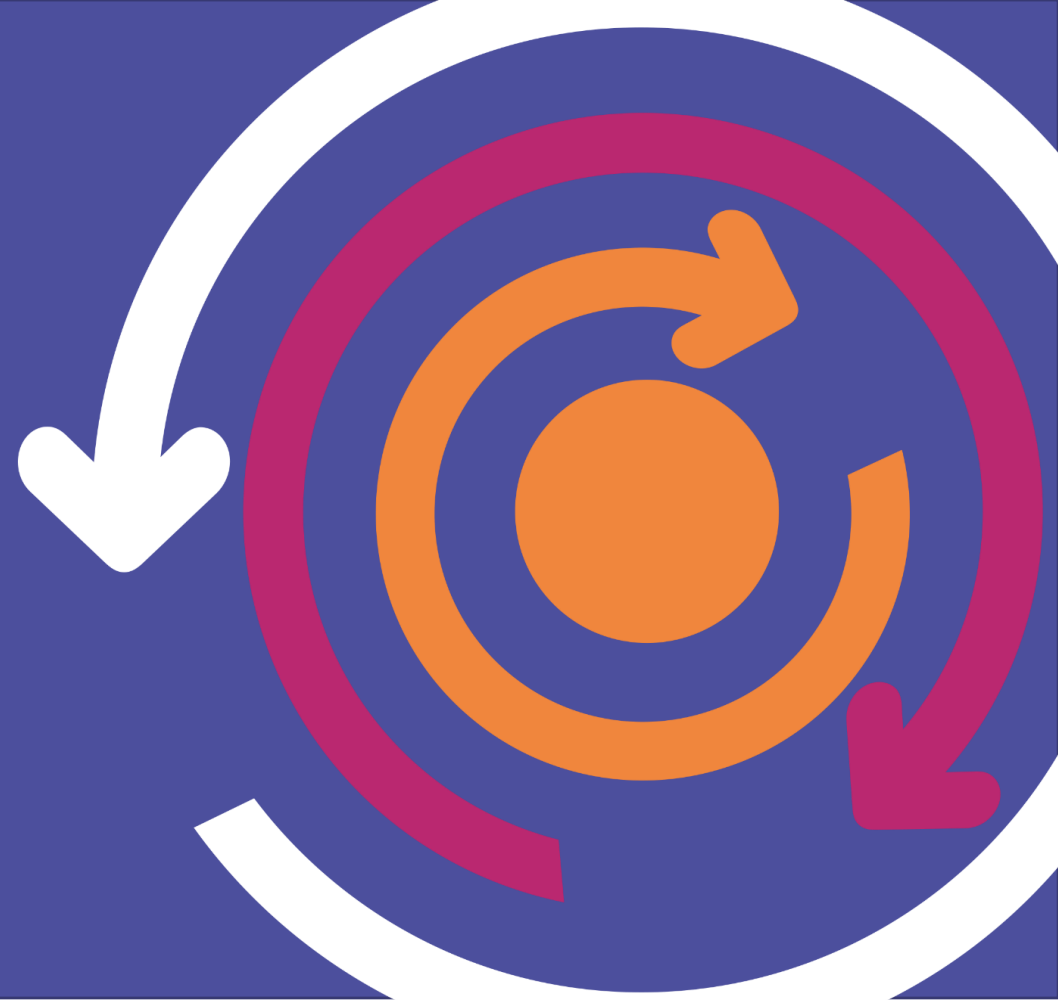


Working with perpetrators of violence against older women

Heinrich Geldschläger (Conexus)
Apolline Parel (AGE Platform Europe)

25 and 26 September 2025



MARVOW 2.0

Coordinated Multi-Agency Response
to Violence against Older Women



Funded by the
European Union

Presentations

- The Trainers

The Participants (you):

In break-out rooms of three, please have a short (6 min) conversation sharing:

- Your name, organisation and country
 - One-Word-Check-In: how do you feel today?
 - Would you feel uncomfortable giving your age to the other participants? Why?
 - What is one thing you are hoping to learn or take away from this training?
- The Training

Objectives

- Understand the specific dynamics of gender-based violence (GBV) against older women.
- Identify how societal ageism and gender norms intersect in cases of GBV against older women.
- Recognize age-related factors that shape the perpetrator's behaviour
- Develop adapted intervention strategies for working with older perpetrators

Agenda

Introduction:
Violence against Older Women

Age and perpetration of violence

Perpetrators of
Violence against Older Women

Older perpetrators of IPV

Tailoring interventions to older
perpetrators of IPV

Agenda

1st session

Presentation:
Training, trainers and participants

Introduction:
The MARVOW 2.0 project

Definitions, types, prevalences of
violence against older women

Violence against older women
in your countries



MARVOW2.0 project

- General objective: to improve the (Multi-Agency) Response to Violence against Older Women

Based on previous projects: WHOSEFVA + TISOVA + MARVOW

Time frame: 1/04/2023 - 31/03-2026 (3 years)

7 implementation countries: Austria, Greece, Bulgaria, Italy, France, Cyprus and Spain

Participating organizations: specialized in DVA/GBV, European networks on older people (AGE) and DVA/GBV (WAVE, WWP-EN)

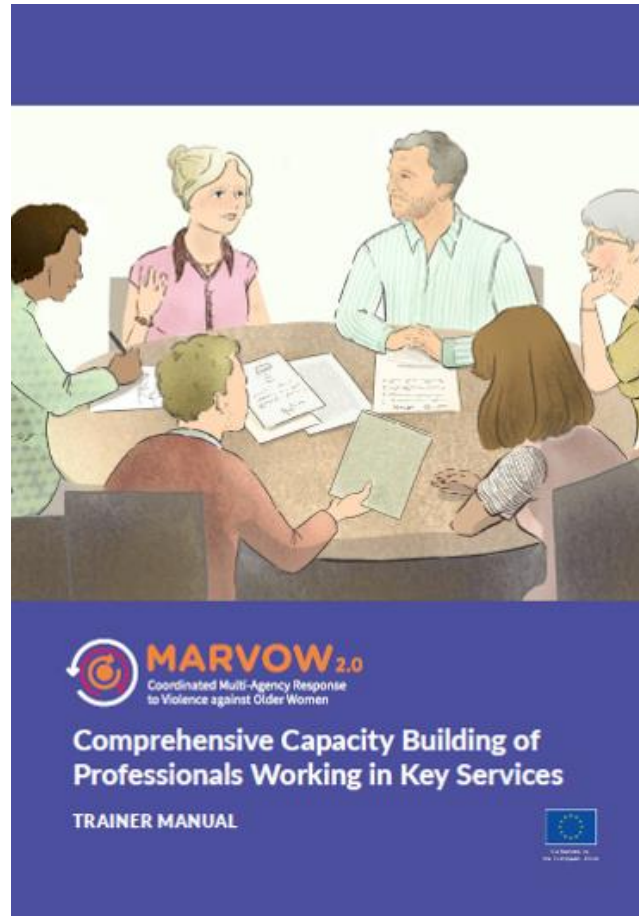
MARVOW2.0 project consortium

- Austrian Women's Shelter Network (AÖF), Austria, Coordinator
- European Network for the Work with Perpetrators of Domestic Violence (WWP EN), Germany/EU
- Women against Violence Europe (WAVE), Austria/EU, Associate Partner
- Age Platform Europe (AGE), Belgium/EU
- Union of Women Associations of Heraklion Prefecture (UWAH), Greece
- Conexus Association (Conexus), Catalonia/Spain
- Association NAIA (NAIA), Bulgaria
- Anci Associazione Regionale Comuni Italiani Lazio (ANCI LAZIO), Italy
- SC PSYTEL (Psytel), France
- Mediterranean Institute of Gender Studies (MIGS), Cyprus

MARVOW2.0 objectives

- Develop a specific risk assessment check list to be used by frontline professionals
- Develop and deliver a comprehensive training programme for professionals at national/local level and replication trainings at European level
- Introduce, test and mainstream a protocol for coordinated multiagency work and case management
- Create policy recommendations to improve legal frameworks and service provision
- Disseminate & promote the project and its results among different stakeholders (professionals, policy makers, and general public at national & EU level)

MARVOW2.0 products



- Training Manual
- Specific Risk Assessment Check-list
- Campaigns

MARVOW2.0 campaigning

MARVOW 2.0
Coordinated Multi-Agency Response
to Violence against Older Women

FACTSHEET I
Violence against older women

...refers to any gender-based act of violence that leads to physical, sexual, or psychological harm or suffering in women aged 60 years and older. This also includes the threat of such acts, coercion, or arbitrary deprivation of liberty, regardless of whether they occur in the public or private sphere.

28%
31% of all women in the European Union (EU) are over 60 years old. Additionally, life expectancy for women in Europe is increasing, in 2022, it was 84 years.²

...of older women surveyed had experienced some kind of violence or abuse in the previous 12 months.¹

The most common forms of violence against older women are:

| | |
|---------------------|-------|
| EMOTIONAL | 23.6% |
| FINANCIAL | 8.8% |
| VIOLATION OF RIGHTS | 6.4% |
| NEGLECT | 5.4% |
| SEXUAL | 3.1% |
| PHYSICAL | 2.5% |

As Europe ages, the issue of violence against older women becomes more urgent. To date, very few studies have been conducted on violence against older women. This highlights the lack of data, awareness and research in this area.

The recent EU gender-based violence survey only gathered data for women up to the age of 74, hence the data below refers to older women from the ages of 65-74:³

| | |
|--|---|
| 26.1% | 8.1% |
| of women experienced violence by an intimate partner in their lifetime | of women experienced economic violence by an intimate partner |

1. Laine, M.-L., et al. (2011). Prevalence Study of Abuse and Violence against Older Women. Results of a Multi-cultural Survey in Austria, England, Finland, Lithuania and Portugal. European Report of the AGEVO Project. Firenze: National Institute for Health and Welfare (Istituto).
2. Ageing Europe – looking at the lives of older people in the EU. Brussels, 2022.
3. EUROSTAT, PMA, DGE, EU gender-based violence survey, 2024.

Co-funded by the European Union

1 in 3 women in Europe is over 60

MARVOW 2.0
Coordinated Multi-Agency Response to Violence against Older Women

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But when we talk about violence against women... older women are often left out

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It's time to change that. Violence doesn't stop with age! And neither should support.

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Let's see what's invisible...

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What people see...

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...what's really happening

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MARVOW2.0 final conference

Unseen no more!

**POLICIES AND
PARTNERSHIPS TO
PROTECT OLDER WOMEN
FROM VIOLENCE**



3 February 2026
Brussels

SAVE THE DATE!

Who are “older women”?

Within the MARVOW2.0 project:

- ✓ **Chronologically, women aged 60 or older (60+)**, according to WHO
- ✓ Some countries (including Spain) would prefer a definition of women aged 65 or older (65+), in agreement with retirement age.
- ✓ But age is also a **social construct** .

More in the next session ...

What is “Violence against Older Women”?



Three main types:

1. Elder Abuse
2. Domestic Violence and Abuse
3. Intimate Partner Violence

Elder Abuse - definition

“A single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.”

Most widely used definition, by Action on Elder Abuse (1995), adopted by the World Health Organisation (WHO, e.g., Global Report on Ageing and Health, 2015)

Domestic Violence - definition

“Any act of physical, sexual, psychological or economic violence that occurs within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim.”

Article 3(b), Istanbul Convention (Council of Europe, 2011)

Intimate Partner Violence - definition

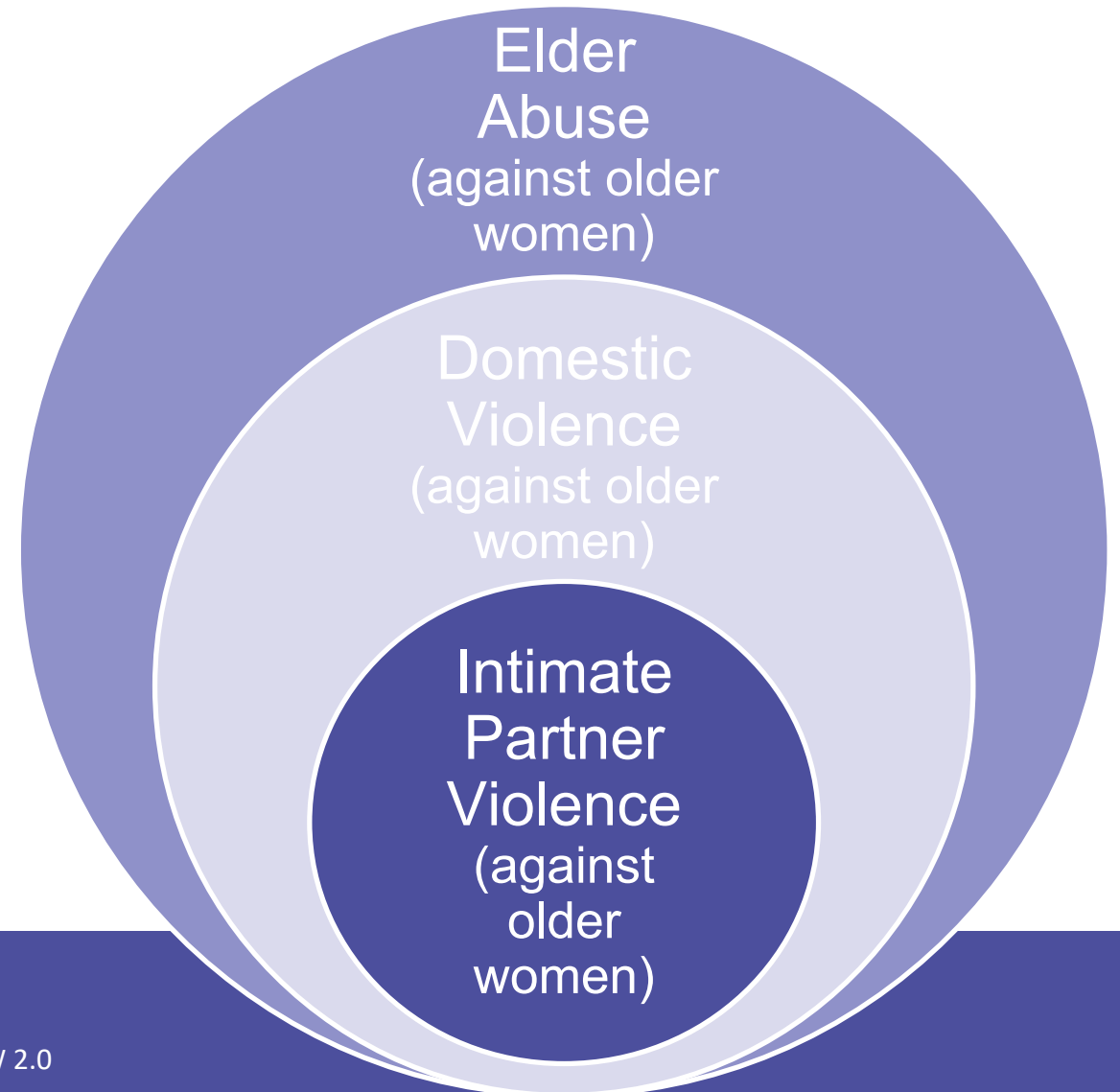
“Any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship.”

World Health Organization (WHO), World Report on Violence and Health (2002)

Violence against Older Women

Three main types:

1. Elder Abuse
2. Domestic Violence and Abuse
3. Intimate Partner Violence



Prevalence and specificities of Violence against Older Women (VOW)



In break-out rooms (of 3 or 4), please discuss

- What do you know (or imagine) about the prevalence of violence against older women (in your country)?
- What are the obstacles to victims/survivors' help-seeking?
- What are the challenges to addressing VOW (identification, protection and support)?

Prevalence of elder abuse (12m, WHO)

| | Community settings ¹ | Institutional settings ² | |
|---------------------|---------------------------------|--|-------------------|
| Type of abuse | Reported by older adults | Reported by older adults (and proxies) | Reported by staff |
| Any abuse | 15.7% | Not enough data | 64.2% |
| Psychological abuse | 11.6% | 33.4% | 32.5% |
| Physical abuse | 2.6% | 14.1% | 9.3% |
| Financial abuse | 6.8% | 13.8% | Not enough data |
| Neglect | 4.2% | 11.6% | 12.0% |
| Sexual abuse | 0.9% | 1.9% | 0.7% |

¹ Elder abuse prevalence in community settings: a systematic review and meta-analysis.

Yon Y, Mikton CR, Gassoumis ZD, Wilber KH. Lancet Glob Health, 2017.

² The prevalence of elder abuse in institutional settings: a systematic review and meta-analysis. Yon Y, Ramiro-Gonzalez M, Mikton C, Huber M, Sethi D. European Journal of Public Health 2018.

Prevalence of GBV against older women

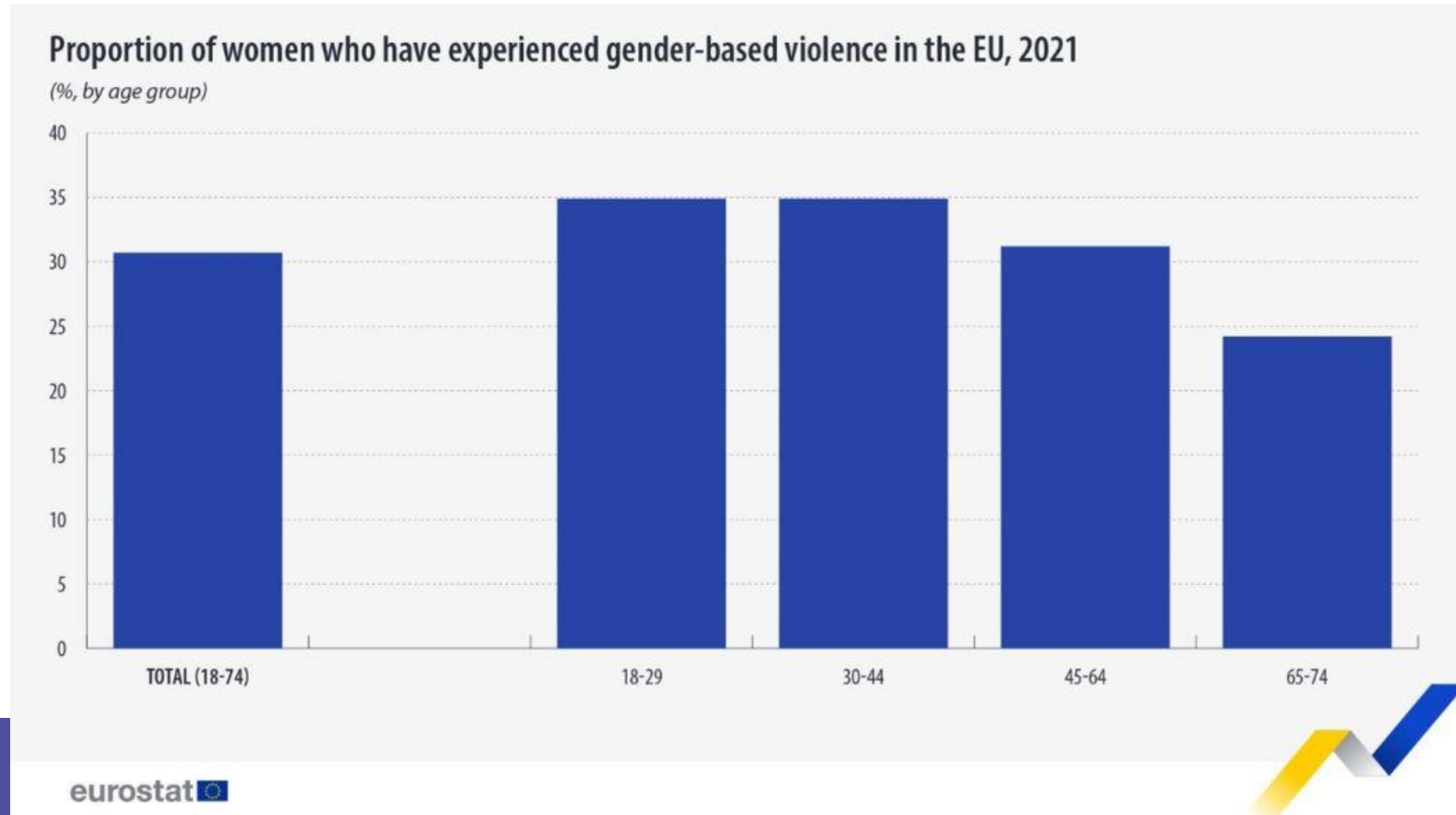
EU Gender-Based Violence Survey (2024)

based on interviews with 114 023 women in the 27 Member States

| Lifetime (since 16) | Older Women (65-74) | All women (18-74) |
|---|----------------------|-------------------|
| Psychological/physical/sexual violence by intimate partner | 26.1% | 31.8 % |
| Physical/sexual violence by domestic perpetrator | 16.5% | 19.3% |
| Physical/sexual violence by non-partner | 13.1% | 20.2% |
| Overall Physical/sexual violence by any perpetrator | 24.2% | 30.7 % |



Prevalence of GBV against older women



Prevalence of DVA against older women: UK



| Women 65-74 | Last year | | Lifetime (since 16) | |
|-------------------------------|---------------|-----|---------------------|------|
| | % (95% CIs) | n | % (95% CIs) | n |
| Partner abuse | 2.1 (1.9–2.4) | 314 | 11.9 (11.3–12.5) | 1778 |
| Other family abuse | 1.1 (0.9–1.3) | 156 | 6.0 (5.6–6.4) | 882 |
| All domestic abuse (combined) | 3 (2.7–3.3) | 433 | 14.6 (13.9–15.3) | 2151 |

Hannah Bows
 Durham University, UK
 Merili Pullerits
 City St George's, University of London, UK
 Iain Brennan
 University of Hull, UK

Domestic abuse in later life: A secondary analysis of the Crime Survey for England and Wales

European Journal of Criminology
 1–22
 © The Author(s) 2025



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 DOI: 10.1177/14773708251335388

Prevalence of IPV against older women: Spain



Macro-survey on violence against women (2019)

| | Women 16-64 | | Women 65+ | |
|--|-------------|-----------|--------------|-------------|
| | lifetime | 12 months | lifetime | 12 months |
| Intimate partner violence | | | | |
| •Physical and/or sexual | 2,6% | 1,6% | 4,4% | 0,9% |
| •Psychological | 14,1% | 10,1% | 16,2% | 9,9% |
| •Economic | 2,5% | 1,7% | 5,2% | 2,6% |
| Reports to the police / justice | 22,5% | | 17,6% | |
| Access to psychological support | 28,1% | | 13,3% | |
| Disclosure to somebody (informal help) | 81,3% | | 54,5% | |
| 40% had experienced violence for 40+ years , 27% for 20 to 30 years, average: 21 years | | | | |

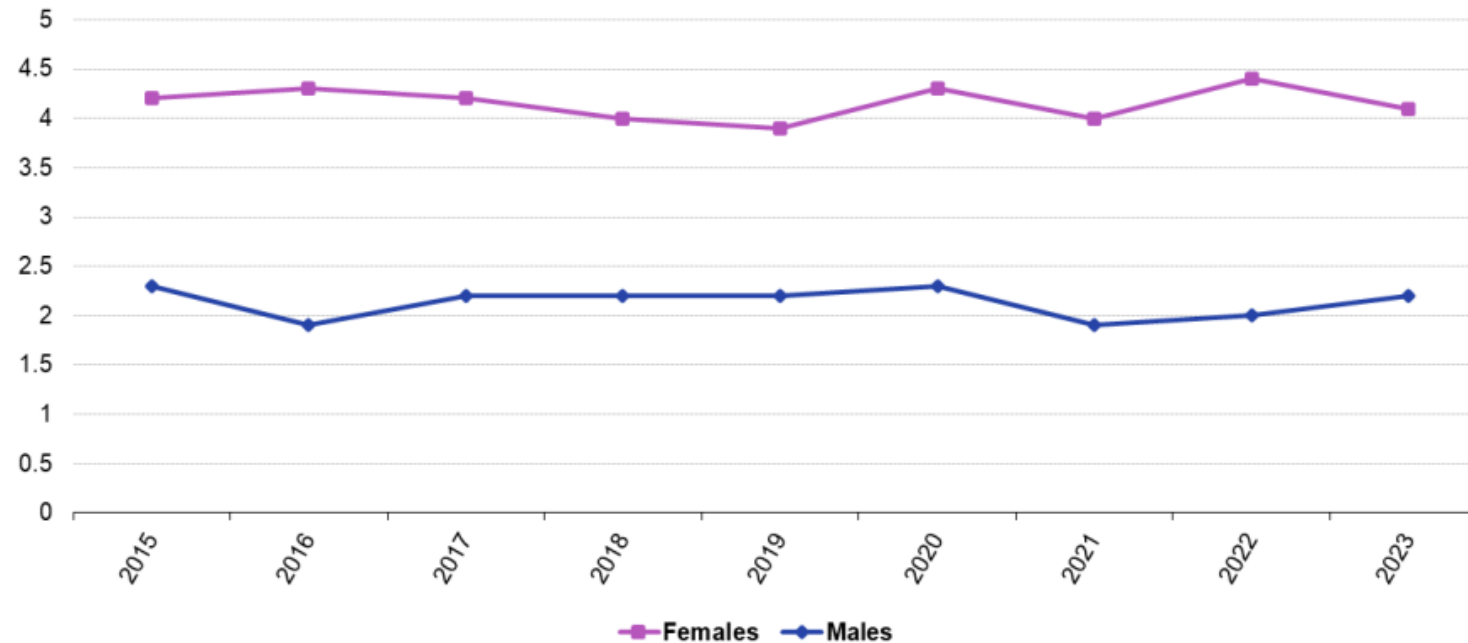
*Only around 6% of the cases attended by public victim support services were women over 60 years (Catalonia, 2022)

Femicides of older women

- **Lack of official femicide data from many countries!**
- **In Spain, 13.4% of women killed by their (ex)partners in the last ten years (2014-23, 71 of 522 cases) were aged 61 or older**
- **United Kingdom (England & Wales): 1 in 8 women killed by men since 2009 were aged 70+ (262 of ~2,000 cases, Femicide Census), older victims (65+) made up ~11% of intimate-partner homicides (Domestic Homicide Project)**
- **Data from MARVOW2.0 partners:**
 - Austria (AÖF): around 1/3 of femicides between 2020 and 2023 were of women 60+**
 - Bulgaria (NAIA): 41 femicides against women 60+ between 2020 and 2025 (37%), 1/3 committed by (ex) partner)**
 - France (Psytel): 21% of the 102 women killed by their (ex) partner were aged 70+**
- **In 2023, 569 women aged 60+ were victims of intentional homicide in the EU (data missing from a few countries including UK, Belgium, Bulgaria, ...)**

Femicides of older women

Intentional homicide victims by family members or intimate partners, male and female, 2015-2023
(police-recorded number of victims per one million inhabitants)



Note: Calculated on responding countries that cover the 75%-82% of the EU population.
Source: Eurostat (crim_hom_vrel)

Obstacles to older survivors' help-seeking



- **Normalization** of Abuse: through long-term abuse or cultural beliefs of older generations
- **“Learned helplessness”**: after decades of abuse change doesn’t seem possible
- **Fear of Retaliation/Escalation**: or of abandonment by the abuser (as caregiver) or being placed in an institution
- **Shame and Stigma**: especially after a long marriage or if the abuser is a child (sense of failure)
- **Loyalty/Protecting the Abuser**: particularly when the abuser is an adult child or a frail spouse
- **Dependency**: Financial, physical, or emotional dependency make disclosure threaten basic needs impossibility or difficulty of accessing the labour market, fear of poverty and homelessness
- **Lack of Awareness of Rights/Options**: such as availability of legal options and support services
- **Cognitive or Physical Impairments**: make communication and help-seeking difficult
- **Isolation**: Abusers often isolate older victims from friends, family, and community
- **"Invisibility"**: VOW is often less recognized or "invisible" in public discourse, policy, and even within support services (see MARVOW2.0 campaign)

Barriers to Detection of Violence against Older Women



- **Ageism and Stereotyping:** Professionals may not consider older women as individuals with sexualities and relationships / victims of domestic violence or that injuries are simply due
- **Lack of Awareness and Training:** Many professionals lack specific training in recognizing domestic violence in older adults, particularly non-physical forms
- **Time Constraints,** especially in healthcare settings, make comprehensive assessments and building rapport for disclosure difficult
- **Privacy Concerns:** especially if a caregiver or family member (potentially the abuser) is present
- **Lack of Standardized Screening Tools:** Absence age-appropriate screening protocols and risk assessment instruments for domestic violence in older women
- **Reluctance to Intervene:** Professionals might be hesitant to "interfere" in what they perceive as private family matters or fear straining the working relationship
- **“Learned helplessness”:** belief that older women won’t change (report / separate) or that there are no adequate solutions / support offers available for them

Barriers to Provision of Support to Older Women



- **Unsuitable Accommodation:** Many domestic violence shelters are not equipped for the physical, medical, or mobility needs of older women or perceived as unsuitable due to the presence of younger women with children
- **"One Size Fits All" Approach:** Services are often designed for younger victims, failing to address the unique concerns of older women
- **Digital Exclusion:** lack of digital skills or internet access as a barrier to accessing online resources or communicating with services
- **Geographical Barriers:** Rural isolation, lack of transportation, and mobility issues
- **Financial Barriers:** lack of independent resources to leave, secure new housing, or pay for legal assistance
- **Language and Cultural Barriers:** For older women from minority ethnic backgrounds, a lack of culturally sensitive services or language support can be an additional barrier
- **Lack of Coordinated Responses:** Poor coordination between health, social care, housing, and DVA services means older victims can fall through the cracks

Social context of VOW

| AGEISM | SEXISM |
|---|--|
| <p>Age stereotypes</p> <p>Paternalism and infantilization</p> <p>Homogenization and reductionism</p> <p>Negative representation and/or invisibility of older persons</p> <p>Asexualization</p> <p>Forced passivity and/or elimination of agency</p> | <p>Gender stereotypes</p> <p>Androcentrism</p> <p>(Re)victimization and reductionism</p> <p>Representation within power relationships: submission and control</p> <p>Hypersexualization and objectification</p> <p>Appropriation of agency</p> |

Agenda

2nd session

Who are 'older people'?

Impacts of ageism and age discrimination

Introduction to the human rights-based approach



Who Are *Older People*?

In small groups (3-4 people), discuss the following questions:

- Who do you think of when we say “older people”?
- How do you picture older women, older men? Why?
- What other differences and/or diverse identities can you think of among older people?

Older People Are a Very Diverse Group

Older people are:

- A very **diverse** group.
- They have different perspectives, aspirations, lived experiences and needs that heavily depend on a wide range of factors.
- **Rights holders** - they are entitled to the same human rights as everyone else, no matter their age.
- They are not frail, passive, or inactive members of society.
- **Older people experience ageism and age discrimination at a systemic level.**
- [1 in 2 people are ageist against older people.](#)
- **Gender-based violence can occur across the life course** and may be exacerbated in older age.

Impacts of Ageism and Age Discrimination?



- ***Ageism refers to how we think (stereotypes), feel (prejudice), and act (discrimination) towards others or ourselves based on age*** (World Health Organization).
- Ageism is widespread across countries, **affects people of all ages**, and has serious and far-reaching consequences for people's health, well-being and human rights.
- Older women face **multiple** and **intersecting forms of discrimination**.
- **Stereotypical attitudes about gender do not disappear with age** but are compounded with assumptions about later life, such as frailty, dependence, lack of ability and passivity (UN Independent Expert, 2021).
- **Gender inequality in older age is the result of disadvantages accumulated over the life course and further exacerbated by ageism and age discrimination** (UN Independent Expert, 2021).

Recognising Ageist Attitudes

In small groups (3-4 people), discuss the following questions:

- Can you think of some common **ageist attitudes or stereotypes about older people** that you may have seen or heard in everyday life (media, work, healthcare, family, advertising)?
- Can you think of the impacts that ageism and age discrimination can have on older people?
- Are there specific ageist attitudes that you may have noticed towards older women specifically?

Introduction to the Human Rights-Based Approach



Questions to all participants:

- What comes to your mind when you hear the words ‘human rights’?
- Why/How are they relevant to your field of work?
- How are they relevant for combating gender-based violence against older women?

Introduction to the Human Rights-Based Approach



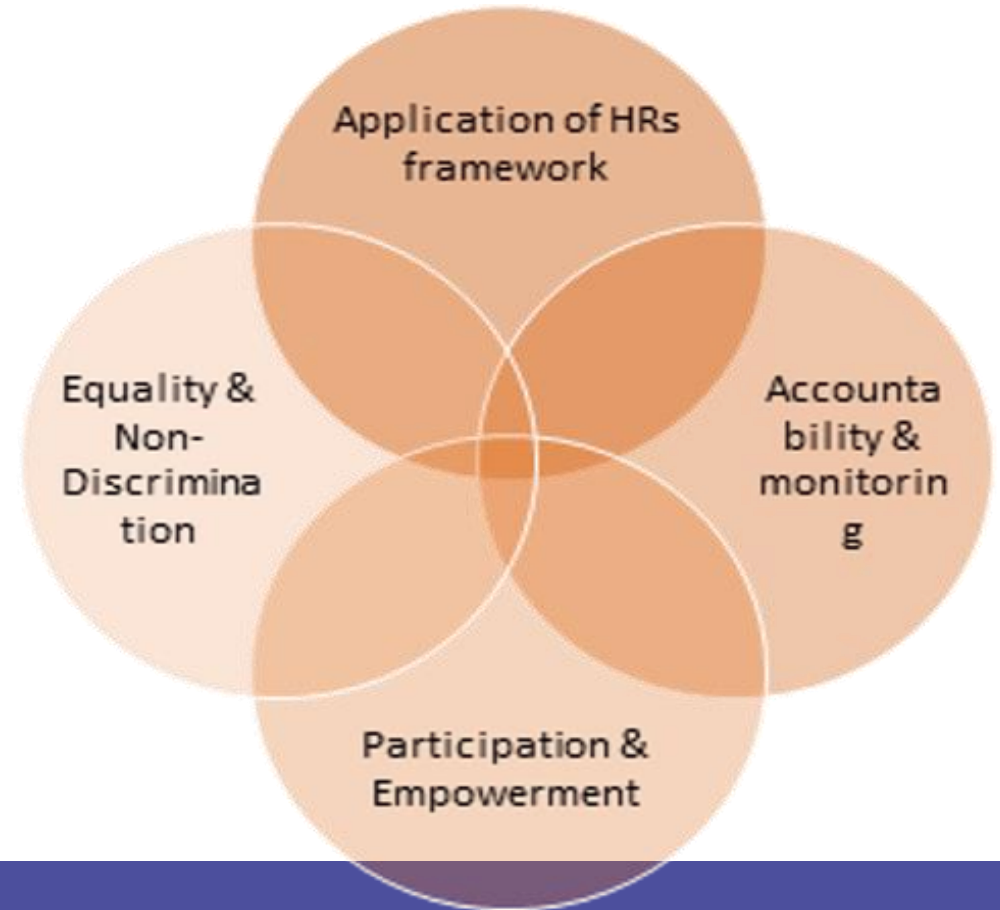
Human rights are:

- **UNIVERSAL:** Human rights are rights that all people are entitled to have.
- **INALIENABLE:** We have human rights simply because we are human. They cannot be taken away.
- **INDIVISIBLE:** Their enjoyment depends on the full enjoyment of all rights.
- **EQUAL:** They ensure that people are treated fairly and with respect.
- **ACCOUNTABLE:** Human rights are guaranteed by international treaties.

Introduction to the Human Rights-Based Approach



- The Human Rights-based Approach is a **strategy to implement human rights**.
- It is built on 5 key pillars:
 - Participation
 - Accountability
 - Non-discrimination and Equality
 - Empowerment
 - Legality > decisions and policies must be grounded in legal human rights standards.



Introduction to the Human Rights-Based Approach



- From international treaties into practical actions:
 - Collection and analysis of **gender and age-disaggregated data**, that do not stop at a certain age.
 - Empowerment and participation of older people in the planning and decision-making progress.
 - Allocation of resources to organisations that specifically address the concerns of older people.
 - Reduction of **gender inequality** (in line with the UN Sustainable Development Goals).
 - **Older women are rights holders.**
 - Challenge ageist and sexist stereotypes about older people.

Agenda – Third Session

Types of perpetrators
of violence against older women

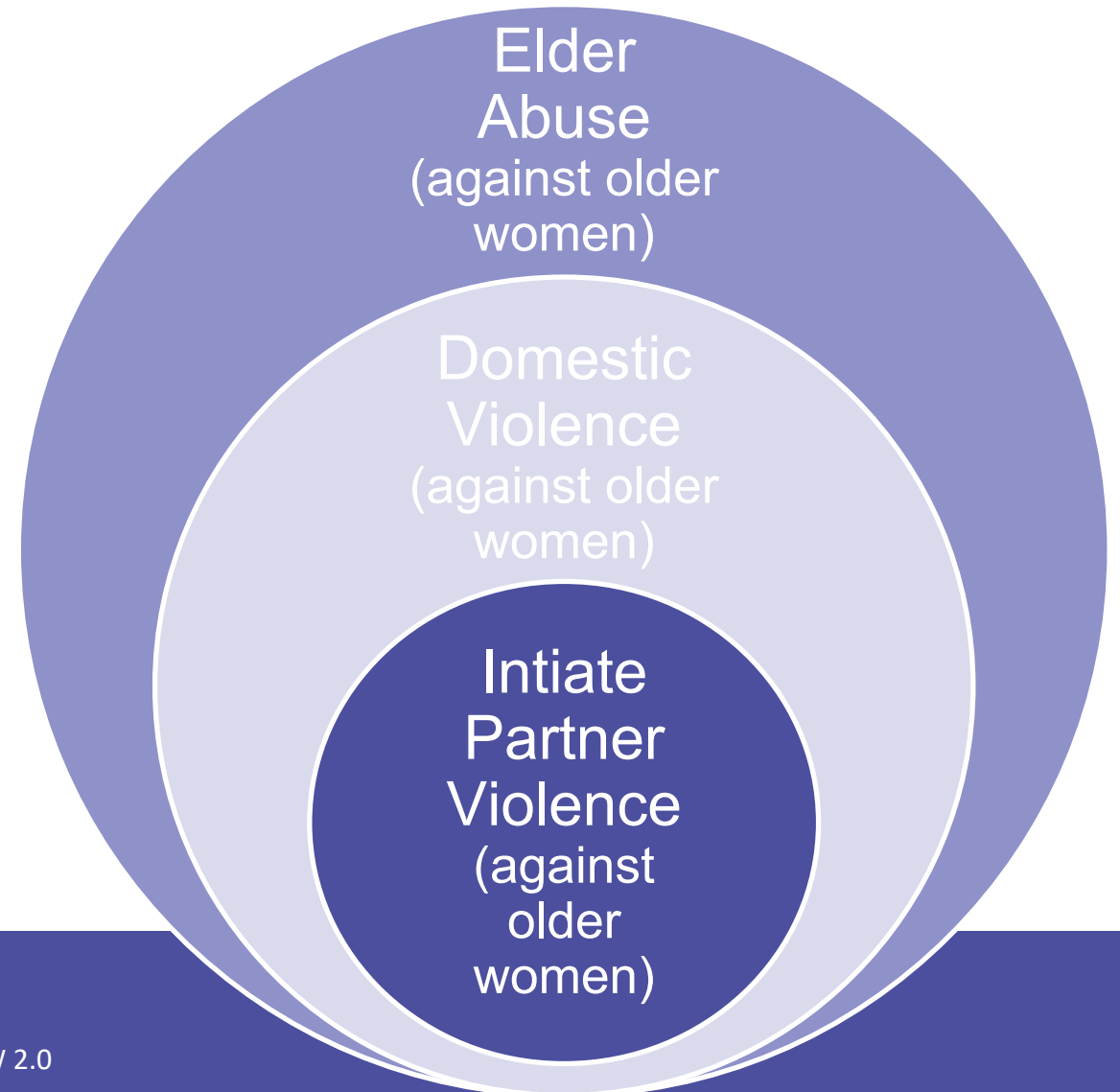
Differences in risk factors,
relationship and abuse dynamics

Implications for intervention

Who is the perpetrator?

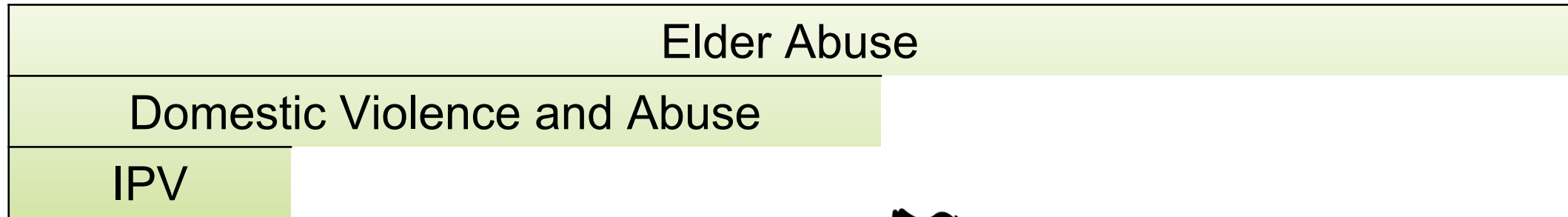
Three main types:

1. Elder Abuse
2. Domestic Violence and Abuse
3. Intimate Partner Violence



Who is the perpetrator?

Recap: Violence against Older Women



partner



son



daughter



grandson



friend



Social worker



Caregiver

Exercise on perpetrator groups

In break-out rooms (of 3 or 4), please discuss for

1. (Ex) Partners – groups 1, 4, 7, ...
 2. Family members (children) – groups 2, 5, 8, ...
 3. Informal or professional carers – groups 3, 6, 9, ...
- What are the (differential) characteristics and risk factors for this perpetrator group?
 - What are the (typical) relationship and abuse dynamics?
 - What are the implications and challenges for intervention and victim support?

Types of perpetrators: characteristics & risk factors

| | Intimate Partners | Other Family Members (incl. Children) | Carers (Professional / Informal) |
|-----------------------------|---|---|--|
| Perpetrator characteristics | <p>Usually male partners or ex-partners.</p> <p>May have long-standing history of IPV (chronic) or onset in later life due to stress, retirement, illness, or dependency.</p> | <p>Commonly adult sons (or daughters) living with the older woman.</p> | <p>Can be formal carers (paid) or informal (friends / neighbours).</p> |
| Risk factors | <p>Traditional gender norms, entitlement, need for power & control, substance abuse, mental illness, poor conflict resolution, stress of caring, social isolation, dependency and/or frustration due to illness / health decline and/or change in roles and routines (retirement)</p> | <p>Entitlement, lack of empathy/compassion, unemployment, financial dependency, substance abuse, intergenerational family conflict, caregiver stress, cohabitation due to economic issues</p> | <p>Caregiver stress, poor training / poor (coping) skills, low pay, burnout, mental illness, substance use, history of violence, lack of oversight / supervision</p> |

Types of perpetrators: relationship and abuse dynamics



Intimate Partners

Often rooted in coercive control and patriarchal gender roles (usually includes many types of abuse).
Chronic IPV or onset linked to changes with age and shifts in roles (retirement, health, dependency, etc.).
Women may stay due to fear of abandonment, shame or dependency. Isolation is common.

Other Family Members (incl. Children)

Often involves financial exploitation, psychological abuse, neglect, and sometimes physical violence.
Often framed as family conflict or “carer stress”. Abuse can be financial exploitation, manipulation, threats or neglect .
May co-occur with caregiver stress or unresolved family conflicts.
Dependency and living arrangements play a big role.

Carers (Professional / Informal)

Abuse may be opportunistic or systematic exploitation (e.g. financial).
Abuse can be neglect, psychological abuse, physical mistreatment, or financial exploitation.
May be hidden due to victim dependency, cognitive impairment, or victim fear of losing care.
Institutional abuse may be enabled by organizational cultures and go unreported due to lack of oversight.

Relationship & abuse dynamics

Types of perpetrators: relationship and abuse dynamics



Intimate Partners

Other Family Members (incl. Children)

Carers (Professional / Informal)

Implications & challenges for intervention & victim support

Requires understanding the life-course dynamics of IPV, possible chronic patterns vs. late-onset violence.
Key challenge: older women often feel tied to relationship and fear of / guilt for abandonment.
Interventions must adapt to physical / cognitive health and safety planning.
Adapt risk assessments to capture older IPV patterns.
Address isolation, health, and gendered beliefs. Position and (lack of) support of children often key.

Difficult to address due to strong family ties and/or beliefs around family, financial co-dependence. Risk of victim self-blame and refusal to report. Intervention must balance support for the victim with safe management of the perpetrator, sometimes also dependent. Multi-agency coordination is essential.

Risk of isolation for victim if carer is removed — safeguarding must include alternative care solutions. Need for robust safeguarding, care standards, and accountability. Workforce training, oversight and inspections are key. Victims may fear retaliation or loss of care. Institutional abuse requires systemic response (reporting, regulation).

Perpetrators of Domestic Abuse Against Older Adults: Characteristics, Risk Factors and Professional Responses



Mixed-method study: rapid evidence review, analysis of 69 safeguarding case files, and interviews with 66 professionals (Bows et al., 2022):

- **Limited Knowledge on Perpetrators:** significant lack of studies focusing on perpetrators of domestic abuse against older adults (only 2 out of 75 reviewed papers): information on perpetrator backgrounds (health, drug/alcohol use, criminal history, employment) is very scarce.
- **Perpetrator Profiles:** Perpetrators are typically male, most commonly adult sons, followed by partners. The fewer female perpetrators are primarily daughters, a smaller proportion partners.
- **Common Risk Factors:** Poor mental health and drug/alcohol abuse are common among perpetrators, particularly adult sons/daughters. A criminal history is also frequently observed in adult sons or daughters, but less so in intimate-partner violence. Other common risk factors include physical and/or mental health issues in victims and/or perpetrators, dependency, generational attitudes, norms, beliefs, ageism, and negative attitudes towards older people.
- **Invisibility of Abuse:** Abuse of older adults is often invisible to services and infrequently identified as domestic abuse. This is attributed to generational norms, lack of awareness among professionals / the community, and policies/tools that do not adequately consider older adults.

Perpetrators of Domestic Abuse Against Older Adults: Characteristics, Risk Factors and Professional Responses



Mixed-method study: rapid evidence review, analysis of 69 safeguarding case files, and interviews with 66 professionals (Bows et al., 2022), contd.:

- **Stereotypes Affecting Identification:** Stereotypes of perpetrators as young, male partners/spouses continue to influence understandings of domestic abuse, leading to abuse by other family members (e.g., adult sons/daughters) being overlooked. Older perpetrators are often considered vulnerable and assumed incapable of being abusive, leading to victims not always being believed or assumptions of low risk.
- **Inadequate Risk Assessments:** Very few instances of risk assessment use were recorded in safeguarding case files, and the applicability of existing domestic abuse risk assessments for older adults is not clear, particularly when the perpetrator is an adult son/daughter.
- **Gaps in Perpetrator Interventions:** The very few specialized perpetrator programmes available are primarily designed for younger adult men who abuse their partners, making them less relevant for older perpetrators or those who abuse their parents.



PERPETRATORS OF DOMESTIC ABUSE
AGAINST OLDER ADULTS
CHARACTERISTICS, RISK FACTORS AND PROFESSIONAL
RESPONSES

Dr Hannah Bows, Bridget Penhale, Paige
Bromley, Merili Pullerits, Natalie Quinn-
Walker & Asmita Sood

MARVOW 2.0

Homework for tomorrow (5th session)

In the 5th session tomorrow, we will do an exercise on risk assessment and how it can be complemented with additional age-specific risk factors

- **Please, bring the risk assessment tool or instrument you routinely use in your work**
- **In case you don't use any risk assessment instrument regularly**
 - **Find out about the ones available in your context and get trained to use (one of) them ;-)**
 - **You can use the SafeLives DASH risk checklist tomorrow (on you padlet)**

Agenda

4th session

Developmental challenges of old age and violence perpetration

Types of perpetrators of IPV against older women: chronic vs. late onset

Case studies

Differences in risk factors, relationship and abuse dynamics

Implications for interventions and victim safety

Developmental challenges of old age and violence perpetration



Video

<https://www.youtube.com/watch?v=CNmJmiwxpPs>

Aging, power, gender and violence perpetration



Discussion

- *How does aging impact the (perceived) power of the individual? (e.g., physical power, social power, financial power, ...)*
- *How could this impact men specifically?*
- *How could this older men's use of violence in intimate relationships? (e.g. they could try to increase their power in the family home, as a compensation for being powerless in other areas of life).*

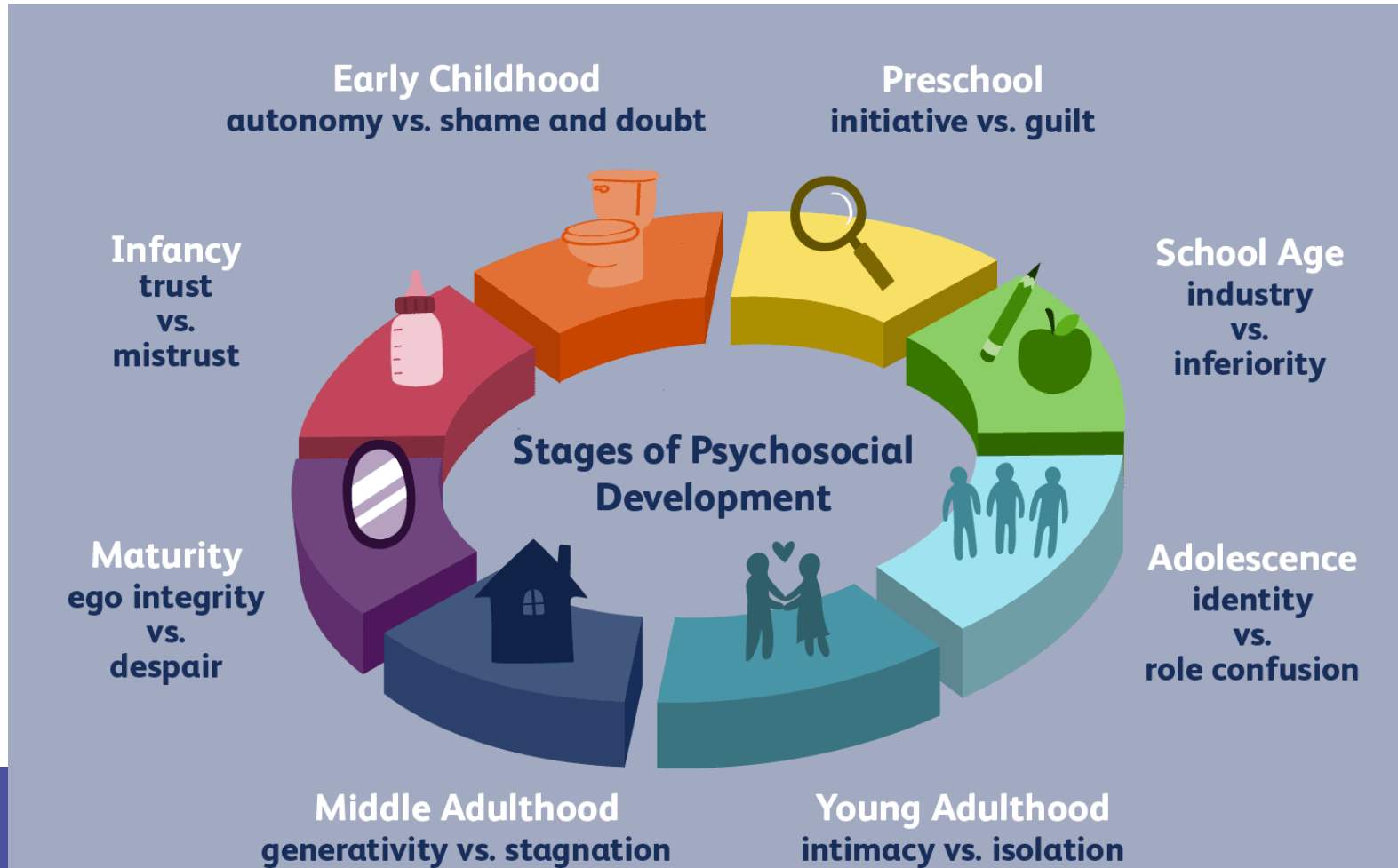
Aging, power, gender and violence perpetration



Reflection

- **Power:** Ageing implies a perception of reduced power for most people, physically, socially, economically.
- **Gender:** Men can experience this loss of power as demasculating (and possibly humiliating), since it opposes traditional masculinity norms such as physical strength (protector); social, professional and economic success and influence (provider); sexual activity (procreator); autonomy; etc.
- **Violence and abuse:** Some men use violence and abuse to compensate feelings of powerlessness and / or demasculation trying to increase their power in the relationship / family.

Erik Erikson's stages of psychosocial development



Maturity phase (integrity vs despair)

- Facing major shifts: depending on others, accepting aging of body and health, facing termination of life, losing power
- People who believe they have had a positive impact on the world through their contributions live the end of life with a sense of integrity.
- Those who feel they have not measured up to certain standards—either their own or others’—develop a sense of despair.
- Success in this stage will lead to the virtue of **wisdom**. Wisdom enables a person to look back on their life with a sense of closure and completeness, and also accept death without fear.
- How can we support integrity development within perpetrator programmes?

Trajectories of IPV perpetration against older women



| Chronic abuse | Late onset abuse |
|--|---|
| Abuse began earlier in life, often decades ago | Abuse begins (or significantly escalates) in later life |
| Deeply ingrained abusive patterns, often coercive control and isolation | Often response to new stressors associated with aging (e.g., retirement, health issues, caregiving burden) |
| (Physical) abuse sometimes reduces with age, but can also increase and/or change | Often more emotional, verbal, and neglectful abuse, sometimes financial |
| Different constellations of health / care / dependency | Cognitive decline / dementia of the perpetrator sometimes significant issue |
| Profound and cumulative negative impacts on the victim's physical health (chronic pain, stress-related illnesses), mental health (depression, anxiety, PTSD), and self-worth | Victim may feel ambivalence, acknowledging the abuse but also recognizing the partner's illness or genuine struggle |

Exercise on chronic vs. late onset IPV

In break-out rooms (of 3 or 4), please read the assigned case study

1. William and Mary (chronic IPV) – groups 1, 3, ...
2. Arthur and Charlotte (late onset IPV) – groups 2, 4, ...

and develop a brief plan to address

- Intake, assessment & motivation for change (vs. minimization, justification & victim blaming),
- change of abusive behaviour and relationship in the intervention.

Therapeutic relationship with older perpetrators

When reading the case studies, what emotions and relational dispositions arise toward the older men described?

- Are our feelings and relational dispositions different in cases of older perpetrators?
- Do we feel more understanding / pity / anger / X for them?
- Does that lead us to
 - underestimate risk?
 - collude with them?
 - be more/less confrontative?

Therapeutic relationship with older perpetrators

| | |
|--|---|
| Clear stance against any type of violence or abuse and beliefs or attitudes supporting them | Accept the older man as a person and understand his experience and history |
| ➤ hold men accountable | ➤ collaborative and trustful working relationship |
| ✓ make change possible | |

Therapeutic relationship with (older) perpetrators



Different positions and the therapeutic relationships they produce

| Collusion | Balanced | Confrontation |
|---|--|---|
| Alliance forms | Alliance forms with the part of him that wants to change | No Alliance, rather opposition |
| You sit alongside him to review others' behaviours | You assist him to review his abusive behaviours | You confront him with his wrongdoings |
| You empathise when he talks about himself as victim of others | You empathise when he feels bad about his abuse | You don't empathise at all |
| There is little challenge or conflict | You make gentle but persistent invitations to the man to challenge himself | There is a high level of challenge and conflict |
| ... | | |

Adapted from Iwi & Newman (2015, p. 26)

Older perpetrators: “not quite ideal”

Study based on interviews with 66 professionals working across safeguarding, health, criminal justice, and domestic abuse services in the UK (Bows et al., 2024):

- **Older perpetrators are "not quite ideal"**: they fall short of the "ideal offender" stereotype (male, physically large, strong, stranger, overtly violent) and thus are often not recognized.
- **"Nice old man"**: Middle-class older men who are respected in the community are often disregarded as potential abusers (assuming the best in older people).
- **"Vulnerable old man"**: Older intimate-partner perpetrators are often described as having their own health needs, disabilities, frailties, or dependencies on the victim for care, leading to the risk of abuse being downplayed, or the focus shifting to the perpetrator's needs.
- **"Vulnerable familial perpetrator"**: Similarly, adult sons or grandsons are frequently perpetrators, often having chaotic lifestyles involving drug and alcohol dependencies, mental health issues, and housing problems. They are often not labeled as abusers because they don't fit the "ideal" spouse/partner stereotype and have their own vulnerabilities.
- **Domestic abuse is repackaged as a health issue**: which has significant implications for professional practice.

Analysis of Arthur's Case



Perpetrator Characteristics and Risk Factors:

- **Long-Standing Chronic Abuse:** Arthur's behavior is a clear example of chronic, long-standing IPV, having spanned "practically all their 45 years of marriage."
- **Gendered Beliefs and Entitlement:** Arthur explicitly states, "She knows I've always been the man of the house, responsible for everything. It's just how things are."
- **Exposure to Childhood Domestic Violence:** His reference to "having been exposed to parental domestic violence in his childhood (and being afraid of his father then)" is a significant risk factor.
- **Minimization and Victim Blaming:** Arthur's response, "She exaggerates. I never hit her, not like that. A bit of shouting maybe, but that's just normal marriage stuff, isn't it? She can be quite difficult," perfectly reflects the tendency to minimize their actions and externalize blame.
- **Lack of Insight into Victim's Fear / Access to arms:** His comment about the gun indicates that he cannot comprehend the terror his actions induce and is a significant risk factor (access to arms).
- **Substance Use:** He "drinks moderately every day and sometimes a little more 'when she gets on my nerves'," but "does not see himself as having an alcohol problem."
- **Later-Life Health and Mobility Issues:** these issues, making him physically dependent on Jane, have influenced the *form* of the abuse (physical violence stopped) but not the *underlying control*.

Analysis of Arthur's Case



Implications and Challenges for Intervention with Arthur

- **Resistance and Lack of Engagement:** Arthur's withdrawn demeanor and statement "I'm here because my probation officer told me so" indicate low intrinsic motivation, so motivational work will be paramount initially.
- **Minimization and Denial:** His persistent minimization of the abuse ("She exaggerates... normal marriage stuff") will similarly require efforts to help him acknowledge harm and take responsibility.
- **Deeply Ingrained Beliefs:** His statement "It's just how things are" reveals deeply embedded gendered beliefs that will have to be challenged and dismantled / transformed.
- **Explore the intersection of age, power gender and violence:** Explore Arthur's experience of ageing (incl. physical health) regarding his masculine identity and the relationship with his use of violence.
- **Foster integrity / purpose in later life:** Support Arthur in generating alternative ways of being an older man and find purpose (vs. despair)..

Analysis of Arthur's Case



Implications and Challenges for Victim Support with Jane

- **Decades of Trauma:** Jane has endured 45 years of abuse, leading to profound psychological and emotional harm, including eroded self-worth. Her recovery journey will be long and complex.
- **Financial and Social Dependency:** Arthur's control over finances and prevention of her working mean Jane has likely minimal independent financial resources and a limited social network, making leaving extremely difficult.
- **Caregiving Role:** Her role as his primary carer adds a complex layer of dependency. She might feel a sense of obligation or guilt about ceasing care, even if it's for her safety.
- **Son's Support is Crucial:** Michael's recognition and support are vital, but support services will need to help Jane build a broader independent support network and safety plan.
- **"Invisible" Abuse Recognition:** For Jane, recognizing the psychological abuse as equally harmful as physical violence, especially after decades of normalization, might be an ongoing process.
- **Systemic Failures:** The fact that the abuse went unreported for so long highlights systemic failures in identifying and responding to IPV in older adults.

Analysis of Andrew's Case



Perpetrator Characteristics and Risk Factors:

- **Late-Onset Abuse Triggered by Life Changes:** Andrew's abuse is clearly "late-onset," with Maria explicitly stating their relationship "has totally changed since his retirement 4 years ago and, especially, since Maria's accident 2 years ago."
- **Cognitive Impairment/Health Issues:** Andrew's concerns about "forgetting things like appointments, taking his medicine for diabetes or some news he's heard on the radio" suggest potential early cognitive decline / dementia.
- **Caregiver Strain and Resentment:** Maria's accident two years ago shifted her into a care-receiving role, making Andrew a primary caregiver.
- **Gendered expectations / entitlement:** Complaints about Maria "not 'being the same' as before the accident and not fulfilling her duties anymore," specifically regarding household and sexual relationships
- **Financial Stress and Perceived Inequality:** Andrew's resentment over his "ridiculous" pension and having to "ask Maria for money" because her pension is "far higher" highlights gendered frustration about financial stress and perceived power imbalances.

Analysis of Andrew's Case



Perpetrator Characteristics and Risk Factors:

- **Depression and Dissatisfaction with Retirement:** Andrew's admission of feeling "a little down" after retirement and saying "this is not the retirement I imagined" points to mental health challenges (like depression) and dissatisfaction with later-life transitions.
- **Suicidal Ideation/Dependency:** His admission that if Maria divorced him "there would be no reason to go on" reveals an emotional dependency on her, and suicidal ideation linked to the relationship's continuity. This indicates a risk of controlling and abusive behaviors, particularly if he perceives her pulling away, and of suicide or murder suicide.
- **Dependency-related coercion / isolation:** Blocking external help ("I don't want anybody to poke around in my place") and attempting to sedate his wife without consent ("tried to 'calm' her by giving her pills so she could sleep better").
- **Lack of support:** Andrew has nobody to talk to and "doesn't want to bother" his children.

Analysis of Andrew's Case



Implications and Challenges for Intervention with Andrew

- **"Vulnerable Old Man" Stereotype:** Possible trap of perceiving Andrew as a "vulnerable old man" due to his health issues and depression, downplaying his abusive capacity.
- **Lack of Intrinsic Motivation:** Andrew's skepticism ("not sure that this is what he really needs," "making a mountain out of a molehill") and conditional willingness ("might as well give it a try to keep the family together") indicate low motivation.
- **Addressing Confounded Issues:** Intervention must address not only the abusive behaviors but also his mental health (depression), potential cognitive decline (forgetfulness), and his struggles with later-life transitions (retirement, caregiving).
- **Insight into Coercion (Pills):** Attempt to "calm" Maria with pills is a red flag for coercive control and potentially medical abuse, requiring direct and sensitive confrontation.
- **Support for generating purpose in later life,** including as a man
- **Support in creating a social network:** through the group and / or community activities
- **Coordination** with medical services for mental health and cognitive screening.

Analysis of Andrew's Case



Implications and Challenges for Victim Support with Maria

- **"Trapped" Feeling:** Maria's dependence on Andrew for care (despite home-care services) and her emotional bond ("can't imagine leaving him") create a sense of being trapped (despite the fear).
- **Difficulty Labeling as Abuse:** Maria's statement "she doesn't recognise Andrew and that he never used to act like this before" indicates that she may struggle to label his actions as "abuse" due to the sudden shift in his behavior and her perception of his "overburdened" state.
- **Caregiver Blame/Guilt:** Her belief that he is "overburdened" might lead her to feel responsible for his behavior, hindering her ability to prioritize her own safety.
- **Invisible Abuse for Services:** Services must be diligent in recognizing Andrew's actions as abuse, not just a symptom of his stress or illness.
- **Need for Coordinated Support:** The involvement of the social worker, nurse, and GP highlights the need for a multi-agency approach to ensure her safety, medical needs, and emotional support are met, without solely relying on Andrew for care.
- **Involving the family / children:** to believe and support their mother.
- **Safety Planning:** Despite her reluctance to report / leave, a comprehensive safety plan is crucial, addressing the escalation and the potential for increased danger, especially with the use of pills.

Victims and Perpetrators as caregivers

Results from a study on 245 older victims in the Spanish risk assessment and management system AtenPro (2018)



| Frequency and perpetrator attitudes and behaviours according to victims surveyed | Perpetrator has been caregiver | Victim has been caregiver |
|--|--------------------------------|---------------------------|
| Frequency (of victim / perpetrator as caregiver) | 12% | 65% |
| Accidents caused by him, in which you were harmed | 7% | 27% |
| Increase in physical violence | 7% | 40% |
| Abuse in which he takes advantage of your/ his illness or disability | 3% | 54% |
| He isolated you from the world | 17% | 60% |
| Increase in psychological abuse | 28% | 73% |

A Study of Male Perpetrators of Intimate Partner Violence over 55 Years of Age in the UK



Qualitative research on the perspectives of 14 perpetrators convicted of (IPV) and their probation officers in the UK (J. Hawksworth, 2023, PhD thesis U. of Bristol):

- **Centrality of Gender:** Rigid gender (masculinity) norms play a central role in shaping their life course, inhibiting help-seeking behaviours and limiting adaptation to life changes and transitions in later life, such as starting a second family, retirement, or relocating.
- **Other Limiting Continuities:** other limiting factors at an individual level, such as mental health issues, autism, and childhood experiences.
- **Lack of Gender Awareness:** The perpetrators' personal accounts do not show an awareness of the role of gender, nor is it reflected in their experiences with interventions before.
- **IPV Risk and Aging:** IPV-related risk in later life is not inherently linked to the embodied experience and effects of aging itself. Instead, the analysis suggests an interplay between situations of change in later life, individual continuities, and the prevailing gender structure.
- **Invisibility of Victim-Survivors:** The voices and experiences of victim-survivors are largely absent from the perpetrator narratives, except when consequences were minimized and blame attributed.

Agenda

5th session

Tailoring interventions
to older perpetrators

Additional risk assessment
(MARVOW2.0 risk factor checklist)

Individual / group work

Coordination / victim support /
multi-agency collaboration

Feedback and evaluation

Tailoring our interventions to older perpetrators



1. Overview on the (little) existing research
2. Practice examples from WWP EN membership
(based on surveys within the MARVOW and MARVOW2.0 projects)

Tailoring our interventions to older perpetrators



A meta-analysis (Jewell & Wormith, 2010) found that older perpetrators were

- 16% more likely to complete treatment than those who were younger
- significantly more likely than younger perpetrators to complete either CBT or unspecified programmes in comparison to Duluth programmes
- more likely to complete short programs (i.e., 16 or fewer weeks) than longer programmes

Jewell, L.M. & Wormith, J.S. (2010). Variables associated with attrition from domestic violence treatment programs targeting male batterers: A meta-analysis. *Criminal Justice and Behavior*, 37, 1086-1113.

A Study of Male Perpetrators of Intimate Partner Violence over 55 Years of Age in the UK



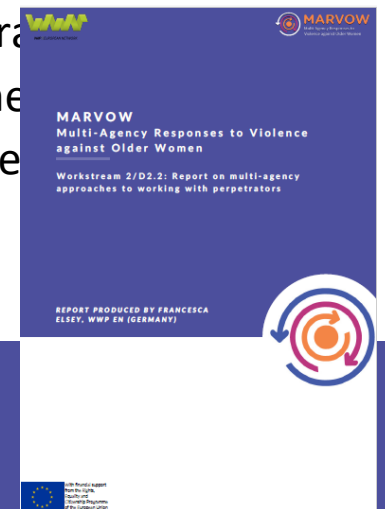
Theory of Adaptation to Change (J. Hawksworth, 2023) to identify areas for intervention:

- **Challenge and alter “invisible” gender-related beliefs**, expectations, and attitudes (e.g. sense of entitlement, misogynistic attitudes) as the main contributor to IPV-related risk in later life. Perpetrators often lack awareness and this is typically not addressed in prior interventions.
- **Increasing Help-Seeking and Engagement**: This often involves addressing concrete, tangible needs during crises such as areas like accommodation, mental health, alcohol use, and financial problems.
- Interventions **Responsive to Anticipated Circumstances**: Responding to evolving needs and anticipated areas of change (e.g., retirement, health decline, changes in family structure) across different life stages helps to enhance adaptation and reduce IPV risk.
- **Interrupting Limiting Continuities**: Interventions should "interrupt continuities" that limit adaptation to later-life changes, including gender beliefs, past experiences, and individual-level factors (like mental health or childhood experiences).
- **Validation of Perpetrator Accounts (within limits)**: non-judgmental approach during interviews, recognizing that perpetrators may have insights into how their individual-level issues impact their behavior, even if they lack "gender awareness".

WWP EN's survey among members I (2021)



- **Albania (Woman to Woman/Counselling Centre for Men and Boys):** specialized group programme for older perpetrators in cooperation with a senior care home, which provides cognitive-behavioral and educational sessions tailored to older men, and coordinates closely with elder-care institutions.
- **Ireland (Men's Development Network – MEND):** case-by-case adaptations including offering mediation or couple-focused dialogue acknowledging that older couples often “decide to spend the rest of your years together,” rather than assuming separation
- **United Kingdom (MEND / MyCWA):** Muslim Women's Centre (MyCWA) reports that longer-term engagement is needed for older couples, recommending no fixed time-limit (sometimes 5–10 years) to achieve change, “level of change required by both the victim and the perpetrator is overwhelming... most services aren't set up for it”
- **Slovenia (Society for Nonviolent Communication – DNK):** emphasize leveraging local networks by training community elders and healthcare providers to recognize and refer older abusers and highlight the need for informed referrals and for collaboration with addiction services given many older abusers' substance



WWP EN's survey among members I (2021)



- **Croatia (UZOR Family Assistance):** Staff note high rates of alcohol-related cognitive impairment and dementia among older offenders and recommend involving psychiatric services, as well as **enlisting the perpetrator's adult children** (often caregivers) in intervention planning, since family members can strongly influence older abusers' behavior.
- **Sweden (MVU Reception Against Domestic Violence):** observe many referrals from elder-care facilities and that most older couples cohabit and want to stay together, complicating separation-based interventions. In practice MVU relies on adjusting standard content (for example, offering housing assistance when needed)

WWP EN's survey among members II (2023)



Part of the MARVOW2.0 project, online survey Oct/Nov 2023

- **20 member organizations answered, from 18 different countries**
- **Only one organization** indicated they had “any **specific procedures** for perpetrators whose victims are older women (60+)”, referring to a programme for children to parent violence (no further detail was provided), and the University of Bristol mentioned a **PhD research** on the issue
- **None used a specific risk assessment tool**

Situation re older perpetrators in BIPs in the US



- **No distinct programs for seniors**; the lack of age-specific curricula means adjustments are informal (e.g. speeding through irrelevant content for men past child-rearing age). A review emphasizes that courts and law enforcement lack specific mechanisms for older abusers, especially in assessing dangerousness
- Because older perpetrators often have different risk profiles (e.g. higher suicide risk), experts recommend **age-adjusted risk screening and supervision**. For example, elder-abuse advocates note that older intimate-homicide offenders are “more likely to express suicidality, less likely to be estranged, and less likely to have known histories of partner violence” so standard lethality questionnaires should be modified by age
- Some jurisdictions **incorporate geriatric assessments** (e.g., dementia screening) into offender intake to adapt treatment plans.
- Justice guidelines suggest **longer supervision and cooperation with healthcare providers** for older offenders, reflecting that change may take more time.

Tailoring interventions: Intake and assessment



- **Engage community resources.** Partner with local clinics, faith leaders, and family networks to reinforce messages, and encourage help-seeking and referrals.
- **Screening for cognitive decline / dementia and mental health:** involving specialists as needed.
- **Risk Assessment:** Risk Assessment should be adapted / complemented with specific risk factors, including higher murder-suicide risk – see MARVOW2.0 checklist.
- **Substance abuse support:** Long-term alcohol/drug problems are common in older offenders and combining perpetrator interventions with addiction treatment or referrals is often essential.
- **Increase Help-Seeking and Engagement:** by addressing concrete, tangible needs during crises such as accommodation, mental health, alcohol use, and financial problems.
- **Intersection of age, power, gender and violence:** explore the adaptation to changes in later life and their impact on the sense of power (loss), male identity and use of violence
- **Sense of integrity (vs. despair):** Explore sense of purpose in life and its sources and motivations

Risk assessment exercise, part 1



1. Individually, please, apply your usual risk assessment tool to the case of Andrew and Maria. If you don't have a RA tool you use regularly, you can use the DASH risk checklist (Safe Lives, on your padlet).
2. Share your assessment of the risk for Andrew and Maria (low, medium, high, imminent danger; referral to multi-agency risk management?)
3. Are there any possible risk indicators in the case study that have not been reflected in the assessment through your tool?

The MARVOW2.0 Risk Factor Checklist



Development

- Based on risk factors from previous EU projects TISOVA and WHOSEFVA, and on a systematization of existing risk assessment tools for violence against women and older people (including the Elder Abuse Suspicion Index, EASI, and the Risk on Elder Abuse and Mistreatment Instrument, REAMI).
- Also based on 21 needs assessment roundtables with 309 professionals across partner countries, gathering input on existing practices and tools. Most participants noted a lack of specific tools for older women victims of violence.
- An external expert reviewed the checklist favorably.
- The checklist underwent testing with 415 frontline professionals during the MARVOW 2.0 Training for Professionals. Feedback from this testing led to improvements.

The MARVOW2.0 Risk Factor Checklist



Use

- Its main objective is to provide guidance to frontline professionals who already use a risk assessment tool, serving as a **complementary checklist** rather than a standalone tool.
- It is intended for professionals in various sectors, including healthcare, social services, police, judiciary, helplines, victim support, and perpetrator programs.
- The target group for this checklist is women aged 60 years or older who are victims of violence from perpetrators with whom they are familiar, such as intimate partners or family members.
- It should not be used with older women victims with neurological deficits, such as those diagnosed with dementia, due to the need for specialized expertise in such cases.

The MARVOW2.0 Risk Factor Checklist



| Risk factor | Areas to explore (victim / survivor) |
|--|---|
| Psychological or mental health issues (age-related) | <ul style="list-style-type: none">✓ Psychiatric treatment, medications✓ Changes in sleep, appetite, concentration, memory, problems or difficulty communicating |
| Functional dependency / disability | <ul style="list-style-type: none">✓ Poor mobility✓ Physical impairment, needs for special medical equipment (wheelchair, walker, etc.) or medical products✓ Changes in vision or hearing |
| Medical issues | <ul style="list-style-type: none">✓ Illness✓ Lack of medical treatment / limited access to medical examination or treatment✓ Carer (perpetrator) not reporting serious symptoms or changes in condition |
| Environment | <ul style="list-style-type: none">✓ Tensed atmosphere in the home✓ Damaged objects in the victim's home / room |

The MARVOW2.0 Risk Factor Checklist



| Risk factor | Areas to explore (victim / survivor) |
|---|---|
| Financial dependency | ✓ Lack of adequate income or finances |
| Financial Abuse | ✓ Victim does not have access or not able to manage her finances, e.g. pension, other source of income, property rights ✓ Disappearance of valuable items from the home (jewellery, objects...) ✓ Unpaid bills |
| Lack of social / formal support for the victim | ✓ None or low involvement in social or other services ✓ No or controlled access to phone and electronic devices ✓ Erosion of bonds between generations in the family (not close to her children or siblings) ✓ Family (especially children) does not identify, minimises or justifies the abuse, does not support the older woman in related needs and / or is allied with the perpetrator |

The MARVOW2.0 Risk Factor Checklist



| Risk factor | Areas to explore (victim / survivor) |
|---|---|
| Changes in relationships | <ul style="list-style-type: none">✓ Sudden appearance of a distant relative (she vaguely knows) who wants to take care of her, live in her home✓ Sudden appearance of a new friend or romantic interest - this usually happens with the recent death of a spouse / partner |
| Inappropriate / inconvenient household living arrangements | <ul style="list-style-type: none">✓ Shared housing with perpetrator, other family members (no privacy, safety)✓ Inappropriate conditions (accessibility, special needs) |
| Adherence to traditional social gender norms | <ul style="list-style-type: none">✓ Victim does not recognise / identify the violent behaviour✓ Victim minimises violence or justifies it as normal✓ Victim unaware of the situation because it's been going on for a long time✓ Victim unwilling or feeling unable to change anything |

The MARVOW2.0 Risk Factor Checklist



| Risk factor | Areas to explore (perpetrator) |
|--|---|
| Difficulties / stress adjusting to age related changes in the perpetrator | <ul style="list-style-type: none"> ✓ Stress and/or frustration related to (new) role as caregiver (inadequate caring and/or coping skills, etc.) ✓ Distress related with dependence, illness, cognitive impairment, etc. ✓ Distress and or frustration related to retirement (loss of social role, prestige, occupation, income, etc.) ✓ Being at home full time ✓ Loss of driving licence |
| Ongoing history of perpetrating domestic violence | <ul style="list-style-type: none"> ✓ Previous criminal charges / convictions ✓ Chronification of the abuse |
| Lack of social / formal support for the perpetrator | <ul style="list-style-type: none"> ✓ No social network (family, friends) ✓ None or low involvement in social services (home visits by social workers, regular check-ups, senior care) |

The MARVOW2.0 Risk Factor Checklist



| Risk factor | Areas to explore | YES / NO / N/A (no information available / not assessed) | Comment on what has been observed by you as a frontline professional | Comment on what has been reported by the older woman | Comment on what has been reported by another person and whom | Comment on whether there is an increase in frequency and/or severity |
|---|--|--|--|--|--|--|
| Psychological or mental health issues (age-related) | <ul style="list-style-type: none"> • Psychiatric treatment, medications • Changes in sleep, appetite, concentration, memory problems or difficulty communicating | | | | | |



The MARVOW2.0 Risk Factor Checklist

Application

- Through professional judgement and ideally in the team, the assessment with the usual RA tool and the additional risk factors identified in the Risk Factor Checklist should be integrated
- According to the level of risk assessed, risk management should be planned and delivered, including:
 - Referrals to multiagency risk management and monitoring systems (e.g., MARAC, MARVOW2.0 case management tool)
 - Protection measures and / or safety planning for the victim / survivor
 - Treatment planning for the perpetrator

Risk assessment exercise, part 2

1. In pairs (breakout rooms, please, apply the MARVOW 2.0 risk identification checklist to the case of Andrew and Maria.
2. Do the additional risk factors change your assessment of the risk?
Which ones and in what way?
3. Does the MARVOW2.0 risk identification checklist seem helpful as a complementary tool?

Tailoring interventions: group / individual work



- **Flexible programme length and intensity:** On the one hand, practitioners advise **no strict time limit** on achieving progress (which might take years), on the other, older men may fare better in **shorter, intensive programs** (≤ 16 weeks) that focus on concrete skill-building.
- **Individual vs. group:** individual work might allow better adaptation to possible cognitive decline, the group can function as social support (be aware of and address a possible “minority status” of older men) and a source of purpose / usefulness
- **Materials and activities:** may need simplification, slower pacing, and accommodations (e.g. written / specific materials for hearing- or vision-impaired participants).
- **Focus on practical skills:** Emphasize communication and empathy training tailored to older life-stages. Cognitive–behavioral techniques may be particularly effective.

Tailoring interventions: group / individual work



- **Address gender-related beliefs / masculinity:** challenge expectations and attitudes both towards women (e.g. sense of entitlement, misogynistic attitudes) and towards themselves (limiting help-seeking and adaptation to changes in later life) as a main contributor to IPV-related risk in later life.
- **Address life transitions:** Interventions should address (and anticipate) changes in later life (e.g., retirement, health decline, changes in family structure, caregiver roles) and how they are experienced (gender perspective, power) to enhance adaptation and reduce IPV risk. Support the generation of **purpose** in later life (vs. despair).
- **Address cohabitation.** Plan for cases where the couple stays together: safety measures with the perpetrator.
- **Social isolation and support network:** Programmes can leverage community bonds involving local figures (mayors, pastors, doctors) whom seniors trust and / or engage the abuser's adult children or other relatives as support.

Tailoring interventions: group / individual work



- **Coordinate multiservice support.** Link offenders to geriatric mental-health and substance-abuse services if needed.
- **Victim safety:** safety protocols should consider older couples' context: because older victims are often physically frailer, safety planning must be more proactive. Older victims' autonomy should be valued while protecting them, including whether the perpetrator should have separate accommodations during the intervention.
- **Victim support:** Older abusers and victims often *remain together*. Safety planning must account for the victim's possible dependence on the perpetrator (for daily care or finances). Programmes should liaise with elder services (e.g. adult protective services, caregiver support) and ensure victims (often spouses) get elder-specific supports (e.g. advocacy, sheltered housing) simultaneously with the perpetrator's treatment.
- **Train staff on aging.** Facilitators need training in aging-related issues (sensory and cognitive decline, ageism, etc.).

Thank you!



Tailoring our interventions to older perpetrators

In break-out rooms (of 3 or 4), please develop ideas, strategies and concrete proposal on how to tailor your interventions to older perpetrators regarding

1. Intake and assessment (especially risk assessment)
 - groups 1, 4, 7, ...
2. Individual and/or group work (contents, methods, etc.)
 - groups 2, 5, 8, ...
3. Coordination / victim support / multi-agency collaboration
 - groups 3, 6, 9, ...