Violence and Abuse against Elderly People in Norway

A national prevalence study

Astrid Sandmoe
Tore Wentzel-Larsen
Ole Kristian Hjemdal

NASJONALT KUNNSKAPSSENTER
OM VOLD OG TRAUMATISK STRESS

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Norwegian Centre for Violence and Traumatic Stress Studies A/S
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The Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS) was established on 17 November 2003. The company is a subsidiary of UNIRAND AS, which is wholly owned by the University of Oslo.

The tasks of the centre include research, development work, education, information and guidance on the following topics:

- Violence and abuse in close relationships
- Forced migration and health of refugees
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Our vision: A better life for those affected by violence and trauma.

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The report is translated in its entirety. In addition, Appendix 1 and 2 are included to provide in-depth explanations about the statistical analyses. The information letter to the participants and the questionnaire have not been translated. The content of the questionnaire is explained in chapter 2.3.

Most of the questions in our survey are taken from two completed national prevalence studies, respectively in Norway and Ireland. The Norwegian report on violence and rape in Norway in a life course perspective (NKVTS report no 1, 2014, Thoresen and Hjemdal (Eds.)) is not translated but has an English summary. This report is available via www.nkvts.no.The Irish study, *Abuse and Neglect of Older People in Ireland: Report on the National Study of Elder Abuse and Neglect* (Naughton et al. 2010) was published by the National Centre for the Protection of Older People at University College Dublin. The report is available via www.ncpop.ie.

NKVTS, 29 March 2019

Astrid Sandmoe
Project Manager

Preface

This report deals with a national survey on the personal safety and quality of life of women and men aged 65 or more in Norway. The project is part of the Norwegian Centre for Violence and Traumatic Stress Studies' (NKVTS) research programme on violence in close relationships for the period 2014 to 2019. The research programme was initiated on behalf of the Ministry of Justice and Public Security.

First and foremost, we would like to thank those who took part in the survey, and took the time to answer the questionnaire and share their experiences with us. Ipsos was responsible for administrating the survey and Kristin Rogge Pran was the project manager. She executed the project and communicated with us in an exemplary manner.

The members of the Network Group for Elder Abuse [Nettverksgruppen for eldrevold] gave useful feedback during the project. The questionnaire also benefitted from the constructive input of many people, including the Regional Centre for Violence, Trauma and Suicide Prevention [RVTS]: Grete Ystgård (RVTS-Central Norway), Geir J. Olsen (RVTS- Western Norway), Marie Haavik (RVTS-Eastern Norway), Aud Mari S. Fjelltun and Dagfinn Sørensen (RVTS-Northern Norway), Kristin B. Adeler and Gyri Scheie (Protective Services for the Elderly - helpline), Janne Røsvik and Knut Engedal (Norwegian National Advisory Unit on Ageing and Health), Wenche Malmedal (Norwegian University of Science and Technology, Geir Aas (Norwegian Police University College) and Yngvil Grøvdal here at NKVTS.

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Astrid Sandmoe
Project Manager

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Summary

The report deals with the first national survey of personal safety and quality of life among older men and women living at home in Norway. The purpose of the survey has been to gain knowledge on the prevalence of violence and abuse in the population aged 65 and older and of the relationships they have with the perpetrators. The report also points to some possible associations between exposure to violence and socio-demographic conditions, perceived health and quality of life, and whether exposure to violence earlier in life has an impact on such exposure in later years.

The basis of this survey is a study on violence and rape in Norway published by the Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS) in 2014, which looks at the population aged 18 to 75. The findings in the study are also compared with similar prevalence studies among older people in other European countries. The project is part of NKVTS's research programme on violence in close relationships for the period 2014 to 2019. The research programme has been initiated on behalf of the Norwegian Ministry of Justice and Public Security.

Methodology

The survey is a national cross-sectional study in which 2,463 people aged 66 to 90 (1,232 men and 1,231 women) responded to a postal questionnaire. The total response rate was 45.9%. Ipsos managed the collection of data, which took place in the first half of 2016. The questionnaire asked specific questions about severe physical violence and severe sexual assault at any time before the age of 65, about both severe and less severe physical violence, and about sexual, psychological, and economic abuse after the age of 65 years and within the past year. Questions regarding neglect relate only to the past year. In addition, there were questions about socio-demographic conditions, health, lifestyle and support needs, contact with support services, and police reporting.

Comprehensive questionnaires about complex topics can be difficult to answer for some respondents, and not all of the forms were completed in full. Some of the questions only had to be ticked if the respondent had experienced what was being asked about, and these questions did not have a “no” option. Because we do not know for certain whether the lack of a tick means that the person had answered “no” or chosen not to answer, we have decided to grade the results based on the number of respondents that answered one or more of the questions within the same group of questions (e.g. severe sexual abuse) and where these answers refer to actual occurrences. In addition, we have analysed the results using the total number of respondents (2,463) as the basis – i.e. as if anyone who did not tick the question answered “no”. These occurrences are presented under the term “low” in the tables. This means that we cannot provide “exact” estimates, but for some of the occurrences we provide the actual and the low estimates. The prevalence is most likely to be between these two estimates.

Results

Overall prevalence of violence and abuse

The overall prevalence of violence and abuse against elderly people living at home aged 65 and over was between 6.8% and 9.2%. There were no significant differences between the men and women. Of the 168 people who reported that they had been a victim of violence or abuse, the majority had experienced psychological abuse (98 people), followed by physical violence (58 people), sexual abuse (26 people), and economic assault (21 people). There were no significant differences in the prevalence of violence and abuse between the younger group of elderly people (aged 66 to 75) and the older group (aged 75 to 90).

The overall prevalence of violence, abuse, and neglect during the past year was between 5.2% and 7.2%. These gender differences were also small.

Violence in close relationships

For those who had been a victim of violence aged 65 and above, the perpetrator was a close relationship in about eight out of ten cases. For exposed during the past year, the perpetrator was a close relation in about nine out of ten cases.

Conditions associated with exposure to violence among the elderly

Exposure earlier in life

The risk of being exposed to violence and abuse in older years was substantially greater if the victim had been exposed to violence earlier in their life. 12.7% (312 out of 2,451 respondents) reported that they had experienced severe physical violence and 5.6% (123 out of 2,203 respondents) reported that they had experienced severe sexual assault before the age of 65 years. Here there were clear gender differences; more men had experienced physical violence while more women had experienced sexual assault.

Respondents who had experienced both severe physical violence and severe sexual assault before the age of 65 were eight times more likely to be subjected to one or more types of violence or abuse after the age of 65 years compared with the group which did not report such experiences earlier in their lives.

Socio-demographic conditions

There were significantly more victims among women, but not among men, who were separated or divorced compared with those who had not been a victim of violence.

Exposure, lifestyle, and health

Both men and women who had been victims after the age of 65 years were less satisfied with their lives and considered their health to be far worse than those who did not report any experience of violence. Several victims also reported that their physical health and emotional problems restricted their usual activities and day-to-day lives within and outside of their home, as well as their social interaction with others. The group of respondents who particularly

stood out were those who had been victims of violence or abuse both before and after the age of 65. This group of respondents also had the greatest number of chronic illnesses.

In contrast to men, significantly more women who were victims of violence reported cardiovascular diseases, stroke, and injuries following falls than was the case for unexposed women. More male than female victims had respiratory diseases, while there were substantially more victims than non-victims among those with a mental illness – men and women alike.

Contact with others, support services, and the judiciary
Fewer victims than non-victims had anyone they could trust to talk to. If the victim did tell others about their situation, this was primarily their family. Only 11 victims reported that they had been in contact with support services. Of the nine people who said that they had reported an incident to the police, only two were investigated.

Conclusions

- The results of this study indicate that between 56,500 and 76,000 people living at home have been victims of violence or abuse after the age of 65 years.
- Violence and abuse towards elderly people in Norway is a serious social and public health problem.
- The study has revealed clear relationships between violence, ill health, and physical and social functioning.
- The study shows that older people who have been victims of severe physical violence or severe sexual abuse earlier in their lives are more likely to be victims of violence in their older years.
- Elderly victims of violence rarely contact support services for help.
- Violence and abuse in the elderly population is still an invisible social problem.

1 Introduction

1.1 Background to the project

This report presents the results of the first national cross-sectional study on violence and abuse against the elderly aged 65 or older living in their own home.

Through international prevalence studies, overviews of research and interview studies of victims, as well as perpetrators of the violence, we have acquired more knowledge in recent years about violence in close relationships. The World Health Organisation's status report highlights Norway's efforts within many areas of this social problem (WHO, 2014). At the same time, it states that Norway has not carried out national prevalence studies on violence against the elderly, does not have any policies, plans of action and support systems in place, nor prevention programmes specially aimed at the violence to which the elderly are exposed (WHO, 2014). This project will contribute towards filling the knowledge gaps the World Health Organisation has identified.

The project is included in NKVTS' research programme on violence in close relationships for the period 2014 to 2019.
The research programme was initiated on behalf of the Ministry of Justice and Public Security. The frame of reference for the programme is given through the Norwegian Storting's White Paper "Forebyggelse og bekjempelse av vold i nære relasjoner" (Preventing and Combating Violence in Close Relationships. It's about Surviving), in addition to the plan of action, "Et liv uten vold" (Life Without Violence) (Ministry of Justice and Public Security, 2013a, 2013b. Both these documents highlight the need for additional knowledge on the scope and consequences of violence in close relationships across all age groups from a generation and lifetime perspective.

The project's reference point is a national prevalence survey on violence and rape from a lifetime perspective, published by Thoresen

and Hjemdal at NKVTS in 2014. The study revealed that victims of physical violence and sexual abuse early in life were at greater risk of becoming victims of violence in adulthood. It also revealed that violence impacted the health of the victims. This was especially true of the exposed women.

1.2 Purpose of the study

Knowledge about the prevalence of violence and abuse against the population's older cohorts is limited. We need to acquire more knowledge on exposure to violence within a greater range of elderly cohorts. This applies to residents of institutions and those in private residences. This study concerns elderly people living in their own homes. We also have limited knowledge about the potential association between exposure to violence and health.

Purpose of the study is to:

- map the prevalence of violence and abuse against individuals above of 65 years;
- map how much of the violence is committed by a close relative of the victim;
- map whether exposure to violence in childhood impacts exposure to violence in old age;
- map the potential association between exposure to violence and socioeconomic circumstances;
- map the potential association between exposure to violence, self-perceived health and quality of life,
- map the contact with the support services and legal system.

The last section of the report summarises the findings of the study and presents several recommendations for the prevention of violence against elderly cohorts in Norway.

1.3 Definitions and clarification of concepts

Two definitions of violence and abuse are used in this study, both of which are discussed in more detail in this and the following chapter. The World Health Organisation provides the professional frameworks for actions that

should be characterised as violence and abuse against the elderly (WHO, 2014). In addition, it is necessary to adhere to the provisions of the Norwegian Criminal Code relating to violence in close relationships. This study not only investigates violence in close relationships, but also all violence against the elderly, including from non-family members.

The World Health Organisation defines violence as follows:

> Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002).

Krug et al. (2002) emphasises that the concept of “the use of physical force or power” includes neglect and all types of physical violence, sexual and psychological abuse, and suicide and self-harm. The World Health Organisation defines and explains elder abuse in the following way:

> Elder abuse is any act of commission or omission (in which case it is usually described as “neglect”), that may be either intentional or unintentional and involves persons aged 60–65 years or more (the age bracket for “old age” varies by country but often coincides with the official age of retirement). The abuse may be physical, sexual, psychological (involving emotional or verbal aggression), or financial, or involve other material maltreatment and result in unnecessary suffering, injury or pain, the loss or violation of human rights, and a decreased quality of life for the older person (WHO, 2014, p. 32).

This definition has been further developed from the so-called Toronto Declaration (WHO, 2002) with the addition of an explicit reference to human rights as well. As the definition states, financial abuse is included, but suicide and self-harm are not. The last-mentioned definition of the World Health Organisation (WHO, 2014) forms the basis for our study.

We use the concepts of violence and abuse to describe a variety of actions. The term ‘elderly’ is a relative concept that assumes different meanings depending on social and cultural factors in a society. In our society it is often used as a subjective concept to describe the person’s perception of feeling old or the opposite, i.e. when a person does not identify him/herself as old despite reaching retirement age. This study uses the term ‘elderly’ as an objective concept in that it only describes age and not the characteristics of the person. A person is considered elderly upon turning the age of 65, which is the age limit used in most European and North American studies on elder abuse (Perel-Levin, 2008).

1.3.1 The Norwegian Criminal Code relating to violence in close relationships

The World Health Organisation’s general definition of violence and abuse indicates that the impact of the acts determine whether it is abuse - not the actual acts themselves (WHO, 2014). This implies that the victim’s experiences are largely taken into consideration. The Norwegian Criminal Code has a different perspective in that different types of acts are categorised with different levels of criminal liability.

The Norwegian Criminal Code (2005), Section 282, with additions through the Act of 2009, states that abuse in close relationships is punishable with up to six years of imprisonment if a person:

> **“by threats, force, deprivation of liberty, violence or other degrading treatment seriously or repeatedly abuses**
> a. a present or former spouse or cohabitant,
> b. a present or former spouse or cohabitant’s relatives in direct line of descent,
> c. a relative in direct line of ascent,
> d. a member of the person’s household, or anyone in the person’s care».

This means that this section of the Norwegian Criminal Code does not explicitly mention financial abuse. Nonetheless, if the elderly is

exposed to financially motivated threats and force, such acts will fall under the provisions of the Criminal Code.

Sexual abuse

Pursuant to Section 291, any person who commits the following sex crimes could be sentenced to up to ten years of imprisonment:

a. Engages in sexual activity by means of violence or threats.
b. Engages in sexual activity with any person who is unconscious or for any other reason incapable of resisting the act.
c. By means of violence or threats compels any person to engage in sexual activity with another person or to carry out similar acts with himself or herself.

A sentence of three to fifteen years of imprisonment is given for acts of rape set out in Section 291 in the following cases:

a. insertion of the penis into the vagina or anus,
b. insertion of the penis into the aggrieved person's mouth,
c. insertion of an object into the vagina or anus, or
d. if the offender brought about a state as specified in section 291 b) in order to obtain sexual activity

If the acts do not constitute rape, there could be other non-consensual sexual acts or sexually abusive behaviour in the presence of or towards someone who has not given their consent. (Norwegian Penal Code, 2005; Section 297; Section 298).

1.3.2 Operationalisation of the definition

In prevalence studies, it is necessary to define the criteria that will be used as a basis to determine what physical violence, neglect, and psychological, sexual and financial abuse is. Table 1.1 specifies the criteria used as a basis in this study. The table is a modified version of the criteria used as a basis in prevalence studies in Ireland (Naughton et al., 2010), the United Kingdom (O'Keeffe et al., 2007) and in New York (Burnes et al., 2015; Lachs, Psaty & Berman, 2011).

Table 1.1 Operationalisation of different types of violence, abuse and neglect

Type of violence and abuse	The elderly person has been exposed to some of the following acts at least once:
Physical violence	Slapped, punched or hit with another type of hard object. Scratched, pinched, subject to hair pulling, pushed, kicked, choked, burned or scolded, threatened/attacked with a knife/other weapon, physically assaulted in any other way.
Psychological abuse	Exposed to undue pressure, threats or harassment by keeping track of time spent or where the victim has been. Prevented from meeting others or limited deprivation of liberty. Been systematically overseen/ignored or made to feel inferior. Verbal threats.
Sexual abuse	Forced to perform some of the following sexual acts by means of physical power or threats to harm someone close to the elderly person. To watch pornography, be touched in a way the elderly person disliked or forced to show his/herself naked or exposure to flashing or otherwise sexual violations. Exposure to performed or attempted vaginal, anal or oral intercourse, the touching of genitalia or other severe sexual acts.
Financial/ material abuse	Persuaded or coerced into transferring money, assets or property to others. Spending of the victim's money without it being agreed or preventing the victim from disposing of their own money, assets or property in the way desired.
Neglect	The victim depends on help and has not received enough to maintain personal hygiene, has been left alone without essential help, enough food and drink or medication has not been given in the way prescribed.

1.4 Why did violence against the elderly become a separate concept?

Violence against the elderly has been present at all times and in all cultures, as it has been for other groups in the population. In the 1970s violence against the elderly was put on the agenda in an innovative way when Baker (1975) wrote about "granny battering" in a medical journal. This resulted in violence against the elderly largely becoming a 'medicalised' problem where frailty and age were the defining aspects. Prior to this, violence against the elderly was considered more of a social and interpersonal problem (Phelan, 2013).

The term elder abuse has continuously been under debate and many have been critical towards the term. Phelan (2013) refers to

Macdonald (1997), who described elder abuse as a horrific phrase. Macdonald was one of many who believed that the term should preferably highlight violent acts towards the victim, regardless of the person's age.

No established overarching theoretical framework with an accepted joint definition of the phenomenon 'elder abuse' has been established, which causes problems for the development of the research field (UN, 2013). The framework includes theoretical perspectives where social exchange, environmental pressure, caregiver stress and the cycle of violence are the most common (UN, 2013).

There are three main interpretive frameworks and definitions that use the same terms, but within different frameworks with varying emphasis on gerontological (the aging person) and geriatric (the elderly sick) perspectives. One interpretive framework, "older adult mistreatment", which has its origins in socio-gerontology and sociology, is defined through the Toronto Declaration (WHO, 2002) mentioned in Chapter 1.3. Our study is based on this framework for understanding.

Another interpretive framework stems from geriatrics and is referred to as "abuse of vulnerable adults". The definition used here is from the National Research Council (NCR) in the USA:

> Abuse of vulnerable older adult refers to intentional actions that cause harm or create a serious risk of harm (whether or not intended) to a vulnerable elder by a caregiver or person who stands in a trust relationship to the elder, or failure by a caregiver to satisfy the elder's basic needs or protect the elder from harm (Bonnie & Wallace, 2003, p.40).

Here a trusted person is putting the frail, dependant elder in harm's way or personally harming the elder or harming the elder by not taking the correct action. The framework focuses on the theory of risk and vulnerability. It was originally taken from the medical disciplines to understand child abuse (Anthony, 1987; here at UN, 2013).

The third interpretive framework is intimate partner violence, which is related to women of all ages and reflects a gender-based understanding of male power in terms of violence against women in couple relationships. Nonetheless, the definition also includes physical violence and sexual abuse of women in public spheres by strangers. As a result, the definition is ambiguous and relatively unsuitable both for research and in practice. The definition was developed in 1996 by an expert panel connected to a state-owned public health institute in Alabama in the USA:

> Intimate partner abuse is defined as violence against women that incorporates intimate partner violence (IPV), sexual violence by any perpetrator, and other forms of violence against women, such as physical violence committed by acquaintances or strangers (Saltzman, Fanslow, McMahon, & Shelley, 2002; here at UN, 2013, p.4).

During operationalisation of the definition, psychological abuse is included; however, neglect and financial abuse are excluded when not part of psychological abuse. As mentioned, the underlying theoretical framework falls within the power and control perspective. The purpose of the definition, was to obtain a common theoretical viewpoint on gathering data, especially regarding male violence against women. This definition has not been accepted to the same extent as the other two definitions. Much of the reason for this may be down to the fact that it tries to embrace different concepts and thus becomes more confusing that clarifying. Another reason could be that the definition is limited to women, yet research shows that elderly men are also exposed to intimate partner violence and sexual abuse (Reeves, Desmarais, Nicholls & Douglas, 2007)

It is important to be aware of these three main perspectives for understanding elder abuse. The definitions adopted by the World Health Organisation were initially developed in the United Kingdom (Action on Elder Abuse, 1995), whilst the other two definitions stem from American research and practice, where most of the research has been initiated by the medical professions. Regarding operationalisation of the definitions, the gerontological and geriatric

research environments disagree. Several major studies in the USA have included self-neglect in the definition of violence against the elderly (Dong, 2015; Dong et al., 2009). Self-neglect is omitted from all three of the definitions explained here. Most European researchers and professional environments share the view that self-neglect should not be included in the definition, as this type of self-harm is often seen in connection with types of dementia or psychiatric disorders (Saldarriaga-Cantillo & Rivas Nieto, 2015). Another reason is that self-harm does not involve a trusted person, only the person concerned. This makes it difficult to compare international studies on violence against the elderly when the operationalisation of the definitions includes dissimilar phenomena.

In Scandinavia, attention paid to violence in close relationships during the first few decades was especially aimed at vulnerable women and children. Skjørten (2009) has looked at the gender and age dimension with regard to violence in close relationships, and demonstrates that the maltreatment of women was historically highlighted by the feminist movement. It had a clear gender perspective with less focus on an age perspective. The opposite occurred within the discipline of elder abuse where age not gender was essential. As presented in this chapter, the discipline of elder abuse is largely rooted in elderly care where neglect of the frail elderly was and is an important element. Violence in elderly couple relationships has, however, been under-communicated in our society. Intimate partner violence that continues into retirement has much of the same dynamics as intimate partner violence among younger people even though the age dimension may be important for preventing and remedying the problem (Skjørten, 2009).

1.5 Research on elder abuse

This chapter focuses on prevalence studies on violence against the elderly living in their own homes, in addition to studies on violence and health. The referenced studies were conducted in a western context since this is most relevant to our study.

1.5.1 Prevalence studies

This is the first time a major prevalence study has been conducted on violence against the elderly in Norway. The first small study, conducted approx. 30 years ago, estimated a prevalence rate of one to three per cent (Hydle & Johns, 1992; Stang & Evensen, 1985). The results from the Norwegian prevalence study (aged 18-75 years) on violence and rape from a life course perspective indicated that men and women in the 65-75-year-old age cohort were less at risk of physical and sexual violence than younger age cohorts (Thoresen & Hjemdal, 2014). In a similar Swedish study (aged 18-75 years), the prevalence of physical violence and sexual abuse was lowest among the oldest. For sexual abuse, the prevalence during the last year was 10.3% for the youngest women and 0.7% for the oldest (3.4% in total). For the youngest men, the prevalence rate was 2.9%, but zero among the oldest (Heimer, Andersson & Lucas, 2014).

The World Health Organisation estimates an annual prevalence rate of approximately three to four per cent for violence against the elderly in European countries (Sethi et al. 2011). In 2017, a systematic review and meta-analysis of 52 prevalence studies with a varying number of subjects (from 135 to 6,748 people) were published (Yon, Mikton, Gassoumis & Wilber, 2017). Twenty-five of the studies were from 14 European countries.

The prevalence figures showed large differences with a combined annual global prevalence of 15.4%, the same as the countries in the European region (Yon et al., 2017). The researchers did not find any significant gender differences globally or in the European countries. Yon et al. (2017), found that prevalence studies with a small sample had significantly higher prevalence rates compared to studies with a large number of subjects.

Yon et al. (2017) considered that the research quality of the ABUEL study (Abuse and Health among the Elderly in Europe) was good. This study consisted of sub-studies from Greece, Italy, Lithuania, Portugal, Spain, Sweden and Germany (Fraga et al., 2014; Soares et al, 2010). In addition, Yon et al., considered that the national study

from the United Kingdom (O'Keeffe et al., 2007) and Ireland (Naughton et al., 2010) were methodologically sound. These three studies are found in table 1.2. Most of our information comes from the Irish study to which we primarily compare our findings in this study, as we have, for example, the survey's questionnaire.

Table 1.2 Three selected European prevalence studies on violence and abuse against the elderly

Study, author and year	Country	Sample and method	Prevalence of violence and abuse the past year
UK Study of Abuse and Neglect of Older People: Prevalence Survey Report (O'Keeffe et al., 2007)	England, Scotland, Wales and Northern Ireland	People aged 66+ living at home. Random sample (national representation) Face-to-face interviews.	For all types of violence and abuse combined, incl. neglect (N=2106): 2.6% (55 people)[a] 4% (84 people)[b]
Abuse and Neglect of Older People in Ireland: Report on the National Study of Elder Abuse and Neglect (Naughton et al., 2010)	Ireland	People living at home aged 66+ Random sample (national representation) Face-to-face interviews.	For all types of violence and abuse combined, incl. neglect (N=2021): 2.2% (44 people)[a] 2.9% (58 people)[b]
Abuse and Health among Elderly in Europe - ABUEL (Soares et al., 2010)	Germany, Greece, Italy, Lithuania, Portugal, Spain and Sweden	People aged 66+ living at home Random sample. (from a city in each country). Self-administered questionnaire in Germany and Sweden. Other countries: Face-to-face interviews.	The total prevalence of neglect was not specified. (N=4467). Physical: 2.7% (121 people)[b] Psychological: 19.4% (867 people)[b] Sexually: 0.7% (31 people)b Financially 3.8% (170 people)[b]

[a] The perpetrator was a family member, close friend or carer.

[b] The perpetrator had a close relationship with the victim or was another family member, a carer, friend, neighbour or acquaintance.

In the ABUEL study, the Swedish study consisted of a regional survey from Stockholm (N=626) with an annual prevalence totalling 30.8% (Fraga et al., 2014). Two other Swedish regional prevalence studies have been conducted on violence against elderly persons. In

Eriksson's study (2001) in Umeå, 16% of the women and 13% of the men aged 65-85 (N=1091) had been exposed to violence and abuse after turning the age of 65. In the Gotland study (N=3400), the total prevalence for both men and women was 15% after turning the age of 65 (Kristensen & Lindell, 3013). Neither of the last two-mentioned studies specify the annual prevalence.

1.5.2 Violence, abuse and health

In the prevalence study from the United Kingdom, 5% of the women and 2.6% of the men with self-reported poor or very poor health stated that they had been exposed to violence or abuse during the past year (O'Keeffe et al., 2007). Accordingly, 1.5% of the women and 0.1% of the men, who had been exposed to abuse, considered their health to be good or excellent. Those who considered their life as low-quality and had most symptoms of depression, had a higher abuse prevalence rate. Of those who did not have a chronic condition, 1.5% were exposed. Of those who had a chronic condition/health problem, 2.2% were exposed. When including those who were neglected, the prevalence rate increased to 4.5%. (O'Keeffe et al., 2007).

In the Irish study, the highest violence and abuse prevalence rate was among the respondents aged 70-79, who considered their health to be poor or very poor. To measure physical and mental health in this study, an American instrument (SF-8™ Health Survey) was used. The results showed that those with low scores for physical and mental health had an overall higher abuse prevalence rate (Naughton et al., 2010).

In the ABUEL study, those exposed to physical violence, and psychological, sexual and financial abuse, reported significantly more physical complaints than those who had not been exposed (Soares et al., 2010).

The Norwegian study on violence and rape in Norway from a life course perspective showed that those exposed to severe violence and sexual abuse had a higher prevalence of mental health problems than those who were not exposed depending on gender and when the events took place (Thoresen & Hjemdal, 2014).

In addition, the Swedish population study on the assiciation between health and the exposure of men and women to violence showed that those who had been exposed to sexual and psychological abuse in childhood had a higher prevalence of mental disorders and psychosomatic symptoms. Among women aged 56-74, who had been exposed to severe physical violence or sexual abuse, heart attacks were two to four times more common than in those who had not been exposed (Heimer et al., 2014).

2 Methodology

The investigation was a national cross-sectional study with 2,463 men and women aged 66-90 living at home, who had responded to a postal questionnaire regarding safety and quality of life.

In general, the preferred data collection method for population studies dealing with a complicated topic is the conduction of interviews where the interviewer and interviewee meet or telephone interviews (Polit & Beck, 2010; Yon et al., 2017). With such methods, both parties can ask clarifying questions and provide explanations as required. As a data collection method, interviews are costly and were therefore outside the financial framework of this project. This was one reason for the use of a postal questionnaire. The advantages and disadvantages of the selected method is discussed in more detail in chapter eight.

2.1 Participants and data collection

To investigate the prevalence of violence and abuse after turning the age of 65 years, including during the previous twelve months, the respondent had to be 66 years of age. The upper age limit was set at 90. Furthermore, the inclusion criteria were that the person had to live in a private household, be capable of giving consent and completing the questionnaire in Norwegian.

The Norwegian Tax Administration authorised extraction of the sample from the Central Population Register (DSF). This task was carried out with the help of the company Evry and the criteria deployed in this process provided a representative sample of the citizens of Norway aged 66-90. The selection reflected geographical settlement in all regions of the country as well as the distribution of the age group in respect of gender and marital status. DSF does not have any direct information about people with an institution as their registered address. Evry provided assistance to exclude people whose address contained the name of an institution.

The ethnicity and mother tongue of residents in Norway can vary. As per 1 January 2017, there were 65,248 immigrants above of 60 (SSB, 2017b). Not all immigrants command written Norwegian to the degree that they can respond to a questionnaire. The questionnaire was not translated into other languages because each language would only apply to a small number of people and the associated costs did not fall within the project's framework. Regardless of this, it would have been difficult to distribute the questionnaire to people within the different language communities.

Ipsos administrated the data collection, as they did with NKVTS' prevalence study on violence and rape in Norway (Thoresen & Hjemdal, 2014) on which this study is built. A letter of invitation was sent with the questionnaire. As presented in Table 2.1, a pilot survey was conducted prior to sending the final questionnaire. A telephone reminder was sent in both the pilot and main surveys. A postal reminder was also sent in the main survey.

During the pilot survey, sixteen people informed us that they did not want to take part. Of these, five reported an age-related reason and two of the reasons given (relating to questions deemed personal or odd) could point to an exposure to violence or similar issues. Three of the respondents were willing to be interviewed by telephone. Those who were contacted by telephone were asked if they had encountered any special problems completing the form in terms of font size or other matters.

The feedback generally did not indicate a need to change the questionnaire. Table 2.1 provides a general overview of the data collection.

Table 2.1. Data collection

Invitation letter and questionnaire	Date sent	Number sent	Number received	Number excluded
Pilot survey One telephone reminder with an offer to conduct a telephone interview.	15.02.16	100	48	
Main survey One telephone reminder with an offer to conduct a telephone interview + one reminder by mail.	14.03.16	5,400	2,420	
The recipient has an unknown address, is incapacitated from taking part, is in a nursing home or has died.				129
Data collection ended	01.07.16		2,468	

Of the 2,468 forms received, an additional five responses were excluded as they did not fulfil the requirements of the project. The total sample for the study was therefore 2,463 respondents.

2.2 Survey sample

The plan for the survey was to include a representative sample of the elderly population of Norway living at home, i.e. residents above 66 years. The sample was to reflect the distribution of the elderly population according to gender, age, marital status and place of domicile (county). To achieve this, an application was sent to the Tax Administration of Norway for permission to extract a sample of 5,500 people from the National Population Register. Information about the names, personal identification numbers, addresses, gender, age and marital status of those extracted was sent directly to Ipsos. Names, personal identification numbers and addresses, except for the postal code and municipality were not disclosed to the researchers at NKVTS.

2.2.1 Withdrawal

A letter with a questionnaire and information about the survey was sent to the 5,500 people thus selected. Sixty-five of the letters that were sent were returned to sender due to an unknown address. In addition, we were informed that 64 people could not take part in the survey as they had died, were seriously ill, no longer lived at home or were incapable of responding to the questionnaire. The gross sample

size for the study was thus reduced to 5371 people, 2,770 women and 2,598 men. A total of 2,468 response forms were returned. Five of these forms were rejected, one because someone other than the respondent had answered, one because the respondent lived in a nursing home, one because the respondent was under the age of 66 and two because it was impossible to interpret the answers. The final sample was therefore based upon 2,463 respondents giving a total response rate of 45,9%, i.e. 44,4% for the women and 47,4% for men. A higher response rate would have been preferable. Nonetheless, the response rate was considered acceptable since the representativeness of the sample in our study largely corresponds with the gross sample size. This is described in the next chapter.

2.2.2 Representativity

Earlier surveys on the risk of exposure to violence and abuse within the population have shown that prevalence is unevenly distributed varying with a number of demographic-, sociodemographic and socioeconomic characteristics. Gender, age, region of domicile, marital status, income, as well as a certain level of education, are especially significant to such variation. Should the characteristics of the respondents deviate from the rest of the population, it could greatly impact the prevalence figures resulting from the survey. In order to generalise the results of the survey to cover the elderly population as a whole, it is therefore important to investigate the level of representativity of the respondents for this population group.

Since the original sample of 5,500 people was extracted from the Norwegian Population Register, the basis for the extraction was equal distribution of gender, age, marital status and geographical distribution in the population above 66 years as a whole. By using these variables, we can therefore compare those who responded to the survey with all those who were originally extracted (herein referred to as the gross sample size).

As with the population above 66 years in general, the gross sample size included slightly more women than men, i.e. 2,770 women (52%) compared to 2,598 men (48%). The higher response rate on the part of men, however, resulted in an equal representation of the genders among the respondents, i.e. 1,231 women compared to 1,232 men.

The response rate sank with increasing age. While 50% responded in the 65-69 age bracket, the response rate sank to 47% in the 70-74 age bracket, to 40% in the 75-79 age bracket and then down to 33% in the 80 and older age bracket. This results in an over-representation of the younger age brackets among the respondents, especially among women, and a similar under-representation of the oldest.

Table 2.2 Age distribution in the gross sample and among the respondents, 5-year groups

Age bracket	Share of gross sample (N=5500)						Share of respondents (N=2463)					
	Women		Men		Total		Women		Men		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
65 – 69 years	825	28,4	832	32,0	1657	30,1	424	34,4	436	35,4	860	34,9
70 – 74 years	818	28,2	754	29,0	1572	26,6	390	31,7	370	30,0	760	30,9
75 – 79 years	528	18,2	504	19,4	1032	18,8	202	16,4	225	18,3	427	17,3
80 years+	732	25,2	507	19,5	1239	22,5	215	17,5	201	16,3	416	16,9

The response rate was relatively equal in different parts of the country, apart from Northern Norway where considerably fewer responses were received compared to the rest of the country.

Table 2.3 Regional response rates

Region	Response rate
Oslo	45,2
Eastern Norway, excluding Oslo	44,2
Western Norway	44,0
Central Norway	44,3
Northern Norway	38,0

This means that the elderly in the northernmost regions are slightly under-represented, while for the rest of the country there are only small differences between the share of the gross sample and among the respondents.

Table 2.4 Regional distribution of the respondents in the gross sample

Region	Gross sample (N=5500)		Respondents (N=2463)	
	N	%	N	%
Oslo	449	8,2	206	8,4
Eastern Norway, excluding Oslo	2431	44,2	1101	44,7
Western Norway	1247	22,7	556	22,6
Central Norway	836	15,2	388	15,8
Northern Norway	537	9,8	212	8,6

When selecting the sample, it was assumed that the marital status of the respondents would reflect the pattern of the elderly population as a whole. However, it was found that the response rate was significantly higher for those who were married or had a cohabitee (52,6%) than for those who were single (24%), separated and divorced (31.6%), and for widows and widowers (36.4%). Consequently, those who are married or cohabit are over-represented among the respondents and all other types of marital status are under-represented.

Table 2.5 Distribution of marital status among the respondents and in the gross sample

Marital status	Gross sample (N=5500)		Respondents (N=5500)	
	N	%	N	%
Married/cohabitee	3245	59,0	1707	69,6
Single	313	5,7	75	3,1
Separated or divorced	759	13,8	240	9,8
Widow/widower	1183	21,5	431	17,6

[a] Self-reported. Ten respondents omitted to state their marital status

We do not have information about the educational level of the entire sample extracted from the National Population Register, therefore it is not possible to compare the gross sample with the respondents. However, it is possible to compare information provided by respondents about their education with the educational level of the elderly population as a whole by looking at the education statistics from Statistics Norway for those aged 67 or older. This approach reveals that respondents of both sexes were on average better educated than the population as a whole. The proportion of male respondents who were only educated to primary/lower secondary school level was lower than was the case for men in general. Among the female respondents, a larger proportion had completed education at primary/secondary school level than was the case for women in general.

Table 2.6 Education level of the population and the respondents. Percentages

	Both gender combined		Women		Men	
	Population	Resp.	Population	Resp.	Population	Resp.
Primary and secondary education	31,8	36,5	35,9	47,3	26,8	25,7
Upper secondary education	48,0	25,3	47,4	21,4	48,9	29,1
University and university college education, undergraduate	14,9	26,0	14,6	25,1	15,3	26,9
University and university college education, postgraduate	5,3	11,7	2,1	5,5	9,1	18,0
No completed education	..	0,5	..	0,9	..	0,3

Of the respondents, 79 (41 women and 38 men) omitted to specify their education.

The respondents were asked to estimate their gross income during the survey. We do not have any information about the income of the gross sample extracted from the Norwegian Population Register and therefore can only make a comparison with Statistic Norway's (SSB) general statistics for household income. These statistics cannot however be fully compared with our information on income, as SSB registers household income after tax; we asked the respondents to state their gross income, which most people will interpret as income before tax. SSB's categorisation of various types of households does not fully correspond with ours either, therefore we have limited the comparison to include one-person households and couples (married/cohabitees) with no children living at home.

Table 2.7 Household incomes of the respondents and entire population above 66 years. Percentages

Income level	Living alone		Couple with no children living at home	
	Population	Respondents	Population	Respondents
Less than 200,000	18,8	18,1	16,1	0,9
NOK 200,000 - 299,999	53,6	28,8	25,5	3,9
NOK 300,000 - 399,999	18,6	27,6	24,4	12,1
NOK 400,000 - 499,999	5,4	13,3	11,8	20,0
NOK 500,000 - 599,999	1,7	6,9	6,1	20,8
NOK 600,000 - 749,999	0,9	3,6	3,2	18,7
NOK 750,000 - 999,999	0,5	0,9	0,8	15,6
NOK 1,000,000 and above	0,5	0,9	0,8	8,0

Of the respondents, 379 (249 women and 130 men) omitted to state their income.

Even though the income levels are not fully comparable, it appears that a larger proportion of the respondents come from upper income households.

To correct the distortion between gender, age, place of domicile and marital status in the final sample of respondents in relation to the gross sample from the Norwegian Population Register, population weights were added. Such weighting resulted in an increase of the percentage of women who are exposed to several types of abuse, whilst for men there was no change or only a slight drop. The differences between the weighted and unweighted prevalences are however very small (see Appendix 1). As a result, we decided to use the unweighted data.

2.3 The Questionnaire

The questionnaire had 13 pages with 88 questions. Six questions had an open response box, three required the insertion of a cross, but also had a comment box. The remaining 79 questions required the insertion of a cross with set multiple choice questions. Forty-two of the questions applied to all the respondents, whilst the other questions applied to victims of violence.

Table 2.8 shows the types of violence and abuse before and after turning the age of 65 years the respondents were questioned about. The terms ‘severe’ and ‘less severe’ violence or sexual abuse are used to describe the potential consequences of the various actions. The subjective experience could be different.

Table 2.8 Questionnaire - questions on violence and abuse

Questions about		Before turning the age of 65 years	After turning the age of 65 years	previous 12 months
Physical violence	Severe violence	✓	✓	✓
	Relation to the perpetrator	✓	✓	✓
	Less severe violence		✓	✓
	Relation to the perpetrator		✓	✓
Sexual abuse	Severe abuse	✓	✓	✓
	Attempted severe abuse	✓	✓	✓
	Age of first abuse incidence	✓		
	Relation to the perpetrator	✓	✓	✓
	Less severe violence		✓	✓
	Relation to the perpetrator		✓	✓
Pscychological and financial abuse			✓	✓
Neglect				✓

Questions were also asked about:

- sociodemographic circumstances;
- health, lifestyle and required assistance;
- concerns about violence and physical assault from other people;
- the victim's fear of being injured;
- physical injuries;
- whether the incident was told to others, contact with the support services and whether the incident was reported to the police;
- the victim's situation at the time of responding;
- how it felt like to answer the questions and permission to be contacted again.

Questions about severe physical violence and sexual abuse *before* turning the age of 65 years were included on the questionnaire, but questions about less severe violence and sexual abuse were omitted. The study on elderly Finnish women and intimate partner violence conducted by Piispa (2004), showed that the elderly did not report less severe violence as often as younger women. Piispa maintains that the possible reasons could be cultural changes in society, but also that less severe incidents are not remembered equally well if a long time has passed since the violence occurred.

Two studies primarily function as a reference point for this study. The first is the national prevalence study on violence and rape in Norway conducted by NKVTS (Thoresen & Hjemdal, 2014). The second is the national prevalence study in Ireland on older people's experience with abuse and neglect, conducted by the National Centre for the Protection of Older People [NCPOP] (Naughton et al., 2010). In the following sections, the terms NKVTS study and NCPOP study will be used when explaining which questions were taken from these studies.

Sociodemographic Data

The questions were related to gender, age, marital status, who the respondent shared their home with, number of children and the respondent's current main occupation. In addition, there were questions about the respondent's birthplace and how long the person had lived in Norway, education and the household's total income.

Health and Lifestyle

There were questions about how satisfied the respondent was with his/her life and whether the person had any chronic condition(s) or suffered from any other health problems during the previous six months. There were nine response alternatives for different diseases and conditions. In addition, there was an open box where the respondent could describe other conditions.
Questions related to sensory loss (vision and hearing) were included as recommended by Professor Wallhagen.[1]

As in the NCPOP study, the SF-8™ (Short Form) Health Survey was also included in our questionnaire. This is an American instrument that can be used to measure the physical and mental health status of the respondent during the previous four weeks. The instrument requires an approved licence from Optum (2017). The SF-8™ is the predecessor of SF-12 and SF-36, both of which are more complex instruments.

1 Wallhagen, M., UCSF John A. Hartford Center of Gerontological Nursing Excellence and the University of California, (2015). [Recommendation to include questions related to loss of hearing received by e-mail in September 2015].

The SF-8™ and SF-12 were tested prior to the NCPOP study, and it was found that elderly people preferred the SF-8™ (Naughton et al. 2010).

The SF-8™ has eight questions related to perceived health, physical functioning, pain, vitality, and social and emotional functioning. The SF-8™ measures the overall physical and mental health of respondents. Subsequently, the results are compared with the average health status of the American population based on studies from 1998. Optum approved our translation of the SF-8™ from English to Norwegian and issued a licence to use our questionnaire.

Physical Violence

The questions relating to physical violence were taken from the NKVTS study. The questions related to *less severe violence*, were taken from Conflicts Tactics Scale (Straus, Hamby, Boney-Mccoy, & Sugarman, 1996). These questions were related to slapping, scratching, pinching, hair pulling or pushing. The NCPOP study only had one combined question for less severe violence (pushed, grabbed, shoved or slapped).

The questions related to *severe physical violence* were taken from the national study of American youth conducted by Kilpatrick et al. (2003) and were adapted to the NKVTS study. Our study includes the same eight questions related to stranglehold, punching, hitting with a hard object, kicking, burning/scolding, threats about using or actually using a knife/weapon or other type of physical assault. The NCPOP study has six of the same questions, but omits questions related to stranglehold or other severe physical assault.

The NCPOP study includes questions related to physical restraint, such as the administration of too many sedatives, confinement, being tied up or prevented from using mobility assistive devices, etc. According to the provisions of the Norwegian Criminal Code, Section 282, these acts are defined as mistreatment, since they entail coercion and deprivation of liberty. It is relevant to investigate these areas for the frail elderly, who rely on caregivers. Studies show that this problem complex is especially relevant for people in residential care with cognitive failure caused by dementia

or other organic brain diseases (Jacobsen et al., 2017). Even though these issues may be relevant for some of the respondents in this study, we did not include such questions, as the study's target group was elderly people, who live at home and are capable of giving consent, and have the functional ability to complete a questionnaire independently.

Sexual abuse

The questions related to sexual abuse were taken from the NKVTS study, which was based on "The National Women's Study" in the USA (1992) by Kilpatrick, Edmund and Seymur. Their study asked specific questions about unwanted sexual acts. Our study included four sub-questions related to whether the respondent had been forced to perform sexual activity through violence or threatening conduct towards the victim of violence or another person close to him/her. The first question was related to vaginal and/or anal intercourse with penetration by means of penis, fingers or other objects in the vagina and/or rectum. The other question was related to oral intercourse/sex, the penetration of the penis into the mouth. Both these questions are defined as rape in the Norwegian Criminal Code. The last two questions related to touching and other serious, non-specified, sexual acts.

The NCPOP study had one question about sexual abuse: "Has anyone touched you or tried to touch you in a sexual way you did not like/against your will?" This is a general question about sexual abuse that fails to specify whether it was rape or other types of sexual violation. All the other prevalence studies on elder abuse also failed to ask questions about which types of sexual acts had been performed (O'Keeffe et al., 2007; Soares et al., 2010).

Our respondents were asked if they had been exposed to less severe sexual abuse, such as being forced to watch pornography, touched in a way the victim did not like, forced to show themselves naked, exposure to flashing or other sexually violating acts. These questions were used in the Gotland study (Kristensen & Lindell, 2013) that included 13 questions related to pornography, sexual harassment and sexual acts.

Controlling behaviour and psychological abuse

The form had two questions on controlling behaviour and two questions on psychological abuse where the perpetrator was the current or former partner or an adult child. The first question was on whether the respondents had experienced controlling behaviour in terms of what they spend their time on and consistently having to explain where they have been. This question was the same as in the NKVTS study, but here the question was split into two. Our second question related to controlling behaviour asked whether the respondent had been prevented from meeting other people he/she cared about or if their freedom had been infringed.

The questions on psychological abuse asked whether the respondent had been systematically ignored/overlooked, been made to feel inferior or verbally threatened.

Financial abuse

The questionnaire includes three questions on financial abuse. These are about whether the elderly person has been pressured or prevented from disposing of their own funds, assets or property as they wish, or whether other people spend more of the elderly person's money than agreed.

The NCPOP study included more types of acts within financial abuse than we did. Their questions included the changing of a will, forging payment forms, the abuse of the financial power of attorney, the non-payment of expenses for which the perpetrator was responsible or an attempt to carry out any of the said acts.

Neglect

The respondents were asked whether they had relied on help to maintain personal hygiene or to carry out daily chores the previous twelve months. If the answer was "Yes", they were asked to specify who had helped them: Family, others close to them or professionals. Thereafter, they were asked four questions related to neglect: Had they experienced being left without essential help or not been given enough food or drink; not been given help with personal hygiene or medicines not being given as they had been prescribed. These four questions were taken from the NCPOP study. However, the NCPOP study had a total of

ten questions related to need for help. These included food shopping and access to essential assistive devices in order to walk and move.

2.3.1 Conditions for classification as a victim

In order to be classified as a victim *before* turning the age of 65 years, the person had to specify at least one incident of severe physical violence or performed/attempted severe sexual abuse. These acts could have taken place in childhood and up to the age of 65 years.

To qualify as a victim *after* turning the age of 65, the respondent had to specify at least one incident of severe physical violence or of performed/attempted severe sexual abuse, less severes sexual abuse or financial or psychological abuse (including controlling behaviour). The incidents must have taken place after the victim turned 65 years of age and up until the time of the survey. For the respondents, this time span could vary from one to twenty-five years.

Those who had been exposed to violence or abuse *during the past year* had to specify at least one incident of the different types of violence or abuse described in the previous section or a neglectful experience during the previous twelve months.

Our study distinguishes between psychological abuse and neglect in a way that differs from that presented in the NCPOP study. In order to be classified as a victim, the NCPOP study set the condition that either there must have been ten or more incidents during the previous twelve months, or that a one-off incident must have led to serious consequences for the victim. Our study does not require multiple incidents to have occurred during the past year; a single incident is sufficient. This is because we have fewer questions on psychological abuse and neglect than the NCPOP study. We included questions with the assumed worst consequences for the victim.

2.3.2 Deviating information and inconsistent answers

Forms where the respondents' information related to age, gender and marital status deviated from the information in the National Population Registry were registered, scanned and reviewed manually. Comments related to deviations in the SPSS file were

added on seven forms. The questions related to violence and abuse were multiple choice questions and required the insertion of a cross in columns and rows. If the respondent was not a victim of violence, the instruction was to answer “No, never” or just skip the question. The number of the next question to be answered was given. Not everyone managed to complete the forms according to the instructions, therefore some questions were not fully answered. This is described in more detail in Appendix 2.

Inconsistent answers were particularly related to the question on physical violence (question 39), which had eight sub-questions and three columns to specify the time the incident took place. This was the only main question on type of violence and abuse that did not have a separate column for the answer “No.” When reviewing the forms, it was found that several respondents had inserted a cross for all the answers in the column. As a result, 34 forms were scanned and reviewed manually. There were optical reading errors on three of the forms. Following careful consideration, the answers on 29 of the forms were changed to missing. Based on the respondents’ other answers on the questionnaire, we are certain they thought that this was a “No” column. Most said they were visually impaired, which could have made it difficult to read text with font size 12. These respondents had followed the instruction to skip over the following questions if they had not experienced physical violence and go directly to question 48. The respondents’ answers to their health status, concerns about violence and current situation, did not indicate that they lived under extreme conditions and were exposed to all types of sev violence and abuse.

2.4 Ethical considerations

The Regional Committee for Medical and Health Research Ethics [REK]assessed the project and found that it fell outside the scope of the Norwegian Health Research Act. The Norwegian Centre for Research Data [NSD] found that the project complied with the personal data regulations and approved the project on 19 January 2016. Following the recommendation of NSD, the upper age limit for participation in the study was set at 90-years-of-age. NSD

believed that it was possible for respondents over the age of 90 to be recognised if their exact age was given and that a third person (perpetrator) could therefore be identified. Throughout the project period, NSD was contacted for advice and guidance as we tried to clarify inconsistent answers regarding exposure to physical violence.

An invitation letter and questionnaire were sent to all individuals in the gross sample informing them that participation in the survey was voluntary and that they consented to partake by returning the completed questionnaire. They were informed that Ipsos would receive the forms and that the researchers at NKVTS were subject to confidentiality. It was also stated that the answers would be treated confidentially and would not be linked to an address list if the respondent did not give permission to be contacted again.

The addressee was invited to partake in a national survey on personal safety and quality of life. Even though it was stated that the intention was to map violent experiences, we believe that the letter did not put the victim at any special risk of getting into a difficult situation. Compared to younger cohorts, fewer people probably live with violent perpetrators since one-person households increase with age. This made it possible for victims to answer the survey without the presence of the perpetrator. Ipsos completed the first round of reminders by telephone and then offered telephone interviews. They also offered telephone interview appointments later. Ipsos has experience with this type of interview and takes care of the important elements to ensure that victims are not further exposed due to the telephone call (Thoresen & Hjemdal, 2014).

Questions on violence experinces may bring back non-processed bad memories that the victim may need help to deal with . At the end of the questionnaire, it was stated that the survey was supported by health personnel. The contact details of the Protective Services for the Elderly - National Helpline were provided. Respondents who felt the need to talk to someone were encouraged to telephone them.

2.5 Statistical methods

Withdrawal analyses were based on age, gender and place of domicile (county or larger region) and carried out by logistic regression of withdrawal against these three variables with interaction between gender and age, the latter being a continuous variable. Logistic regression was used to assess the risk of violence after the age of 65 related to those who had been exposed to violence before turning 65 years and those who reported non-exposure.

Comparison of categorical variables between men and women and between exposed and non-exposed to various types of abuse used contingency tables and chi-squared tests, unless otherwise specified. The P-values of such tests are specified in the text or written in the tables. We chose to specify the exact P-value instead of just stating whether it was significant or not. This is compliant with the recommendations of the American Statistical Association (Amstat News, 2016), who state that the exact P-values must be specified to avoid misuse and misunderstandings.

There are some low-quantity combinations, therefore exact tests were carried out where necessary with 100,000 Monte Carlo replications.

Analysis of variance (ANOVA) was used to test the health measurements in the SF-8™ (Short Form Health Survey) with Tamhane's test for paired comparisons.

All analyses were performed in IBM SPSS Statistics for Windows, version 24. Reference is also made to Appendix 2, which describes the statistical analyses in more detail.

3 Violence, Abuse and Neglect

This chapter presents the prevalence of violence and abuse. Here we describe the total prevalence and prevalence for each type of abuse, as well as the relationship between the victim of violence and the perpetrator. We also highlight some of the aspects of being a victim of violence both in old age and earlier in life. At the end of the chapter, we compare the respondents who have not reported violence or abuse to those with such experiences. This involves four groups, which will be explained in more detail.

3.1 Prevalence of violence and abuse after the age of 65 years

The total prevalence of physical violence, psychological, sexual and financial abuse for victims exposed after turning the age of 65 years was between 6.8% and 9.2%. The presentation in Table 3.1 is not limited to perpetrators closely related to the victim.

Table 3.1 Prevalence of violence and abuse after since 65 years

	Number	%	Low %[a]	N
Physical violence	2344	2,5	2,4	58
Psychological abuse	2189	4,5	4,0	98
Sexual abuse	1909	1,4	1,1	26
Financial abuse	2235	0,9	0,9	21
Total for all types	1821	9,2	6,8	168

[a] Number divided by the total sample size (2,463). See the explanation below.

We consistently found small gender differences in the prevalence of violence and abuse after turning the age of 65 years, and the gender differences were not significant ($p^{3}0,155$). For psychological abuse, however, the prevalence rate among women was 5.1% and 3.9% for men. The total prevalence for abuse was 9.8% among women and 8.7% among men. If the total sample size is used as a basis, the

prevalence rate was 6.8% for both genders. These calculations are explained in the next section.

The presentation in this and similar tables requires some explanation. Most of the variables for different types of violence and abuse are a combination of variables constructed on the basis of several individual questions. In most cases, this means a positive value if at least one question has a positive answer. For a negative value, however, all the questions must have a negative answer. In cases where no answer has been given, this means that missing values for the combination of variables would more likely lean towards negative values rather than positive ones if all questions had been answered. Because of this, some prevalence rates may have been over-estimated. A more detailed explanation is found in Appendix 2. Therefore, in Table 3.1, for example, percentages have also been calculated based on the total sample size of 2,463. We have described these instances as low estimates and placed them under the heading ‘Low %’. These estimates are based on setting all missing values to “No” answers and they cannot be used as estimates without reservations. The actual prevalences probably lie between the given prevalence figures and the low estimates. Similar low estimates have also been calculated elsewhere in the following.

The prevalence found in this study are somewhat higher than in several other European studies. In the Irish study, the prevalence rate 5.5%, including neglect (Naughton et al., 2010). In the British study (O'Keeffe et al. 2007), the prevalence rate for physical violence was (0.8%) and for sexual abuse (0.3%) after turning the age of 65 years, lower than in our study, but financial abuse (1.2%) was slightly higher. The study included perpetrators, who were family members or other trusted persons, such as friends or caregivers employed by the care services, but excluded acquaintances or strangers (O'Keeffe et al., 2007).

Thoresen and Hjemdal's study (2014) on violence and rape in Norway showed that younger people were more exposed to violence than the elderly. The study had a lifetime perspective with respondents aged 18-75. In our study, which only deals with elderly

cohorts, there are no significant differences (p=0.760) between the elderly (aged 66-69) and the very elderly (aged 80-89). Table 3.2 shows the total prevalence of violence and abuse within the various age cohorts for men and women combined.

Table 3.2 Violence and abuse since 65 years for the different age groups

Age cohort	Total N=1821	Exposed > 65 years N=168		
	N	%	lav %	N
66-69 years	686	10,1	8,0	69
70-74 years	591	8,6	6,7	51
75-79 years	291	8,2	5,6	24
80-89 years	253	9,5	5,8	24

In the Irish study (Naughton et al., 2010), the highest percentage of victims was in the 80 years or more cohort (6.9%) and the lowest percentage in the 65-69 years cohort (2.4%). In this regard, two differences exist between our study and the Irish study. The Irish study included respondents right up to the age of 98. They were also asked if they had experienced neglect at any time after turning the age of 65, not only during the past year. It was found that 1.2% had been exposed to neglect, but no one was below the age of 70. Even without including neglect, more of the very elderly would have been exposed, as the prevalence of psychological abuse increases with age, especially for men (Naughton et al. 2010). This is hardly surprising, since the time span for potential exposure is longer for the very elderly than it is for the less elderly. It must therefore be assumed that the percentage will increase with age, unless everyone is exposed during the first few years following retirement.

In our study, most had only been exposed to one type of violence or abuse. It should be noted that Table 3.3 provides an overview of the number of types, but not the number of occurences within the same type. That is, the overview shows how many have been exposed to the various types of violence and abuse at least once after the age of 65. They could have been exposed to one, two, three or four types of violence or abuse. Small and insignificant (p=0.250) gender differences were observed.

Table 3.3 Number of types of violence and abuse for each victim since 65 years

	Total N=1771		Women N=829		Men N=942	
	%	Number	%	Number	%	Number
No types of abuse	93,3	1653	93,2	773	93,4	880
One type	5,4	95	4,9	41	5,7	54
Two types	1,0	18	1,3	11	0,7	7
Three types	0,2	3	0,4	3	0	0
Four types	0,1	2	0,1	1	0,1	1

3.1.1 Violence, abuse and neglect in the past 12 months

The respondents were asked if they had been dependent on help to maintain personal hygiene and to perform daily chores for shorter or longer periods during the previous twelve months. The follow up questions on who had helped and the number of times they had experienced that their needs had been neglected, were only to be answered by those who had stated that they needed such care. In a few other cases (seven), the follow up questions were answered affirmatively and were also included as required care. Of the 2,401 people from whom the answers could be assessed based on this, 7.9% (189 people) required such care.

The 189 respondents who required care during the previous 12 months were classified as neglected if they had answered at least once to one or more questions on neglectful coverage of their care needs and as not neglected if all the questions were answered with "Never." Of the 189, 123 answers could be assessed based on this, and of these 16 (13.0%) reported neglect.

In total, 7.2% (5.2% if the sample size is used as a basis) of the respondents reported violence or abuse the previous 12 months, irrespective of the relationship between the perpetrator and the victim (Table 3.4). The corresponding figure in the Irish survey was 3.3% (Naughton et al., 2010) and in the British survey there was a one-year prevalence of 4% (O'Keeffe et al., 2007).

Table 3.4 Prevalence of violence, abuse and neglect in the past 12 months

	Number	%	Low %[a]	N
Physical violence	2342	1,3	1,2	30
Psychological abuse	2194	3,6	3,2	80
Sexual abuse	1908	0,5	0,4	9
Financial abuse	2251	0,6	0,5	13
Neglect	2335	0,7	0,6	16
Total for all types	1767	7,2	5,2	127

[a] Number divided by the total sample size (2463 respondents)

Consistently, small gender differences were observed in the prevalence of violence, abuse and neglect, and the gender differences were not statistically significant (p=^{3}0.117). For physical violence, however, the prevalence was 4.1% for women and 3.2% for men. The total prevalence of abuse was 6.5% among women and 6.3% among men. If the total sample size is used as a basis, the prevalence was 5.0% for women and 5.3% for men.

In the British study (O'Keeffe et al. 2007), gender differences were observed (3.8% for exposed women and 1.1% for men), but in the Irish study, smaller gender differences (2.4% women and 1.9% men) were observed (Naughton et al. 2010). In the ABUEL study (Soares et al. 2010), significantly more women than men were exposed to sexual abuse, but not physical, psychological or financial abuse.

3.2 Different types of violence and abuse

Physical violence

Of the 58 respondents (2.5%), who reported physical violence after turning the age of 65, 30 had experienced severe physical violence, and 28 had experienced less severe violence. Of the 30, who were exposed to physical violence, 14 had also experienced less severe violence.

During the previous 12 months most reported exposure to less severe violence (19 of 30 victims). Five reported they had been exposed to both severe and less severe physical violence. Six had been exposed to severe violence, but for four of these we do not know whether they had also been exposed to less severe violence.

Of those who had written in the comments box to give more details or to explain the physical assaults, two comments were related to incidents after turning the age of 65 years. One concerned a street robbery and the fear it created in the aftermath. The other comment was from a woman who explained that the incidents of physical violence occurred after her spouse developed dementia.

Sexual abuse

Of the 26 people who reported sexual abuse, around two-thirds (16 people) had experienced severe sexual abuse. Four of these had also experienced less severe sexual abuse.

Of the 16, who reported severe sexual abuse, two stated that they were highly intoxicated and were incapable of giving consent or stopping the perpetrator. Two others stated that they were consistently intoxicated when someone tried to perform the sexual act.

Psychological abuse

Of the 98 respondents, who reported psychological abuse, almost half (45 people) specified controlling behaviour and 68 other types of psychological abuse, such as being systematically ignored or verbal threats. Twenty people reported both controlling behaviour and other psychological abuse.

Financial abuse

For the three questions related to financial abuse, most (10 of 21) stated that others had spent more money than had been agreed. Seven people had experience of someone persuading or pressuring them into giving away money, valuable items or property. An equal number stated they had been prevented from using their own money or disposing of their assets or property as they wished.

3.3 Fear of Injury

Of the 30 people who had been exposed to *severe physical violence after the age of 65 years*, 24 answered the question related to whether they had been afraid of sustaining a serious injury or being killed as a result of the incidents.

Ten of them (an equal number of men and women), had answered they were afraid of sustaining a serious injury. Five had experienced this several times, and two men and one woman had been injured.

For sexual abuse, the question related to the fear of sustaining an injury was linked to incidents both before and after turning the age of 65. Answers were received from nine of the 16 people, who reported *severe sexual abuse after the age of 65 years*. Of these, two men had been afraid of sustaining a serious injury or being killed. Both men stated that they had been injured several times.

Of the 123 people, who reported *severe sexual abuse before turning the age of 65 years*, 96 answered the question. Of these, 23 people, 18 women and five men had been afraid of sustaining a serious injury or being killed. Twelve women and one man had been injured once or several times.

3.4 Risk after the age of 65 years if exposed earlier in life

In the preceding text, we have described the prevalence of violence and abuse reported by the respondents *after* turning the age of 65. In addition, they were also asked about severe physical violence and severe sexual abuse *before* turning the age of 65.

Of the respondents, 12.7% (312 of 2,451) reported that they had experienced severe physical violence before turning the age of 65 and significantly more men (15.9%) were exposed than women (9.5%, $p<0.001$). Some had experienced several types of severe violence. Most had been punched (159 people).

Exposure to severe sexual abuse earlier in life was reported by 5.6% (123 of 2,203 people). Significant gender differences were observed ($p<0.001$) with 89 women (8.3%) and 34 men (3.0%) exposed respectively. Of the 123 victims, 34 stated they had been raped. The victims were asked to state how old they were at the time of the first abuse/attempted abuse. One-hundred of the victims answered this question. Of these, 73 people stated that the abuse or attempted

abuse took place before the age of 18. Twenty-eight people were under 10-years-old when it first occurred.

If a person has also been exposed earlier in life, the risk of exposure to violence or abuse in old age is substantially higher. The study on violence and rape with a life course perspective had the same findings: Sexual abuse in childhood could be linked to severe violence and severe intimate partner violence in adulthood, especially for women (Thoresen & Hjemdal, 2014).

Those in our study who reported both severe violence and severe sexual abuse before the age of 65 had an 8.0 times higher risk (6.0 times higher for women and 11.4 times higher for men) of being exposed to violence or abuse after turning the age of 65 compared to those that did not report such incidents.

For those who reported severe physical violence, but no severe sexual abuse, the risk was 3.4 times higher (4.4 times higher for women and 2.9 times higher for men) of being exposed in old age as well.

For those who reported severe sexual violence, but no severe physical violence, the risk was 4.9 times higher (3.8 times higher for women and 7.5 times higher for men) of being exposed in old age as well.

In a logistic regression adjusted for gender, we found a significant relationship between exposure to severe physical or severe sexual abuse earlier in life and experiencing violence or abuse after turning the age of 65 ($p<0.001$).

3.5 Relation to the perpetrator

The respondents were asked about the relationship they had with the perpetrator at the time the incident took place. The form had 14 answer choices and provided the possibility to state several relationships, where applicable. In the following sections, the perpetrator is described under four collective terms.

Close relatives indicate parents/step-parents, siblings/step-siblings, current or former boyfriend/girlfriend/spouse/cohabitee, adult children/step-children and grandchildren.

Acquaintance covers friends, neighbours, other family members, clients, patients, students, managers, etc., that the victim has met in the course of their job.

Person of authority includes health personnel, managers or others in an association/parish of which the victim was a member.

Unknown includes those not mentioned in the other categories.

3.5.1 Perpetrators of violence and abuse since 65 years and in the past year

Most of the perpetrators of violence were closely related to the victim. The person could have been exposed to several incidents of violence and abuse with potentially different perpetrators involved in the incidents. As a result, the victim may have reported multiple perpetrators (Table 3.5).

Neglect is not included in the overview of perpetrators of violence or abuse. Since we did not explicitly ask for information about the perpetrator of neglect, we do not know for certain who this person was. The respondents' answers stated who the caregiver was, but did not identify the perpetrator of the neglect.

Among the 168 people, who reported one or more incidents of violence or abuse after turning the age of 65 years, it was possible to assess the answers of 153 people to the questions about closely related perpetrators. Of these, approx. eight of ten victims had a close relationship with the perpetrator. Among the 112, who were exposed during the past year, it was possible to assess the answers of 104 people. Of these, approx. nine of ten victims had a close relationship with the perpetrator. This is slightly higher than in the Irish study where the perpetrator was closely related to seven of ten victims (Naughton et al., 2010).

Table 3.5 Close relatives as perpetrators of violence and abuse since 65 years and in the past year

Exposed to at least one type of violence or abuse	After 65 years (N=168)	Past year (N=112)
Exposed women	69 av 80 (86,3 %)	47 av 54 (87,0 %)
Exposed men	52 av 73 (71,2 %)	43 av 50 (86,0 %)
Total women and men	121 av 153 (79,1 %)	90 av 104 (86,5 %)

As to physical violence after turning the age of 65 years, 20 of the 58 victims state that they had a close relationship with the perpetrator. Table 3.6 provides a general overview of the relationship between the victim and perpetrator. Not all victims divulged information about the perpetrator.

Table 3.6 Perpetrators of physical violence since 65 years

Perpetrator of physical violence after the age of 65 years		Partner	Other close relatives	Acquaintances	Strangers/ others
Exposed women (N=29)	N	8	8	6	2
	%	27,6	27,6	20,7	6,9
Exposed men (N=29)	N	4	0	6	9
	%	13,8		20,7	31,0
Total women and men (N=58)	N	12	8	12	11
	%	20,7	13,8	20,7	19,0

Most of the victims of violence in close relationships state that their partner was the perpetrator. Twelve reported that their partner had carried out less severe violence and three stated that their partner had carried out severe violence. Five women stated that adult children/step-children had carried out less severe violence and four women stated that adult children/step-children had carried out severe violence. One person reported severe violence from siblings. One woman reported less severe violence from a grandchild. She was also exposed to violence from another family and acquaintances.

Only one woman reported health personnel as the perpetrator of less severe physical violence, which occurred during the past year.

Perpetrators of sexual abuse after the age of 65 years
Of the 26 people, who reported sexual abuse and a relationship with the perpetrator, one man and three women stated that it was their partner or former partner. No one reported sexual abuse from other people with whom they had a close relationship. Three victims stated that the perpetrator was an acquaintance. One person stated that it was a work colleague, and for three men the perpetrator was a stranger. No one stated that they had been exposed to sexual abuse from health personnel or other persons of authority.

Perpetrators of psychological and financial abuse after the age of 65 years
The questions on psychological and financial abuse assumed close relationship between the perpetrator and the victim. Therefore, we do not know the degree to which the elderly have been exposed to these types of violence from people in authority, e.g., health personnel, caregivers, managers or others in organisations to which the elderly person is attached.

3.5.2 Perpetrators of violence and abuse before the age of 65 years
With regard to exposure earlier in life, the respondents were only asked about severe physical violence and severe sexual abuse before turning the age of 65 years (see chapter 3.4).

Perpetrators of severe physical violence before the age of 65 years
Of 2,451 people, 312 had been exposed to severe physical violence at least once before the age of 65 years. Of these, 235 state that one type of perpetrator carried out the violence, Thirty-eight state two types of perpetrators and 14 three types. Only two state four types of perpetrators and one victim states five types.

Table 3.7 shows the type of relationship between the perpetrator and victim at the time of the violence. Most of the exposed men, but not the women, stated that the perpetrator was a stranger.

In terms of violence in close relationships, more women than men stated they had a close relationship with the perpetrator. For the

women, most of the perpetrators were a current or former spouse/ cohabitee/girlfriend/boyfriend and secondly parents. For exposed men, parents were most frequently stated as the perpetrators of violence in close relationships followed by siblings. Of the 36 victims who stated that a parent was the perpetrator, 26 of the perpetrators were fathers/step-fathers. Sixteen of the perpetrators were mothers/ step-mothers and for six victims both parents were the perpetrators.

Table 3.7 Perpetrators of severe physical violence before 65 years

Perpetrator of severe physical violence		Parent	Other close relatives	Acquaintances	Work colleagues	Stranger	Others
Exposed women (N=117)	N	20	60	7	21	17	3
	%	17,1	51,3	6,0	17,9	14,5	2,6
Exposed men (N=195)	N	16	17	23	43	87	35
	%	8,2	8,7	11,8	22,1	44,6	17,9
Total women and men (N=312)	N	36	77	30	64	104	38
	%	11,5	24,7	9,6	20,5	33,3	12,2

Two of the victims stated that the perpetrator was a person of authority and four stated that the perpetrator was other family member.

Perpetrators of severe sexual abuse before the age of 65 years

Of 2,203 people, 123 reported exposure to severe sexual abuse earlier in life. The perpetrators, as stated by the victims themselves, are found in Table 3.8 and the text below the table. The victim could also state more than one type of perpetrators here as well.

Table 3.8 Perpetrators of severe sexual abuse before 65 years

Perpetrator of severe sexual abuse		Close relative, excluding parents	Other family member	Acquaintances	Stranger	Others
Exposed women (N=89)	N	20	13	24	14	5
	%	22,5	14,6	27,0	15,7	5,6
Exposed men (N=34)	N	6	4	10	8	6
	%	17,6	11,8	29,4	23,5	17,6
Total women and men (N=123)	N	26	17	34	22	11
	%	21,1	13,8	27,6	17,9	8,9

In addition, six women and two men state that their parents were the perpetrators, and three reported a person of authority as the perpetrator. Six women and two men state that the perpetrator was a person they had contact with in their job. In terms of parents as perpetrators of the abuse, six exposed women and two exposed men state that their father/step-father was the perpetrator and one of these men stated his mother was the perpetrator as well.

In total, 26.8% (33) of the 123 victims were exposed to severe sexual abuse from someone with whom they had a close relationship. A large portion of the perpetrators were acquaintances, friends, neighbours or a family member.

3.6 Exposed and non-exposed persons

In order to clarify whether it is possible to link any circumstances to victims of violence in particular, we have divided the respondents into four groups. The first group consists of respondents who have not reported exposure to violence or abuse at any time in their lives. The three other groups consist of respondents who have experienced such incidents. Table 3.9 provides an overview of the groups and distribution between the genders. The four groups will be used in the further presentation of the results.

Table 3.9 Prevalence of violence and abuse throughout life

Violence and abuse		Group I: Never	Group II: Before 65 years only	Group III: After 65 years only	Group IV: Before and after 65 years
Women (N=804)	N	626	98	42	38
	%	77.9	12,2	5,2	4,7
Men (N=924)	N	700	140	42	42
	%	75,8	15,2	4,5	4,5
Total for both genders (N=1728)	N	1326	238	84	80
	%	76,7	13,8	4,9	4,6

Of the respondents, 735 did not answer a satisfactory number of questions and could therefore not be included in any of the groups.

Group I

The first group consists of 76.7% or 1,326 respondents, who reported that they had never been exposed to the types of violence or abuse we enquired about in our survey. Nonetheless, they may have been exposed to less severe physical violence and less severe sexual abuse, psychological abuse and neglect before turning the age of 65 years. We do not have any information on this since they were not asked.

Group II

The second group consists of 13.8% or 238 respondents, who reported that they had reported severe physical violence and/or severe sexual abuse before turning the age of 65 years, but have not been exposed to violence or abuse after turning the age of 65 years.

Group III

The third group consists of 4.9% or 84 respondents, who reported severe and/or less severe violence, severe and/or less severe sexual abuse or financial abuse after turning the age of 65 years and/or neglect during the past twelve months.

Group IV

The final group consists of 4.6% or 80 people, who reported violence or abuse both before and after 65 years. These people state severe physical violence and/or severe sexual abuse before turning the age of 65 years and at least one type of violence and/or abuse after turning the age of 65 years. Neglect is not included.

3.7 Exposure to and anxiousness about violence

Anxiousness and worries about exposure to violence and abuse is something that most people may have experienced at times. This study shows, however, that significantly more of those, who stated that they had experienced violence or abuse, have such worries.

Table 3.10 Anxiousness about potential exposure to violence and threats

Anxiousness about violence or threats when going out alone near their home		Violence and/or abuse				p-value
		Never (N=1326)	Up to 65 years only(N=238)	After 65 years only (N=84)	Before and after 65 years (N=80)	
Women (N=795[a])	N	25 av 618	6 av 98	3 av 42	9 av 37	‹0,001
	%	4,0	6,1	7,1	24,3	
Men (N=920[a])	N	8 av 697	1 av 140	2 av 42	4 av 41	0,001
	%	1,1	0,7	4,8	9,8	

[a] Number of those where exposure to violence is known and where a valid answer was also given for the actual question related to worries about violence.

As shown in Table 3.10, significantly more victims of violence (women and men) stated that they were nervous about potential exposure to violence or abuse when out and about alone in the place where they live. This was particularly noticeable for those who were exposed both before and after turning the age of 65 years. Likewise, this also applies to the respondents, especially women, who are anxious about potential exposure to violence from a person he/she knows (Table 3.11).

Table 3.11 Anxiousness about potential exposure to violence in the past 12 months

Anxiousness about violence from known persons		Vold og/eller overgrep				p-value
		Never (N=1326)	Up to 65 years only (N=238)	After 65 years only (N=84)	Before and after 65 years (N=80)	
Women (N=797[a])	N	1 av 621	1 av 97	3 av 42	8 av 37	‹0,001
	%	0,2	1,0	7,1	21,6	
Men (N=917[a])	N	2 av 693	0 av 140	0 av 42	2 av 42	0,024
	%	0,3	0	0	4,8	

[a] Number of those where exposure to violence is known and where a valid answer was also given to the actual question related to worries about violence.

Such anxiousness is understandable as very few of those exposed to violence after turning the age of 65 years stated that a stranger was the perpetrator.

Table 3.12 Refrained from joining activities in the past 12 months due to anxiousness about a potential assault

		Violence and/or abuse				
		Never (N=1326)	Up to 65 years only (N=238)	After 65 years only (N=84)	Before and after 65 years (N=80)	p-value
Women (N=785[a])	N	9 av 611	6 av 98	2 av 40	7 av 36	<0,001
	%	1,5	6,1	5,0	19,4	
Men (N=901[a])	N	5 av 684	1 av 136	0 av 40	2 av 41	0,101
	%	0,7	0,7	0	4,9	

[a] Number of those where exposure to violence is known and where a valid answer was also given to the actual question related to worries about violence.

Especially women, who had been exposed to violence earlier in life and in old age, abstained from activities because they were anxious about a potential assault. With regard to abstaining from activities due to fear of being assaulted for men, no significant differences were observed between victims and non-victims.

4 Demographics and Exposure to Violence

Chapter 2.2 described several sociodemographic circumstances connected to the people who were invited to partake in the study and those who actually partook in it. We explained the composition in terms of marital status, education and income levels at the time the survey was conducted. We did not ask about occupational status or other sociodemographic circumstances earlier in life.

In this chapter we compare the differences within our sample and the four groups described in chapter 3.6. A comparison will not explain the reason for these differences, but can indicate potential association between sociodemographic variables and the risk of being exposed to violence and sexual abuse or lack thereof, between victims and non-victims.

4.1 Marital status, living arrangements and exposure to violence

As mentioned, married couples and cohabitees are somewhat over-represented in our study (69.6%) compared to the general population (59%). Thus, singles, separated/divorced people and widows/widowers are under-represented. Nonetheless, it is interesting to observe whether any differences exist between the victim and non-victim groups in terms of marital status. Table 4.1 shows that more women who have been exposed to violence or abuse are single, both compared to exposed men and the group of women who had not been exposed to violence or abuse.

Table 4.1 Marital status of victims and non-victims. Percentages

	Violence or abuse			
Marital status	**Never**	**Up to 65 years only**	**After 65 years only**	**Before and after 65 years**
Women	**N=625**	**N=97**	**N=42**	**N=38**
		p=0,001		
Married/cohabitee	67,2	59,8	69,0	44,7
Single, never married/cohabitee	2,7	4,1	0	5,3
Single, separated/divorced	10,1	17,5	7,1	36,8
Widow	24,5	18,6	23,8	13,2
Men	**N=699**	**N=140**	**N=41**	**N=41**
		p=0,069		
Married/cohabitee	81,5	85,7	85,4	80,5
Single, never married/cohabitee	3,4	2,1	0	0
Single, separated/divorced	5,6	7,1	12,2	14,6
Widower	9,4	5,0	2,4	4,9

For women, there were significant marital status differences depending on their exposure to violence and abuse. However, this did not apply to men. In particular, many of the exposed women were separated/divorced. The same tendency was also observed in the Irish prevalence study: It was found that most victims were separated/divorced or married, especially the women (Naughton et al. 2010). The British study found a particularly high prevalence of violence and abuse against separated/divorced women (13,1%). For men it was 0.4% (N=2105). With regard to living arrangements, single-person dwelling was associated with exposure to violence for both genders, but especially for women (O'Keeffe et al. 2007). We did not find any differences in living arrangements in our study (Table 4.2).

Table 4.2 Living arrangements of victims and non-victims

	Violence or abuse			
Living arrangements	**Never**	**Up to 65 years only**	**After 65 years only**	**Before and after the age of 65**
Women, N (%)		p=0,215		
Lives alone	221 (35,2)	35 (37,2)	12 (28,6)	19 (50,0)
Lives with someone	407 (64,8)	59 (62,8)	30 (71,4)	19 (50,0)
Men, N (%)		p=0,785		
Lives alone	122 (17,5)	20 (14,3)	6 (14,3)	7(16,7)
Lives with someone	575 (82,5)	120 (85,7)	36 (85,7)	35 (83,3)

4.2 Education, income and exposure to violence

In the prevalence study on violence and rape in Norway (Thoresen & Hjemdal, 2014), the education level of the respondents was slightly higher than the population in general. This is also the case in our study. Table 4.3 shows the education level of victims and non-victims.

Table 4.3 Education level of victims and non-victims. Percentages

Education	Violence or abuse			
	Never	**Before the age of 65 years only**	**After 65 years only**	**Before and after 65 years**
Women	**N=616**	**N=97**	**N=42**	**N=34**
	p=0,002			
Primary school/middle school (did not lead to upper secondary education)	24,8	14,3	7,1	8,6
Lower secondary school/grammar school	20,7	15,3	16,7	8,6
Vocational college/apprenticeship	12,8	11,2	21,4	17,1
Upper secondary school/sixth form college	10,2	10,2	7,1	8,6
University/university college, undergraduate	26,7	35,7	38,1	45,7
University/university college, postgraduate	4,5	12,2	9,5	8,6
Men	**N=690**	**N=138**	**N=41**	**N=39**
	p=0,715			
Primary school/middle school (did not lead to upper secondary education)	15,3	11,6	14,3	15,0
Lower secondary school/grammar school	8,4	5,8	7,1	12,5
Vocational college/apprenticeship	19,4	17,4	11,9	20,0
Upper secondary school/sixth form college	9,3	8,0	16,7	5,0
University/university college, undergraduate	27,8	35,5	23,8	25,0
University/university college, postgraduate	19,7	21,7	23,8	20,0

Six people (three women and three men) stated that they had not completed any education and were removed from the table.

Men are generally more educated than women, which is also the case for the respondents in this study. There are no significant differences between exposed and non-exposed men. In contrast, there are significant differences in the education level of exposed and non-exposed women. It should be noted that victims are as highly educated as non-victims.

The World Health Organisation emphasises that the importance of education as a risk factor for abuse against the elderly is uncertain (Sethi et al., 2011). A Turkish study showed that there were twice as many victims with low or no education compared to non-victims and an Israeli study showed that highly educated elderly people were less exposed to psychological abuse than were those with low-educational attainment (Sethi et. al., 2011). The ABUEL study found the opposite: Many highly educated elderly people reported psychological abuse, but the ABUEL study did not find any differences between level of educational attainment for victims of other types of abuse (Soares et al., 2010).

The Irish prevalence study (Naughton et al., 2010) found higher prevalence of abuse among women with lower educational attainment and lower prevalence among women with higher educational attainment. The level of education in Ireland differs to that in Norway. The Irish study consisted of 1,109 women over the age of 65 years and older. Of these, 66% had completed primary and lower secondary education and 9% university education (undergraduate or postgraduate), which is approximately the same as the education level of the elderly population in Ireland.
Thirty-six per cent of elderly Norwegian women have completed primary and lower secondary education; in this study 46% of women (N=1,031) had done so. Approx. 17% of elderly women have completed university education in Norway and this applied to 30% of women who partook in this study. The difference in the education level of the respondents could be noteworthy even if a direct relationship does not necessarily exist.

Concerning exposure and income level, the study conducted by Thoresen and Hjemdal (2014) showed that the prevalence of severe

violence and rape more often happened to people who felt they were undergoing financial hardship. The feeling of not having enough money is not necessarily associated with the household's income, but income level can give certain indications. For people living alone, the household's total income will, other circumstances equal, be less than in households being more members.

Tables 4.4 and 4.5 show the relationships between exposure to violence and income for all four combinations of gender and living arrangements.

Table 4.4 Household's total gross income for women divided according to living arrangements

Gross annual income in NOK	Violence or Abuse			
	Never	Up to 65 years only	After 65 years only	Before and after 65 years
Women who live with someone	**N=349**	**N=57**	**N=27**	**N=13**
	p=0,009			
Less than 300 000	4,3	12,3	0	23,1
300 000 – 599 000	57,0	47,4	63,0	61,5
600 000 og over	38,7	40,4	37,0	15,4
Women living alone	**N=181**	**N=34**	**N=10**	**N=16**
	p=0,228			
Less than 300 000	44,2	33,3	50,0	68,8
300 000 – 599 000	54,1	60,6	50,0	31,3
600 000 or more	1,7	6,1	0	0

There are significant connections between exposure to violence and income for women who live with someone. The portion of women exposed to violence is slightly lower in the highest income brackets. Table 4.5 shows that there are no such connections for men.

Table 4.5 Household's total annual gross annual income for men divided according to living arrangements. Percentages

Household's total gross annual income in NOK	Violence and Abuse			
	Never	Up to 65 years only	After 65 years only	Before and after 65 years
Men living with someone	**N=533**	**N=112**	**N=34**	**N=32**
	p=0,181			
Less than 300 000	3,8	3.6	5,9	3,1
300 000 – 599 000	48,6	38,4	61,8	56,3
600 000 og over	47,7	58,0	32,4	40,6
Men living alone	**N=114**	**N=19**	**N=5**	**N=6**
	p=0,760			
Less than 300 000	8,1	36,8	40,0	50,0
300 000 – 599 000	58,8	47,9	60,0	50,0
600 000 or more	13,2	15,8	0	0

5 Lifestyle, Health and Exposure to Violence

This chapter describes how exposed and non-exposed men and women assess their lives, the degree to which they use intoxicants and whether they have health problems. Even though this survey cannot explain the causes of health problems, a comparison between the four groups could indicate potential associations. Categorisation of the groups is explained in chapter 3.6.

Table 5.1 shows that those who have been exposed to violence and abuse were significantly less satisfied with their lives than those who had never been exposed.

Table 5.1 Life satisfaction. Percentages

	Violence and/or Abuse			
	Never	Up to 65 years only	After 65 years only	Before and after 65 years
Women	**N=612**	**N=92**	**N=42**	**N=35**
Very satisfied	42,6	35,9	26.2	14.3
Quite satisfied	48,5	48,9	35,7	45,7
Neither satisfied nor dissatisfied	6,4	9,8	21,4	14,3
Slightly dissatisfied	1,8	5,4	11,9	11,4
Very dissatisfied	0,7	0	4,8	14,3
Men	**N=690**	**N=139**	**N=41**	**N=41**
Very satisfied	38,8	35,5	19,5	19,5
Quite satisfied	48,7	57,6	46,3	48,8
Neither satisfied nor dissatisfied	7,4	3,6	12,2	12,2
Slightly dissatisfied	4,5	2,9	14,6	17,1
Very dissatisfied	0,6	0,7	7,3	2,4

There are significant differences between the four groups both for women and men ($p<0.001$). Those exposed after turning the age of 65 years particularly seem to be less satisfied with their lives.

5.1 Use of intoxicants

The respondents were asked about their use of intoxicants. Table 5.2 shows how often victims and non-victims stated that they drink alcohol. They were not asked the units of alcohol they consumed, only how often they drank. There is no significant relationship between the use of alcohol and exposure to violence and abuse (p=0.081 for women and 0.107 for men).

Table 5.2 Use of alcohol in the past 12 months. Percentages

How many times did you consume alcohol?	Violence and/or Abuse			
	Never	Up to 65 years only	After 65 years only	Before and after 65 years
Women	**N=584**	**N=90**	**N=39**	**N=36**
Never	28,6	18,9	30,8	22,2
Once per month or less	18,7	18,9	15,4	38,9
Two-three times per month	15,6	17,8	23,1	11,1
Once per week	13,5	10,0	12,8	13,9
Two-three times per week	18,3	30,0	10,3	11,1
More often	5,3	4,4	7,7	2,8
Men	**N=686**	**N=138**	**N=42**	**N=39**
Never	14,6	10,9	16,7	33,3
Once per month or less	17,9	15,9	19,0	15,4
Two-three times per month	17,2	18,8	21,4	10,3
Once per week	17,6	13,8	23,8	7,7
Two-three times per week	23,6	29,0	11,9	23,1
More often	9,0	11,6	7,1	10,3

According to the Norwegian Institute of Public Health, 36% of the population drank weekly in 2016, 25% monthly, 22% less often and 18% never (Skretting, Vedøy, Lund & Bye, 2016). Men consumed twice as much as women. Consumption is highest among adolescents and young adults. Nonetheless, those who are 65 years or older drink most frequently even though their alcohol consumption is the lowest (Skretting et al., 2016). In our study, an almost equal percentage of women to that found in the general population consumed alcohol weekly, but men drank more frequently.

The Oslo Health Study [HUBRO] did not show any clear association between how often those exposed to violence and abuse drank alcohol. They did find, however, a significant relationship between exposure in adulthood and the amount of alcohol consumed (Hjemdal, Sogn & Schau, 2012). The violence and rape in Norway study (Thoresen & Hjemdal, 2014) also found a significant relationship between exposure and the frequency of intoxication (defined by drinking more than five units of alcohol or by stating they felt intoxicated).

The Norwegian Competence Centre on Alcohol and Drugs [Kompetansesenter rus] emphasises that the use of medications by the elderly is high. In particular, people over the age of 70 years use many different medications (Frydenlund, 2011). This is not surprising since the risk of disease increases with age. Frydenlund (2011) points out that many elderly women use psychoactive drugs, which can have more potent effect, for example, a sedative effect, when taken with alcohol.

In the Hordaland Health Study [HUSK], it was found that women, who were exposed to physical violence during the past year, took sleeping pills, sedatives and antidepressants substantially more often than non-exposed women. Exposed men took painkillers and sleeping pills more often (Hjemdal et al. 2012). The Oslo Health Study [HUBRO] showed that the exposed had more types of medications and a higher consumption of the medications than the non-exposed (Hjemdal et al., 2012).

A fine line exists between prescribed usage and incorrect/misuse of sedatives or painkillers. We do not have data on general consumption of medications for the respondents, as such an overview would have been too complex for this survey. Nonetheless, the respondents were asked how often they used medications as an intoxicant. The answers are presented in Table 5.3.

Table 5.3 Use of medications for intoxication in the past 12 months. Percentages

	Violence and/or Abuse			
	Never	**Up to 65 years only**	**After 65 years only**	**Before and after 65 years**
Women	**N=381**	**N=65**	**N=31**	**N=26**
Never	71,7	69,2	58,1	42,3
Once per month or less	8,1	9,2	9,7	7,7
Two-three times per month	3,9	6,2	3,2	11,5
Once per week	1,6	3,1	3,2	0
Two-three times per week	3,4	3,1	3,2	7,7
More often	11,3	9,2	22,6	30,8
Men	**N=447**	**N=92**	**N=27**	**N=28**
Never	73,2	76,1	59,3	46,4
Once per month or less	5,1	5,4	0	3,6
Two-three times per month	0,7	1,1	0	3,6
Once per week	1,8	2,2	0	0
Two-three times per week	1,3	0	3,7	10,7
More often	17,9	15,2	37,0	35,7

Concerning use of medications as an intoxicant, we found significant differences between the male groups (p=0.011), but not for women (p=0.156). The percentage of men who do not use medications as an intoxicant is lower than for those exposed after the age of 65 years. At the same time, the percentage who use medications is often higher. The tendency seems to be similar for women, but less pronounced for women.

Five respondents (one woman and four men) used other intoxicants instead of alcohol and medications. Three of them used other intoxicants in addition to alcohol. Three used hashish or marihuana and three used other types of intoxicants. All three who used hashish or marihuana were men who had been exposed to violence and/or abuse: Two of them both before and after the age of 65 years and one only before turning the age of 65 years. The two others state that they have not been exposed to violence.

5.2 Perceived health

The questionnaire had eight questions on physical and mental health based on the standardised SF-8™ scale (see the explanation in chapter 2.3). When we compare the respondents in this study with the health measurements in the SF-8™, a score of ‹ 50 will express lower self-perceived health and a score of › 50 is considered better than the general American population, on which the SF-8™ is based.

Of the 2,238 respondents who answered the health questions, 58% (1,317 people) scored more than 50 for physical health. The figures were 52% for women and 65% for men. For mental health, 72% (1,610 of 2,241 people) scored higher than 50. Of these, 66% were women and 78% men. Most of our sample, especially among the men, considered their health better than average for the American population in 1998. In comparison, 55% of the sample (N=2021) in the Irish study scored more than 50 for physical health (slightly more men than women). For mental health, the result was 74% and here no gender differences were seen (Naughton et al., 2010).

In the following, comparisons have been made between the four groups of exposed and non-exposed people. First, the results are presented for each question and, to conclude, we provide a complete overview in relation to the health measurements in the SF-8™ for physical and mental health.

Table 5.4 shows that fewer victims believed their health was excellent or good. Many more of the victims perceived that their health was poor compared to those who did not state such experiences.

Table 5.4 Self-perceived health in the past four weeks. Percentages

	Violence and/or Abuse			
	Never	Up to 65 years only	After 65 years only	Before and after 65 years
Women	**N=624**	**N=98**	**N=41**	**N=35**
	p<0,001			
Excellent	12,2	10,2	9,8	2,9
Very good	26,6	23,5	22,2	11,4
Good	35,6	31,6	24,4	34,3
Quite good	20,2	29,6	34,1	31,4
Poor	5,0	5,1	9,8	8,6
Very poor	0,5	0	0	11,4
Men	**N=697**	**N=139**	**N=42**	**N=41**
	p=0,002			
Excellent	16,4	18,7	14,3	7,3
Very good	30,8	28,8	16,7	19,5
Good	33,0	30,9	35,7	36,6
Quite good	15,1	16,5	19,0	22,0
Poor	4,7	4,3	9,5	14,6
Very poor	0	0,7	4,8	0

The tendency was the same in the Oslo Health Study (HUBRO) survey where 8,185 women from the age of 30 to 60 years answered questions related to violence and abuse. One of the questions was related to how they perceived their own general health (Hjemdal et al., 2012). Here significant differences were found between the exposed and non-exposed women. Of the women, who had been exposed to abuse both in childhood and adulthood, 37% considered their health to be poor or not quite satisfactory. This also applied to 36% of those had been exposed to at least one incident during the past year, whilst 18% of the women exposed to violence gave the same answer (Hjemdal et al., 2012).

In our study, the groups who considered their state of health was poorer had also experienced limitations in physical activity during the past four weeks. We also found significant differences here (Table 5.5).

Table 5.5 Physical health limiting normal physical activity in the past four weeks. Percentages

	Violence and/or Abuse			
	Never	**Up to 65 years only**	**After 65 years only**	**Before and after 65 years**
Women	**N=625**	**N=96**	**N=41**	**N=38**
	p=0,003			
Not at all	56,3	54,2	51,2	28,9
Slightly	24,6	26,0	22,2	28,9
Some	11,7	13,5	7,3	23,7
Quite a lot	6,7	5,2	17,1	10,5
Incapable of doing physical activities	0,6	1,0	2,4	7,9
Men	**N=697**	**N=140**	**N=42**	**N=42**
	p=0,025			
Not at all	62,4	61,4	59,5	45,2
Slightly	21,4	21,4	19,0	19,0
Some	9,6	10,7	16,7	19,0
Quite a lot	5,6	6,4	4,8	9,5
Incapable of doing physical activities	1,0	0	0	7,1

Reduced physical activity can affect the ability to carry out daily chores. As presented in Table 5.6, this is particularly the case for exposed women, especially those who reported incidents both before and after turning the age of 65 years.

Table 5.6 Physical health and limitations when performing daily chores in the past four weeks. Percentages

Difficulty with performing daily chores at and beyond one's home	Violence and/or Abuse			
	Never	Up to 65 years only	After 65 years only	Before and after 65 years
Women	**N=626**	**N=98**	**N=41**	**N=38**
	p<0,001			
Not at all	61,5	54,1	56,1	28,9
Slightly	24,3	31,6	17,1	31,6
Some	10,1	10,2	7, 3	18,4
Quite a lot	3,4	4,1	19,5	13,2
Incapable of performing daily chores	0,8	0	0	7,9
Men	**N=697**	**N=139**	**N=42**	**N=41**
	p=0,034			
Not at all	70,7	69,1	57,1	51,2
Slightly	18,9	20,1	21,4	22,0
Some	6,7	6,5	16,7	12,2
Quite a lot	2,9	2,9	4,8	9,8
Incapable of performing daily chores	0,7	1,4	0	4,9

Bodily pain may be caused by mistreatment. In the British study, 11% of the victims (N=55) reported bodily pain. All these stated that they had been exposed to physical violence or neglect during the past year (O'Keeffe et al., 2007). In our study, we found significant differences between exposed and non-exposed men in bodily pain during the previous four weeks. As presented in Table 5.7, the picture is not quite as clear for women. The presence of pain may be caused by reduced health.

Table 5.7 Presence of bodily pain in the past four weeks. Percentages

	Violence and/or Abuse			
	Never	**Up to 65 years only**	**After 65 years only**	**Before and after 65 years**
Women	**N=625**	**N=98**	**N=41**	**N=38**
	p=0,051			
Not at all	26,7	17,3	17,1	13,2
Slightly	242,2	45,9	46,3	31,6
Some	18,6	17,3	22,0	34,2
Quite a lot	8,3	11,2	7,3	7,9
Very much	1,8	4,1	4,9	2,6
All the time	2,4	4,1	2,4	10,5
Men	**N=698**	**N=139**	**N=42**	**N=41**
	p=0,004			
Not at all	39,3	34,5	28,6	14,6
Slightly	43,3	42,4	42,9	43,9
Some	11,7	10,8	14,3	31,7
Quite a lot	3,3	9,4	4,8	4,9
Very much	0,6	0,7	2,4	2,4
All the time	1,9	2,2	7,1	2,4

Poor self-perceived health and more bodily pain can affect the energy level of the person concerned in daily life. Table 5.8 shows that exposed men find they lack energy. We did not find any significant differences for women.

Table 5.8 Energy levels in the past four weeks. Percentages

	Violence and/or Abuse			
	Never	Up to 65 years only	After 65 years only	Before and after 65 years
Women	**N=598**	**N=95**	**N=35**	**N=35**
	p=0,429			
No energy at all	5,0	4,2	11,4	11,4
Slightly	20,4	25,3	20,0	31,4
Some	34,6	30,5	34,3	34,3
Quite a lot	35,3	36,8	28,6	22,9
Very much	4,7	3,2	5,7	0
Men	**N=639**	**N=130**	**N=39**	**N=38**
	p=0,012			
No energy at all	3,6	5,4	2,6	15,8
Slightly	13,9	12,3	23,1	21,1
Some	32,3	28,5	33,3	34,2
Quite a lot	42,9	50,8	33,3	23,7
Very much	7,4	3,1	7,7	5,3

Even though there were no significant differences between exposed and non-exposed women in their perceived day-to-day energy levels, the results may indicate that elderly women generally experience low energy levels more than men. If we look at the four groups combined, 27% (206 of 763 women) of the women and 19% (159 of 846 men) of the men had experienced little or no energy during the past four weeks. This did not depend on whether they had been exposed to violence or not. Concerning the ability to take part in social activities, we found differences between the exposed and non-exposed for both women and men (Table 5.9).

Table 5.9 Social activities with family and friends in the past four weeks. Percentages

Physical health or emotional problems affected normal social activities	Violence and/or Abuse			
	Never	Up to the age of 65 years	After the age of 65 years only	Before and after 65 years
Women	**N=597**	**N=95**	**N=35**	**N=36**
	p<0,001			
Not at all	68,0	52,6	42,9	19,4
Slightly	19,9	33,7	40,0	38,9
Some	8,2	7,4	5,7	22,2
Quite a lot	3,2	5,3	11,4	8,3
Incapable of taking part in social activities	0,7	1,1	0	11,1
Men	**N=638**	**N=128**	**N=39**	**N=38**
	p=0,005			
Not at all	71,6	67,2	59,0	34,2
Slightly	19,9	24,2	25,6	34,2
Some	5,5	6,3	7,7	23,7
Quite a lot	2,7	2,3	7,7	7,9
Incapable of taking part in social activities	0,3	0	0	0

Interviews with the elderly in the British prevalence study showed that the exposed had little desire to leave their homes to be with others. They felt lonely and isolated and considered it a consequence of being a victim (Mowlam, Tennant, Dixon & McCreadie, 2007). They expressed a feeling of shame and disappointment that someone they trusted had treated them in such a terrible way. In the case of intimate partner violence, it was the spouse who actively prevented the victim from having contact with family and friends (Mowlam et al., 2007).

The same factors could also be present in our study: Substantially more victims state that physical health and emotional factors affect their normal social activities (Table 5.9). Also, more victims than non-victims state that they have suffered from emotional problems, as shown in Table 5.10.

Table 5.10 Affected by emotional problems in the past four weeks. Percentages

	Violence and/or Abuse			
	Never	**Up to 65 years only**	**After 65 years only**	**Before and after 65 years**
Women	**N=597**	**N=96**	**N=35**	**N=36**
		p<0,001		
Not at all	65,2	46,9	40,0	22,2
Slightly	28,0	36,5	20,0	27,8
Some	4,5	13,5	28,6	27,8
Quite a lot	2,2	3,1	11,4	11,1
Very much	0,2	0	0	11,1
Men	**N=637**	**N=130**	**N=39**	**N=38**
		p<0,001		
Not at all	74,4	61,5	38,5	21,1
Slightly	20,4	30,8	46,2	50,0
Some	3,3	4,6	10,3	23,7
Quite a lot	1,7	3,1	5,1	2,6
Very much	0,2	0	0	2,6

The answers to the last question in the SF-8™, presented in Table 5.11, support the answers to the other questions: Women and men exposed to violence consistently score lower for self-perceived health. The answers also show that both physical and psychological factors affect their daily lives.

Table 5.11 Personal and emotional problems that prevented the performance of usual tasks and daily activities. Percentages

	Violence and/or Abuse			
	Never	Up to 65 years only	After 65 years only	Before and after 65 years
Women	**N=598**	**N=96**	**N=35**	**N=36**
	p<0,001			
Not at all	77,4	68,8	60,0	47,2
Slightly	15,7	24,0	22,9	22,2
Some	5,4	4,2	11,4	16,7
Quite a lot	1,2	3,1	5,7	5,6
Incapable of carrying out daily activities	0,3	0	0	8,3
Men	**N=637**	**N=130**	**N=39**	**N=37**
	p=0,001			
Not at all	83,2	82,3	69,2	56,8
Slightly	12,6	13,1	17,9	16,2
Some	3,0	3,8	10,3	13,5
Quite a lot	0,9	0,8	2,6	10,8
Incapable of performing daily activities	0,3	0	0	2,7

The tables in this chapter show how the respondents scored for each question on the SF-8™. This instrument gives scores for the respondents'' general health, and physical and mental health separately. A higher score on the SF-8™ means better health.
At the beginning of this chapter, we presented the overall score for the health questions of those who took part in the study. In the following, we have made the same comparisons, as in the previous tables, for each gender between the four groups of respondents.

5.2.1 Health measurements in SF-8™, victims and non-victims

If we look at all the respondents combined, we find that the victims' scores for general health, and mental and physical health, are lower than for non-victims. Those who have been exposed before and after turning the age of 65 years have the poorest health. The least difference from the non-victims is seen among those who were only exposed before turning the age of 65 years.

General health

For men, we found significantly poorer general health among those who had been exposed to violence or abuse before and after turning the age of 65 years (p=0,024) compared to non-exposed men. We did not find any significant difference between men who had only been exposed before or after turning the age of 65 years and the non-exposed men. Similarly, for women, only those who had been exposed before and after turning the age of 65 years had significantly poorer general health than those who not been exposed (p‹0,002).

Mental health

In relation to mental health, we did not find any significant differences between men who had only been exposed before turning the age of 65 years and the non-exposed. However, men who were exposed after turning the age of 65 years (p=0.016) or before and after turning the age of 65 years (p‹0.001) had significantly poorer mental health than the non-exposed. For women, there were also significant differences compared to non–exposed women, for both those who had only been exposed after the age of 65 years (p=0.026) or before and after the age of 65 years (p‹0.001). We did not find any significant differences for those who had been exposed before turning the age of 65 years.

Physical health

We did not find any significant differences in physical health between the victims and non-victims; for neither the women nor the men separately. Nevertheless, we did find a significant difference compared to non-victims for those who had been exposed both before and after the age of 65 years when looking at both genders combined (p=0.002).

In summary, this means that the elderly victims assessed their general health, especially their mental health, as poorer than non-victims. This was particularly noticeable for people who had been exposed both before and after turning the age of 65 years. This group also experienced that their physical health as poorer than the other respondents.

The results are consistent with the findings of the Irish study (Naughton et al., 2010). Here, it was found that it was more than three times more likely that the respondents who scored below the average

for physical health (<50 in SF-8™) were exposed to violence, abuse or neglect. For mental health, it was six times more likely that those who scored below the average were exposed (Naughton et al., 2010).

5.3 Chronic conditions

More than half (57.4%) of the 2,356 respondents, who answered the question, had suffered from a chronic condition or other health problems during the previous six months. The percentage was slightly higher for women (60.8%) than for men (54.1%). Table 5.12 shows that more victims, both men and women, have chronic conditions compared to non-victims. The percentage is particularly high for women who have been exposed before and after turning the age of 65 years.

Table 5.12 Presence of chronic conditions

		Violence and/or Abuse				p-value
		Never	Up to 65 years only	After 65 years only	Before and after 65 years	
Women (N=782)	N	344	64	26	34	0,009
	%	56,3	69,9	63,4	89,5	
Men (N=905)	N	348	89	24	28	<0,001
	%	50,9	63,6	61,5	66,7	

The Oslo Health Study (HUBRO) also found that exposed women had more diseases than the non-exposed. Significantly more had hay fever, fibromyalgia and asthma (Hjemdal et al., 2012). Women who had been exposed in both childhood and adulthood had a 4.5 times higher risk of having a heart attack compared to the non-exposed (Hjemdal et al., 2012). The Swedish study on violence and health investigated who had undergone a heart attack during the previous five years. Heart attacks in women between the age of 56 to 74 years, who had been exposed to severe sexual violence in adulthood, were approximately four times more common compared to those who had not been exposed. For the women who reported severe sexual abuse in childhood, heart attacks were twice as common (NCK, 2014). Our study also found significant differences (p=0.015) between exposed and non-exposed women in cardiovascular diseases (including heart attacks). For men, the correlation was not as clear (p=0,054).

Table 5.13 shows the disorders or chronic conditions that were most frequently stated as the cause of the health problems. In addition, skin diseases, gastrointestinal disorders, uterine disorders and other conditions were also reported. Since the occurrences in each of these categories, were relatively low, they have not been included in the table. Diseases of the nervous system have not been included either, as we did not find any significant differences between the exposed and the non-exposed group concerning these diseases.

Table 5.13 Cause of health problems – illness, injuries or disorders

			Violence and/or Abuse				
			Never	**Before 65 years only**	**After 65 years only**	**Before and after 65 years**	**p-value**
Musculoskeletal disorders	**Women** (N=804)	N	180	36	11	18	0,042
		%	28,8	36,7	26,2	47,4	
	Men (N=924)	N	98	23	6	10	0,342
		%	14,0	16.4	14,3	23.8	
Cardiovascular diseases	**Women** (N=804)	N	44	10	7	7	0,015
		%	7,0	10,2	16,7	18,4	
	Men (N=924)	N	113	31	2	8	0,054
		%	16,1	22,1	4,8	19,0	
Cerebral stroke	**Women** (N=804)	N	5	1	1	5	‹0,001
		%	0,8	1,0	2,4	13,2	
	Men (N=924)	N	24	3	1	2	0,815
		%	3,4	2,1	2,4	4,8	
Fall injuries. accidents or similar	**Women** (N=804)	N	19	3	1	7	0,001
		%	3,0	3,1	2,4	18,4	
	Men (N=924)	N	27	6	1	5	0,083
		%	3,9	4,3	2,4	11,9	
Cancer	**Women** (N=804)	N	19	3	5	3	0,018
		%	3,0	3,1	11,9	7,9	
	Men (N=924)	N	48	14	7	3	0,084
		%	6,9	10,0	16,7	7,1	
Mental disorders	**Women** (N=804)	N	7	4	1	7	‹0,001
		%	1,1	4,1	2,4	18,4	
	Men (N=924)	N	3	0	5	5	‹0,001
		%	0,4	0	11,9	11,9	

			Violence and/or Abuse				
			Never	Before 65 years only	After 65 years only	Before and after 65 years	p-value
Respiratory disease	Women (N=804)	N	59	10	4	5	0,897
		%	9,4	10,2	9,5	13,2	
	Men (N=924)	N	51	13	5	9	0,013
		%	7,3	9,3	11,9	21,4	
Metabolic disease or overweight	Women (N=804)	N	65	20	6	10	0,003
		%	10,4	20,4	14,3	26,3	
	Men (N=924)	N	47	7	3	1	0,630
		%	6,7	5,0	7,1	2,4	

We found clear gender differences. Many more exposed women had most types of chronic conditions compared to the non-exposed women. This was not the case, however, for men. There were two exceptions: More exposed men had respiratory diseases compared to the non-exposed men ($p=0.013$). Here there were no significant differences for women. For mental disorders we found significant differences for both exposed women and men compared to the non-exposed ($p<0.001$).

Several of the conditions presented in Table 5.13 may have few symptoms if adequately treated. Of the 1,352 respondents with chronic conditions, 40 people commented that they had few symptoms because they received treatment. Fourteen people stated that their health problems were caused by grief, immense loneliness or through nursing others.

Anyway, chronic conditions and other disorders will be a negative factor if a person is exposed to additional strain, such as violence or abuse. Conversely, exposure can also be connected to the development of diseases.

We did not observe significant differences between victims and non-victims regarding reduced vision and wearing glasses ($p \geq 0.150$). Nevertheless, as shown in Table 5.14, there were significant differences in whether vision was so reduced that it prevented them from performing daily chores, even with the aid of glasses or other low vision assistive devices.

Table 5.14 Impaired vision when wearing spectacles/visual aids

		Violence and/or Abuse				p-value
		Never	Up to 65 years only	After 65 years only	Before and after 65 years	
Women (N= 788)	N (%)	16 (2,6 %)	5 (5,3 %)	3 (7,3 %)	6 (16,2 %)	p=0,001
Men (N=900)	N (%)	11(1,6 %)	6 (4,3 %)	0	3 (7,5 %)	p=0,030

In loss of hearing, we did not find any significant differences. ($p \geq 0.122$). In all four groups, the percentage of women who stated that someone had told them they had poor hearing was between 29.8% and 43.9%. For men it was between 45.3% and 53.7%. There were no significant differences between the groups in relation to using hearing aids ($p \geq 0.194$) and whether they still had problems hearing when using hearing aids ($p \geq 0.076$). Nevertheless, we did find significant differences in being able to hear without hearing aids for both women (p=0.001) and men (p=0.006).

The findings presented in this chapter indicate that exposure to violence both earlier in life and in old age predisposes victims to reduced health and quality of life.

6 Contact with Others, Support Services and the Legal System

Few of the victims told others about the violence they were exposed to or took contact with the support services or legal system. The lack of contact is an interesting finding, as it highlights the fact that when the elderly are exposed to violence, they rarely involve others in their problems. One possible reason is that they have no one they can trust and therefore no one with whom they can discuss their situation.

Table 6.1 shows that significantly more victims did not have anyone to talk to about happy moments, concerns and worries.

Table 6.1 Victims and non-victims who do not have anyone they trust to talk to.

		Violence and/or Abuse				p-value
		Never	Up to 65 years only	After 65 years only	Before and after 65 years	
Women (N=730)	N	26 of 570	7 of 87	8 of 37	9 of 36	<0,001
	%	4,6	8,0	21,6	25,0	
Men (N=841)	N	67 of 638	13 of 124	11 of 40	8 of 39	0,005
	%	10,5	10,5	27,5	20,5	

The table shows cases when exposure to violence is known, as well as valid answers to the question related to whether they have anyone they trust to talk to.

We do not have any information about the respondents' social network. As a result, we do not know if the situation changed with regard to social contacts after the person was exposed to violence or abuse in old age. If a person does not have anyone they trust to talk to, it could indicate that their social network is limited.

Who the victims spoke to about the violence they experienced after turning the age of 65 years

Of those (58 people) who reported severe or less severe violence after they turned the age of 65 years, 15 answered that they had not

told anyone about the violence. Thirty of the victims stated they had told family and friends about the incidents.

Of the 16 people who reported severe sexual abuse after turning the age of 65 years, we only received two answers. One victim had told others about the abuse (not family, friends or health personnel) and one had not done so. Fourteen were exposed to less severe sexual abuse. Two told family or friends and three stated they had not told anyone.

Overall, for violence and abuse after turning the age of 65 years, we received 14 ticks indicating that health personnel had been informed about it and 19 of the victims had ticked the relevant box to indicate they had told others.

Who the victims spoke to about the violence they experienced before turning the age of 65 years

For severe sexual abuse before turning the age of 65 years, 123 people said they had been exposed, 48 of these victims had not told anyone, 47 had told family or friends, 14 had informed health personnel and twelve had told others.

Only two victims stated that they had used a telephone helpline, and this was in connection with incidents before turning the age of 65 years.

6.1 Support services

Of the 168 people who reported violence or abuse (not neglect) after turning the age of 65 years, 110 answered the question on contact with the support services. Only 11 stated that they had had such contact. Most of them (six victims) had been in contact with at least one of the services and one victim had been in contact with all eight of the services. The answer to this question has probably been under-reported, as fewer stated that they have been in contact with the police (two people) compared to those who later stated that they reported the violence (nine people).

One to two victims had been in contact with one or more of these services: helplines, family protection offices, lawyers, police,

accident and emergency centres, home care services or other. A few more had been in contact with their GP (four victims) and a psychologist/psychiatrist (eight victims).

None of the victims stated that they had contacted a crisis shelter, the Protective Services for the Elderly in Oslo, Bærum or Trondheim or the Protective Services for the Elderly - National Helpline.

6.2 The legal system

The questions related to reporting incidents to the police applied to severe physical violence and severe sexual abuse. Few victims reported the violence or abuse.

Reporting physical violence after turning the age of 65 years

Of the 30 respondents who had been exposed to severe physical violence after turning the age of 65 years, only nine persons, including two woman, had ever reported it to the police. An investigation was opened for two of the victims. One was dismissed and the other went to court where the perpetrator was sentenced.

Thirteen victims stated the reason for not reporting violence. Seven of them stated one reason each. None of the victims used the comments box to state other reasons for not reporting the violence, but two explained the circumstances surrounding the episodes of violence.

Table 6.2 Reasons why physical violence since 65 years was not reported

	Number of statements from victims (N=13)
Considered it too trivial	7
Did not want the perpetrator to be punished	6
Did not have any visible injuries	5
Considered it was a family matter and not a case for the police	4
Did not think that it should be reported	3

Most of the victims believed the matter was too trivial to report to the police or the victim did not want the perpetrator to be punished. In addition to the reasons given in Table 6.2, three thought the police

could not help, one stated that they feared the police would not believe what he/she told them, and one person thought the police would not be very understanding.

Reporting sexual abuse after turning the age of 65 years

None of the 16 victims who reported severe sexual abuse after turning the age of 65 years stated that they had reported the matter to the police. Four of the victims (three women and one man) provided an answer explaining why they had not reported the abuse. The three women stated one reason each, i.e. did not think it should be reported, did not have any visible injuries, did not want any more humiliation. The man did not think it should be reported and considered it trivial. In addition, he did not want a court case or the perpetrator to be punished. None of the victims used the comments box to state other reasons as to why the abuse was not reported.

Reporting physical violence before turning the age of 65 years

The questions related to reporting violence to the police initially concerned incidents that occurred after the respondent had turned the age of 65 years, which should have been more clearly explained. Due to the lack of clarity, most of the victims who had been exposed only before turning the age of 65 years, also answered the questions.

It was found that 294 people had been exposed to severe physical violence before turning the age of 65 years, but not afterwards. Of these, 259 answered that they had not reported physical assaults after the age of 65 years. Of the 259 victims, 158 crossed off one or more reasons for not reporting the violence.

We cannot say whether the stated reasons are the most common or important, because not all the victims (294 people) answered the question about why the violence was not reported. Nevertheless, it may be interesting to know the given reasons, as it forms an experiential basis that will probably play a role in potential future exposure to violence. Most stated that they did not think the violence could be reported or thought it was too trivial.

Table 6.3 Reasons why physical violence before the age of 65 years was not reported.

	Number of statements from 158 victims after physical assault
Considered it too trivial	63
Did not think that it should be reported	61
Did not have any visible injuries	25
Considered it was a family matter and not a case for the police	25
Did not want the perpetrator to be punished	15
Did not think the police could help	13
Frightened it would only lead to more violence/abuse	6
Did not think the police would show much understanding	5
Frightened the police would not believe them	4
Did not want any more humiliation	4
Did not want a court case	3

For incidents before turning the age of 65 years, it was also the case that most victims thought the matter was not important enough to report to the police. In addition to the reasons presented in Table 6.3, three of the victims stated that the police or other persons recommended them not to report the matter. Seventy-one of the victims used the open comments box provided for this question. Most comments were descriptions to contextualise the incidents and to further explain why they had not reported the violence to the police. They explained why employees of the police, health or education services had not reported the violence. One of the five victims of physical assault stated that he/she did not dare to report the matter because of threats. The others trivialised the incidents by saying they were not seriously injured, or the perpetrator had been beaten up and therefore punished. Three of them were exposed to physical violence because they were in a war zone or a similar extreme situation.

A quarter of the comments concerned physical violence as part of parenting or they mentioned that school playground fights and teenage gangs were part of their culture when growing up and therefore no one considered reporting it. Three of the elderly were exposed to physical violence from their children and this was explained by the child in question having a mental illness or impaired cognitive ability.

7 Discussion

This study is the first national prevalence study on violence and abuse against the elderly in Norway. The study estimates that the prevalence of physical violence, and sexual, psychological and financial abuse against the elderly after turning the age of 65 years is between 6.8 and 9.2%. Most of the violence against the elderly is carried out by a person close to the victim. Approximately eight out of ten victims had a close relationship with the perpetrator.

As of 1 January 2017, the population of Norway consisted of 830,219 people between the age of 65 and 90 years (Norwegian Statistics, 2017a) If the aforementioned prevalence figures are used as a basis for this population age cohort, it means that 56,500 to 76,000 elderly people have experienced at least one incident of violence or abuse after turning the age of 65 years. Similarly, 5.2% (approx. 43,000 people) were exposed to at least one incident of violence, abuse or neglect during the past twelve months with no differences in number between men and women. In relation to this, approximately nine out of ten victims had a close relationship with the perpetrator.

In the national prevalence study on violence and rape in Norway, the prevalence rate for rape at some point in one's life was 9.4% for women and 1.1% for men (Thoresen & Hjemdal, 2014). Severe physical violence was reported by 22.5% of the women and 45.5% of the men. We cannot make any direct comparisons with our study due to differences in some of the questions and answer choices. For example, our study includes several questions related to severe sexual abuse that is not defined as rape pursuant to the Norwegian Criminal Code (2005). Nonetheless, a diligent comparison between the national prevalence study on violence and rape and our study shows large differences in the prevalence figures.

Of the 1,895 (out of 2,463) respondents that formed the basis for comparison between groups of victims and non-victims of violence among the respondents in our study, 18.5% (349 people) stated that

they had been exposed to severe physical violence and/or severe sexual abuse at least once in their lives. Overall, we did not find significant differences between the genders. If we distinguish between physical violence and sexual abuse, however, significantly more women than men had experienced severe sexual abuse before turning the age of 65 years. For severe physical violence before turning the age of 65 years, it was the opposite: Significantly more men than women had experienced such violence. These types of gender differences were not found after turning the age of 65 years.

The results of this study indicate that the prevalence of violence and abuse in elderly cohorts is lower than in the younger cohorts. We do not know why the older adults appear to be less exposed to violence than younger adults. The low prevalence rate could be due to various reasons. For example, the elderly may have been less exposed to violence in younger years compared to younger cohorts today, i.e. violence has increased in the younger age cohorts. Older adults may under-report incidents and younger adults may over-report. It may also be the case that the samples are divergent, i.e. few of those in the sample of elderly people may have been exposed to violence or too many of those in the general population survey on violence and rape may have been exposed.

In addition, other potential divergencies in our study may have affected the results. This has been explained in chapter eight, which deals with the strengths and limitations of the study.

7.1 Matters that potentially affect reporting

As we get older and our lives progress, we process and adapt our life stories to the circumstances around as they change (Haugen & Krüger, 1999). Incidents in the distant past may be less significant than when the abuse took place and not remembered as well anymore (Piispa, 2004). Piispa (2004) emphasises that for women who live with intimate partner violence over a prolonged period of time there is a tendency for the more serious incidents to overshadow the less serious ones . This may be the reason why the respondents in our study reported almost as much severe physical violence (30 people) as less severe violence (28 people) after they had turned the age of 65 years.

Luoma and Manderbacka (2008) tried to find an explanation as to why elderly Finnish women reported less intimate partner violence in surveys than younger women. The researchers pointed out that there has been a change in social culture in respect of attitudes towards violence in close relationships. It has also become clearer in Norwegian society that violence is not acceptable. This is indicated through legislation, the efforts of the authorities to reduce violence and abuse, as well as the media's attention to these problems, etc.

The oldest participants in our study were born in 1926 and the youngest in 1950. These have lived during an era where the concept of violence has undergone considerable change (Hjemdal, 2014). When they grew up, chastisement of family members was allowed. Legislation prohibiting the physical punishment of children was not passed until 1987. Several of the respondents in our study commented that physical violence was part of parenting in those days. Now, the emphasis is not only on the type of actions that are carried out, but also on the effects of those actions (Hjemdal, 2014). Luoma and Manderbacka (2008) believe that this has resulted in younger women being able to define unacceptable actions as violence and abuse more often than what elderly women can.

In addition, Luoma and Manderbacka (2008) point out that other cultural changes may play a role in reporting violence. The culture of younger women involves more openness surrounding their experiences of abuse and sharing it with others. Talking with others about one's experiences can elicit other types of awareness about the incidents, so they are remembered better. The results of our study may indicate that such openness about violence and abuse is not as common in the elderly population. Firstly, approximately a quarter of those exposed to violence after turning the age of 65 years had no one they trusted to talk to. Thus, they also have less opportunity to share their experiences and problems with others. Nevertheless, elderly victims of violence do not tend to tell anyone about the violence, or if they do, it is generally family or friends.

In 2006, Hjemdal and Juklestad at NKTS published a study about how the elderly perceive violence and abuse, and the reporting of abuse.

Similar surveys were conducted in five other countries (the USA, Japan. Korea, Belgium and Finland). The results indicated that elderly Norwegians largely held the view (more than among the elderly in the other countries) that elder abuse should be kept within the family without any intervention from others. This was considered one of the most important reasons why elderly victims did not contact the support services. Hjemdal and Juklestad (2006) did not find any clear reasons for such reluctance from Norwegians. They highlighted that it could be due to methodical differences in the way the countries conducted the surveys, but that it could equally be due to cultural factors and that the specialised services for elderly victims have barely been established in Norway and are little known to the respondents.

The findings of our survey may suggest that many of the elderly continue to regard this problem as a private matter. It is possible that this need to keep abuse secret contributed to the situation in which only 13 of the 127 people exposed to violence during the past year, provided an answer that described their situation at the time of the survey. Of these, four stated they were still exposed to violence.

Under-reporting may also be the reason why the elderly do not consider the situation as abusive. With financial abuse, there is a fine line between what the elderly consider to be freely given gifts and what they give to others as a result of being pressured, harassed or threatened (Sandmoe, Kirkevold & Ballantyne, 2011). It takes a lot for elderly parents to refuse their adult children financial support. Even if such support leads to additional financial problems and anxiety in their daily lives, it is difficult for them to acknowledge that they are a victim of financial abuse (Jonassen & Sandmoe, 2012).

Regardless of the type of violence the elderly are exposed to, it could be a significant barrier in telling others about their situation and seeking help if the perpetrator is their own adult child. At the same time, remaining silent about the violence or redefining the problem is a coping mechanism to help the elderly maintain their dignity and integrity in what is considered an acceptable parent-child relationship (Sandmoe & Hauge, 2014). Both the local community and society as a whole may have the attitude that an elderly victim has failed as a

parent and deserves what he or she gets (Erlingsson, Saveman & Berg, 2005). This may contribute to elderly victims focusing on causes 'beyond themselves', leading the elderly to consider their adult children to be victims - who cannot adapt to society or who have taken the wrong course for other reasons. When the elderly contact the support services, it is generally to get help for their adult children; not for themselves (Jonassen & Sandmoe, 2012).

7.2 Insufficient contact with the support services

When violence is considered a private matter, the victim may be reluctant to contact the support services. Of the 168, who reported that they were exposed to violence or abuse after the age of 65 years, only 11 stated that they had contacted the support services. This does not only apply to elderly victims, as younger victims of violence rarely contact the support services as well. In the NKVTS study on violence and rape, 60% of the women exposed to violence and 70% of the men had never discussed their experiences with health personnel (Thoresen & Hjemdal, 2014).

If the victim does not take contact with the support services, there is also less chance that violence and abuse is reported. In our study, nine of the 30 victims of severe physical violence after the age of 65 years reported incidents to the police. None of the 16, who were exposed to severe sexual abuse, had done the same. Additionally, none of those who stated exposure to physical violence earlier in life had reported the matter to the police. Two reasons were particularly given: Victims of violence did not think the matter should be reported or they felt it was too trivial.

The reluctance of victims to report violence and abuse that fall under the provisions of the Norwegian Criminal Code (2005), is also seen in cases of domestic violence recorded by the police. Aas (2015) points out that the percentage of elderly people over the age of 62 years in the population as of January 2015 was 19.4%, but only 3.4% cases of domestic violence were recorded. In 2014, most domestic cases of violence concerned young people in their 20s (1,776).

The prevalence dropped with age. There were 674 cases for people in their 50s, but only 258 cases for the elderly (aged 62-100 years). In particular, Aas points out two possible reasons for this. It could be that fewer elderly people are exposed to abuse than younger people or that elderly people experience greater barriers that prevent them from contacting the police. The findings of our study support both these hypotheses.

Nevertheless, it may be the case that the victim of violence in a close relationship does not believe that a report to the police and a focus on a criminal case will help (Grøvdal, 2014). In our study, 104 (84.4%) of those exposed to violence in the past year had a close relationship with the perpetrator. For most of us, family becomes more important as we get older. Involvement of the police and a potential criminal case could divide a family. Losing contact with close family members could be worse for the victim than living with mistreatment (Lithwick, Beaulieu, Gravel & Straka, 1999). Skårderud (2004) describes family life in this way, “Of all forms of life, family life is the best and the worst. It is both vital and lethal at the same time.”

7.3 Health and exposure to violence

This study shows a clear association between exposure to violence and poor health. The association was especially striking for women and men (80 people) who stated that they had been exposed to violence before and after turning the age of 65 years. Of these, significantly more had chronic conditions and perceived their health to be poorer than those who were not exposed to violence.

A person’s health depends on many factors: Genes, lifestyle and external stress. Apart from the respondents’ use of drugs and alcohol, we have little information about their lifestyles. Sørbø (2014) demonstrates that women who are exposed to violence tend to smoke and have more drug and alcohol problems than women who are not exposed. We did not find any significant differences in terms of how often victims and non-victims drink alcohol, and we do not have any information about how much they drink. We found significant differences in the use of medications as intoxicants for

exposed men, but not for women. The respondents provided information about their use of drugs and alcohol during the past year, but we do not know about consumption earlier in life.

The results from this study may indicate that women are more prone to poor physical health when exposed to violence and abuse, especially if they were also exposed earlier in life. Significant differences were found between the exposed and non-exposed women for most of the specified conditions. Apart from psychological disorders and pulmonary disease, we did not find any differences between exposed and non-exposed men.

In general, more men than women reported injuries such as falls, accidents or similar, but in the case of men, they were not especially connected to exposure to violence. For women, however, they were. This was the also the case in the ABUEL study, which found that most men were exposed to physical violence, but most women sustained injuries from the violence (Soares et al. 2010). In addition to physical injuries, violence and abuse can lead to increased stress affecting the autonomic nervous system and immune system in both the long and short-term (Sørbø, 2014). The balance of the body is disrupted by stress hormones such as cortisol, which can give high or low autonomic activation. Both will lead to a predisposition to physical diseases, for example, cardiovascular diseases and diabetes (Sørbø, 2014). The exposed women in our study had significantly higher prevalence of cardiovascular diseases, metabolic diseases, such as diabetes or overweight, in addition to cancers. Our findings are similar to those found in several other studies on the health status of women exposed to violence (Hjemdal et al., 2012; NCK, 2014).

We obtained a fair amount of data on the physical health of the respondents in this study, but have less information on their mental health, social lives and social support. It is claimed that the neurobiological changes seen in victims of violence may also predispose them to mental disorders (Sørbø, 2014). Significantly more exposed men than women reported mental disorders in our study compared to those who were not exposed to violence. Another consistent finding was that more of the exposed for both genders had burdensome emotional

problems making it difficult for them to carry out daily activities. Both physical and emotional health problems impacted their normal social activities with family and friends. The respondents related their answers to the past four weeks, as a result we do not have any information about their previous mental health or social lives.

Much suggests that victims of violence are at higher risk of isolation than non-victims. Isolation can be a consequence of the perpetrator's need to control the victim. Isolation can also result when a victim of violence loses his/her self-esteem and self-respect leading to little desire to be in the company of others (Mowlam et al., 2007). Of those who reported exposure to violence or abuse after the age of 65 years, approximately a quarter did not have anyone they trusted to talk to. In turn, this can make victims feel socially isolated and lonely.

An interview study with 21 elderly women, who were exposed to violence, highlighted the fact that several had an all-embracing feeling of loneliness (Winterstein & Eisikovits, 2005). Loneliness was just as embedded in themselves as within the family and society, it affected their health, identity, and sense of belonging and placement in the world. The life stories of the elderly who had also been exposed to violence in childhood were filled with a feeling of homelessness. The feeling was exacerbated by repeated intimate partner violence leading to an overwhelming sense of loneliness (Winterstein & Eisikovits, 2005).

7.4 International prevalence studies on violence and abuse

The one-year prevalence of violence, abuse and neglect was between 5.2 and 6.4% , which is slightly higher than the two European studies. In the British study the prevalence was 4% and in the Irish study 3% (Naughton et al., 2010; O'Keeffe et al., 2007). The common factor for all the studies is that prevalence was measured for those over the age of 65 years living at home. The perpetrators of the violence had a trusting relationship with the victim of the violence, for example, a family member, friend, acquaintance or health personnel. Other perpetrators such as strangers were included in both our study and the Irish study.

Comparing the results of international prevalence studies on violence against the elderly living at home is not an easy task. Upon closer inspection, we find methodological differences that will impact the results (Yon et al., 2017) This does not mean, however, that the results of any of these studies are 'correct or incorrect'. Each study needs to be assessed on its own merits. We know what the prevalence is in our study, but we cannot automatically conclude that there is more violence and abuse in the Norwegian society than the British or Irish. It may be the case, but such a conclusion cannot be made based on these studies.

In addition to methods and designs, cultural, religious and social factors in each country will affect how respondents assess their own situation and therefore the answers they give.

In the introductory chapter and Table 1.2, we have included three European studies: the British (O'Keeffe et al., 2007), the Irish (Naughton et al., 2010) and the study that covered seven European countries (Soares et al., 2010). The reports from these studies cite the same reference frame.

Methodological differences in samples, data collection and analysis, however, make it difficult to make direct comparisons. Nonetheless, the quality of research can be good for each study separately (Yon et al., 2017).

The mentioned studies take into consideration the World Health Organization's definition of violence and abuse (2014), but differences exist in the way the definitions are operationalised. Yon et al. (2017) emphasises that the meta-analyses were challenging, especially linked to the categorisation and counting of psychological and financial abuse. Yon states that no response was received from the researchers in several studies despite multiple enquiries. We have also experienced such lack of clarity in our study. In the Irish study, the respondent was to either state ten or more cases of psychological abuse or neglect, or assess one incident as serious in order for it to be considered abuse. Our study does not include this type of additional question related to subjective assessment. The

Irish study does not state how they sum up when there are no exact figures, but just a group of numbers. An e-mail enquiry to the Irish research group regarding this matter was not answered.

In our study, 80 people (3.2%) stated that they had experienced psychological abuse during the past 12 months. This prevalence rate is higher than in the British (O'Keeffe et al., 2007) and the Irish (Naughton et al., 2010) studies, which had 0.4% and 1.2%, respectively. The findings in our study, however, correspond with the interview study on elderly victims conducted by NKVTS in 2011 (Jonassen & Sandmoe, 2012). Of the 30 people, who were exposed to one or multiple types of violence and abuse, 22 stated that they were exposed to psychological abuse.

Thirteen people (0.5%) answered that they had been exposed to financial abuse during the past year, approximately an equal number of women and men. In the British study (O'Keeffe et al., 2007), the prevalence rate was approximately the same (0.7%), but for the Irish study (Naughton et al., 2010) it was 1.3%. This finding was discussed with Dr. Phelan in the Irish researcher group. Phelan explained that the prevalence study was conducted during a period when Ireland was in recession and the difficult financial situation may have affected the prevalence of financial abuse (personal message, 29.11.16).

In order to be classified as exposed to violence in our study, it was enough for the person to state one of the mentioned actions under each type of violence or abuse. Our questionnaire has fewer variables than the Irish questionnaire (Naughton et al., 2010) in that multiple circumstances are collected under one question. Furthermore, most of the variables in our study may be considered as more serious than most of the variables included on the Irish questionnaire. We cannot say how this has affected the prevalence rates in the two studies. Nonetheless, most state psychological abuse in both studies. Such abuse constitutes more than half of the total prevalence of violence, abuse and neglect during the past year. The conclusion is that prevalence studies must be assessed based on their own merits and that comparisons often are neither possible nor desirable.

7.4.1 Risk factors for exposure to violence and abuse in old age

This study shows that an important risk factor for exposure to violence in old age is exposure to severe physical violence or severe sexual abuse earlier in life. Those who stated both severe physical violence and severe sexual abuse before turning the age of 65 years had an eight times higher risk of exposure to one or more types of violence and abuse after turning the age of 65 years compared to those who did not state such earlier life experiences. We did not ask the respondents whether they had experienced other types of violence before turning the age of 65 years. Therefore, we do not know if exposure to less severe physical, sexual, psychological or financial abuse or neglect earlier in life increases the risk. Re-victimisation, i.e. when a person has been violated earlier in life and is violated again, has barely been touched upon in prevalence studies on elder abuse. The reason potentially being that these studies focus on prevalence during the past year and after turning the age of 65 years. Yon et al., (2017) points out that prevalence should be calculated for several time increments, including a life course perspective. Re-victimisation only becomes clear when the life course perspective is emphasised. Neither the ABUEL study (Soares et al., 2010) nor the British study (O'Keeffe et al. 2007) include exposure to violence before the respondents had turned the age of 65 years. In the Irish study, the respondents were asked whether they had experienced abuse before they turned the age of 65 years. More than a third of those exposed after the age of 65 years stated that the abuse started before they turned the age of 65 years with the average age being 62 years. However, the Irish study report (Naughton et al., 2010) does not address this in any further detail.

When testing the instrument Indicators of Abuse (IOA) Screen, 48 different factors were assessed and ranked in relation to the importance of being able to identify the elderly victims of violence (Reis & Nahmiash, 1998). The testing of IOA was part of a three-year training and intervention project for home care in Canada. During a period of eighteen months, 341 client cases were followed up with several assessment visits. The criteria were that the client must be

over 55 years of age and have an informal and unpaid caregiver. The validation of IOA showed that 29 of the factors could differentiate abuse cases from non-abuse cases in up to approximately 85% of the cases (Reis & Nahmiash, 1998).

The researchers developed a model where they compiled eight characteristics of the perpetrator (personal and compassionate) and two characteristics of the elderly victim of violence. The four most important indicators that were linked to the perpetrator were: Abuse of alcohol or other intoxicants, depression or personality disorders, mental health problems or behavioural problems (Reis & Nahmiash, 1998). Our study has not investigated characteristics linked to the perpetrator. As a result, we do not know if the same gross sample apply to the perpetrators in our study.

Reis and Nahmiash found that the most important indicator for exposure to violence or abuse in old age was exposure to violence earlier in life.

The other indicator was insufficient social support (Reis & Nahmiash, 1998). As mentioned in the introduction, our study showed that there was a higher risk of exposure to violence in old age if exposed when 'young'. We did not ask the respondents about their social networks, but the results show that significantly more victims of violence did not have anyone they trusted to talk to. They also state that their physical and psychological health reduces their social activities.

The Norwegian prevalence study on violence and rape from a life course perspective showed that more women than men were exposed to sexual abuse, but more men than women had experienced severe physical violence (Thoresen & Hjemdal, 2014). Meta-analyses of 52 prevalence studies on violence against elderly people showed no significant differences between exposure to violence and gender, even when analysing selected groups under different types of violence (Yon et al., 2017). No significant differences between men and women in relation to exposure to violence after the age of 65 years were found in our study either.

In general, it is difficult to assess the relationship between various sociodemographic factors and exposure to violence. It may be the case that certain factors increase the risk of exposure to abuse, but the same factors may also be a consequence of being a victim of violence. Furthermore, sociodemographic differences may represent divergencies in the sample of the different studies. In all likelihood, the differences are due to 'a bit of everything'. For example, in our study significantly more separated/divorced women, but not men, reported that they had been exposed to violence or abuse before and after the age of 65 years. There were also many more separated/ divorced people among the victims of violence in the Irish study (Naughton et al., 2010). We did not find any significant differences in our study with regard to whether the victim of violence lived alone or with someone else. In contrast, the Irish study found a higher risk of abuse if the elderly person shared a household with others.

Various types of violence and different relationships with the perpetrator can lead to variation in risk factors (Soares et al., 2010). We did not analyse selected groups in our study. The reason being that the sample for each group is limited, etc. Examples of the relevant groups are respondents who were exposed to physical or sexual violence carried out by a partner or the group that was exposed to financial abuse from adult children.

Poor health has been highlighted as a risk factor for exposure to violence or abuse in old age (Naughton et al., 2010; O'Keeffe et al., 2007). In the British prevalence study, 4.8% of the men with self-perceived poor health had been exposed to violence, but only 0.5% of the men with self-reported good health (O'Keeffe et al., 2007). Both our study and the British study found significantly more victims of violence with chronic conditions.

However, the picture could be more nuanced. In our study, those exposed both before and after turning the age of 65 years especially considered their health to be poor. This group also had the largest number of chronic disorders. We can deduce that poor health is associated with exposure to violence. However, it is more uncertain whether poor health is a risk factor or a consequence of violence and abuse or both.

8 Strengths and Limitations of the Study

To estimate the prevalence of violence and abuse in the elderly portion of the population within a given time period, a cross-sectional study was selected for the design.

During the survey, the respondents were asked if they had experienced violence or abuse within three time periods - one covered the twelve month period up to the time of the survey (one-year prevalence). These are incidents that happened recently and are most likely to be remembered by the person. The second period covered incidence for the entire time after the person turned the age of 65 years, including incidents during the past year. For 35 % of the respondents (860 of 2,463 people aged 66-70 years) such incidents would have happened within a timeframe of one to five years. For the oldest respondents, aged 80 to 90 years (416 of 2,463 people), the incidents would have occurred during a time period of up to 25 years. The third time period we wanted to investigate was violence and abuse that had occurred at least once from childhood up to turning the age of 65 years. This means that incidents that occurred during a long lifetime will be brought to life again. Most people are better able to remember incidents that caused an emotional reaction or happened recently. This was a contributory factor in our study with regard to why we only asked respondents about severe physical violence and severe sexual abuse before the age of 65 years.

A cross-sectional study does not explain cause and effect in the way a longitudinal cohort study would have done. Nevertheless, a cross-sectional survey can clarify some associations between different circumstances, which was also done in our study (Martinussen, 2010). In connection with this, it is necessary to remember that not all groups of elderly people are represented in the study. The survey was not adapted for elderly people from minority language groups. Furthermore, the survey does not include the groups of elderly people who are most

probably exposed to violence, abuse or neglect. Elderly people, who are physically or psychologically frail, are at higher risk of exposure to violence from someone they have a close relationship with or other trusted persons such as carers. Such groups are, for example, nursing home patients (Drennan et al., 2012; Malmedal, 2013) and people living at home with cognitive impairment and reduced ability to give consent (Lafferty, Fealy, Downes & Drennan, 2014).

Initially, we did not want an upper age limit for the respondents, as most studies indicate that people over the age of 80 years are at higher risk of abuse (Sethi et al., 2011). An upper age limit of 90 years was, however, set following the recommendation of the Norwegian Centre for Research Data (NSD) to safeguard the anonymity of victims of violence and the perpetrators. The upper age limit may also be sensible for other reasons. Disease and frailty increase with age and impact the ability to take part in a postal survey. The need for health and care services in population groups provides information about reduced physical and/or cognitive functioning. In 2016, 13.7% of citizens over the age of 80 years had a long-term place in an institution. The same applied to only 1.6% aged 67-80 years (Haugan, 2016). It is important to obtain information about exposure among the eldest of old people (aged 90+), however, the method adopted in the study would probably have resulted in a low response rate among the eldest.

Regardless of age, the tendency is that more people in good health will take part in surveys compared to those in poor health. In our survey, 42% of the 2,238 respondents considered their health to be poorer than the health target of 50 in the SF-8™ Health Survey (see chapter 2.3). For comparison, 45% of the 2,021 respondents in the Irish scored less than 50. We expected the difference in the physical health of the respondents in these two surveys to be greater due to the choice of method. For people in poor health, it can be more demanding to answer a postal questionnaire than to be interviewed. When someone asks the questions, the person can clarify misunderstandings and write the respondents answers on the form. In terms of physical health, it does not appear that the chosen method has prevented participants from taking part in the survey. In connection with this, it must be remembered

that it is the person's assessment of their self-perceived health that is being measured - not objective physiological health goals. Cultural differences in the Norwegian and Irish societies may also affect the person's expectations towards their own health in old age, but this is something we do not know.

People with higher education have better health than those with lower or no education (Veenstra & Slagsvold, 2009). People with higher education generally have more experience with academic work potentially making it easier for them to cope with a complex questionnaire. There may be a divergence in the sample for this study, in that a larger portion of the respondents have completed higher education compared to the population on the whole. This was also the case in the prevalence study on violence and rape (Thoresen & Hjemdal, 2014). Here the respondents were interviewed by telephone, as such the divergence is not due to varying degrees of ability to cope with a questionnaire. It may also be the case that those with higher education are more willing to answer questions or easier to reach by telephone, but this is something we do not know. Selection biases such as these, however, can occur in most cross-sectional studies (Martinussen, 2010).

Questionnaires as an instrument for data collection has some advantages, even if they do not outweigh the disadvantages. Postal questionnaires for self-reporting complex topics can be challenging for the respondent, as well as for the researchers who will be analysing the answers. The advantage of a printed questionnaire is that the respondent can review it and obtain an overview of what is being asked. Experiences with violence and abuse may be difficult to tell another person - answering a questionnaire might be easier. In particular, severe sexual abuse could be a sensitive matter to talk about. A questionnaire places distance between the respondent and those requesting the information. It also gives the respondent time to think about earlier experiences. The disadvantages are that the interviewer cannot clarify any misunderstandings, ensure that the instructions on the questionnaire are followed and that the correct box is filled in. Insufficient support while answering the questionnaire may have contributed to the receipt of many forms with inconsistent answers or no answers for parts of the questions.

In the invitation letter sent with the questionnaire, the respondents were informed that Ipsos would telephone everyone who did not return the form. If they felt they were unable to complete the form, but wanted to take part in the survey, they could choose to have a telephone interview with an Ipsos interviewer instead. Few respondents took advantage of this option.

Postal questionnaires have been used in two Swedish prevalence studies on the elderly. The studies were based on the self-reporting of violence and abuse, and a relatively high response rate was achieved. The study in Umeå had a sample size of 1,502 people aged 65-81 years and a response rate of 76% (Eriksson, 2001). The Gotland study had a sample size of 6,457 people aged 65 years or more and a response rate of 52.7% (Kristensen & Lindell, 2013). In our study, the gross sample was 5,371 people aged 66-90 years and the response rate of 45.9%. That is, more than half of those who were invited did not take part in the survey. The reasons for this are unknown. Nevertheless, we interpret the response rate as positive feedback indicating that the study was considered useful and interesting even though it was potentially distressing.

8.1 Respondents' feedback on the actual study

Forty-two of the respondents commented on the content of the survey. Many of them had answered the survey even though it was difficult for them. They wrote that the questions brought up memories they had spent many years trying to forget Fifteen people commented that the survey was less relevant to them and that the questions were provoking and terrible. The comments of seven people indicated that they were negative towards the study. This was expressed with words, such as indignation, nonsense, rude and irritating. Half of the comments (from 23 people) wrote that a study focusing on violence against elderly people was good, important and interesting.

The respondents were asked if they could be contacted again to request their participation in an interview survey. Of the 2,298, who answered this question, 52% (540 women and 654 men) were

positive towards this. At least one type of violence after turning the age of 65 years was reported by 168 respondents. Of these, 60% (50 women and 51 men) said they would like to be contacted again. Of the 127, who reported violence, abuse or neglect in the past year, 76 people said they would like to be contacted again. This applied to an equal number of women and men.

These figures indicate that elderly people are not reluctant to talk about violence and abuse, even though the questions specifically described various sexual acts. From the prevalence study on violence and rape in Norway, it was experientially shown that most of the respondents did not object to answering such questions, not even the eldest respondents aged 65-75 years (Thoresen & Hjemdal, 2014). Nevertheless, it should be remembered that we do not know why half of those invited to take part in the study did not respond.

9 Conclusions and Recommendations

This study indicates that the scope of violence and abuse against elderly people in Norway is extensive and equally as prevalent as in other European countries. The results of the study show that violence and abuse against elderly people in Norway is a severe social and public health problem.

The conclusions in this chapter are related to the results of the four most important areas in this study. We have obtained new information about:

- the scope of violence and abuse in the older population group;
- exposure to violence and the health of the elderly;
- special circumstances that make some people more exposed to violence than others in old age;
- violence in old age continuing to be a hidden problem.

We recommend that these areas are further investigated with the following suggested measures.

9.1 Prevalence of violence and abuse

The study indicates that at least 56,500 people aged 65-90 years living in private households have been exposed to violence or abuse after turning the age of 65 years. Even though the results indicate that fewer elderly adults are exposed to violence compared to younger adults, the scope of violence and abuse against the elderly is extensive.

Postal questionnaires were used as the data collection method for the survey. This resulted in several methodological challenges described in the report. This may have affected the results of the study; new studies should therefore be conducted for the same age group. Based on the experiences gained from this project, we do not recommend

postal questionnaires in future prevalence studies, but preferably more direct and personal types of interviews. Nonetheless, since violence and abuse are taboo for some people, trade-offs must be made to enable questionnaires to be sent to respondents upon request, instead of conducting a telephone interview.

Recommendation:
Carry out another national prevalence study on violence, abuse and neglect in five years with a representative sample of elderly people living at home using telephone interviews as the primary method.

9.2 Health and exposure to violence

The study has highlighted substantial associations between exposure to violence and poor health. Significantly more victims have chronic conditions, self-perceived poor health and emotional problems to such an extent that they affect their daily lives. Fewer victims than non-victims are satisfied with their lives and fewer victims have a trusted person to talk to about pleasures in life, grievances and concerns.

The study has primarily investigated the physical health of the respondents. However, we need more information about the association between violence, abuse and mental health, social networks and what support elderly victims receive from day-to-day.

Recommendation:
A new prevalence study should focus more on the mental health, social networks and social support of the respondents, as well as the help they need.

9.3 Violence and the life course

This study shows that an important risk factor for exposure to violence in old age is the person's exposure to severe physical violence or severe sexual abuse earlier in life. The results from the study support the importance of preventing violence and abuse against children and adolescents. The study has given prevention work another dimension:

From a life course perspective, the prevention of violence and abuse in younger years helps reduce exposure to violence in old age.

Recommendation:
National prevalence studies on violence and abuse should maintain a life course perspective and include younger, elderly and the very elderly age groups in the sample. The prevalence of less severe physical violence and sexual abuse, and the prevalence of psychological abuse throughout the life course should be included in the survey.

We do not know how many respondents had experienced less severe physical violence or sexual and psychological abuse earlier in life. Therefore, we do not know if exposure to these types of violence also increase the risk of exposure to violence in old age. It is important to obtain more information about these areas.

The study has given us information about how many people are exposed to different types of abuse, the relationship they have with the perpetrator and how they perceive their health. However, we do not know how the violence affects their daily lives. Interviews with elderly victims showed that the stories of victims of intimate partner violence were different to those exposed to violence or abuse from their own adult children (Jonassen & Sandmoe, 2012). This study has highlighted a group that is especially exposed in old age, this being people who were also exposed to violence earlier in life. What challenges and experiences this has given them during the course of their lives and how they assess their situation could be valuable information for the support services and violence prevention work.

Recommendation:
Qualitative in-depth interviews with a limited number of people exposed to violence before and after turning the age of 65 years, and who have given consent to be contacted again.

9.4 Hidden violence

Violence and abuse cause victims immense stress and can severely affect the health and lifestyle of the elderly person. Nonetheless, few of the victims contacted the support services and only a few told anyone other than their close family about their experiences. Therefore, professionals must take the initiative to talk about violence and abuse. Health and care personnel who come into contact with elderly people with physical and/or mental health problems, should always investigate whether the elderly person has been exposed to violence recently or earlier in life. This should be included as a routine in the health and care services in the same way as midwives ask pregnant women about exposure to violence (Norwegian Directorate of Health, 2014).

Prevalence studies indicate that approx. 4% of pregnant women are exposed to violence (N.K.S., 2016). A survey in 2016 showed that almost half of the midwives followed the guidelines for asking all pregnant women about exposure to violence. Eleven per cent of the midwives never asked about this. The study also showed that 60% of all the 398 midwives who answered the survey uncovered violence (N.K.S., 2016). Obviously, all midwives should follow the guidelines. We believe that the introduction of guidelines has influenced violence prevention work in connection with antenatal care during pregnancy, even though we do not know how many midwives would have asked about exposure to violence in the absence of the guidelines.

Recommendation:
Introduce guidelines for health and care personnel to ensure that all elderly patients are asked about potential experiences with violence or abuse.

Online campaigns initiated by individuals who have experienced violence, abuse or harassment will rarely capture elderly victims. Equally, it is necessary to neutralise the violence and send an important message: Violence is not a private matter that the victim

and family have to handle alone. Violence is a problem that affects society as a whole and help is available. It could make it easier for the victim to contact the support services.

Recommendation:
Prepare information campaigns to inform people that violence against the elderly is a social problem and not a private one.
The campaign should be aimed at the older part of the population, but also the population at large in the form of general public information.

The purpose of the study was to obtain information about the prevalence of violence and abuse in old age, and to investigate the possible associations between exposure and health. The survey has given us a better understanding of violence against elderly people in Norwegian society, and how it affects the person's health and quality of life. This provides a good basis for further research and for the preparation of prevention measures at the social, services and individual levels.

References

Aas, G. (2015). *Overgrep mot eldre i nære relasjoner og politiets rolle [Abuse of the elderly in close relationships and the role of the police] (PHS Forskning 2015:4)*. Oslo: Politihøgskolen [The Norwegian Police University College].

Action on Elder Abuse. (1995). What is elder abuse? *Action on Elder Abuse Bulletin, 11*.

Amstat News. (2016). The Story Behind the ASA Statement on P-Values. Published 1 April 2016; access date 8 November 2017. http://magazine.amstat.org/blog/2016/04/01/pres-apr16/

Anthony, J. E. (1987). Risk, vulnerability and resilience: an overview. In J. E. Anthony & B. Cohler (Eds.), *The invulnerable child* (pp. 3-48). New York: Guilford Press.

Baker, A. A. (1975). Granny battering. *Modern Geriatrics, 5*, 20-24.

Bonnie, R., & Wallace, R. (Eds.). (2003). Elder Mistreatment: Abuse, Neglect and Exploitation in an Ageing America. Washington CNSTAT, Division of Behavioral and Social Sciences and Education: National Academies Press.

Burnes, D., Pillemer, K., Caccamise, P., Mason, A., Henderson, C., Berman, J., . . . Lachs, M. (2015). Prevalence of and Risk Factors for Elder Abuse and Neglect in the Community: A Population Based Study. *Journal of the American Geriatrics Society, September 63*(9), 1906-1912.

Dong, X. (2015). Elder Abuse: Systematic Review and Implications for Practice. *JAGS, 63*, 1214-1238.

Dong, X., Simon, M., Leon, C., Fulmer, T., Beck, T., Hebert, L., . . . Evans, D. (2009). Elder Self-neglect and Abuse and Mortality Risk in a Community-Dwelling Population. *JAMA, 302*(5), 517-526.

Drennan, J., Lafferty, A., Treacy, M. P., Fealy, G., Phelan, A., Lyons, I., & Hall, P. (2012). *Older People in Residential Care Settings: Results of a National Survey of Staff-Resident Interactions and Conflicts.* Dublin: NCPOP, University College Dublin.

Eriksson, H. (2001). *Ofrid? Våld mot äldre kvinnor och män – en omfångsundersökning i Umeå kommun [Violence against older women and men – a prevalence survey in Umeå municipality].* Umeå: Brottsoffermyndigheten [Swedish Crime Victim Compensation and Support Authority].

Erlingsson, C., Saveman, B.-I., & Berg, A. (2005). Perceptions of Elder Abuse in Sweden: Voices of Older Persons. *Brief Treatment & Crisis Intervention, 5*(2), 213-227.

Fraga, S., Lindert, J., Barros, H., Torres-Gonzales, F., Ioannidi-Kapolou, E., Melchiorre, M., . . . Soares, J. (2014). Elder abuse and socioeconomic inequalities: A multilevel study in 7 European countries *Preventive Medicine, 61*(42-47).

Frydenlund, R. (2011). E*ldre, alkohol og legemiddelbruk; En kunnskapsoppsummering [The elderly, alcohol and prescription drug use; A summary of knowledge].* Oslo: Kompetansesenter rus – Rusmiddeletaten, Oslo Kommune [Norwegian Competence Centre on Alcohol and Drugs; Oslo Muniscipality].

Grøvdal, Y. (2014). Ofre for vold - og ofre for straffesaksfokuset [Victims of violence and victims of the focus in criminal cases]. In K. Narud (Ed.), *Vold mot kvinner [Violece against women].* Oslo: Cappelen Damm Akademisk.

Haugan, L. (Ed.) (2016). *Helse-, omsorgs- og rehabiliteringsstatistikk; Eldres helse og bruk av kommunale helse- og omsorgstjenester [Health-, care and rehabilitation statistics; Elderly people's health and use of municipal health and care services.* Oslo: Helsedirektoratet [Norwegian Directorate of Health].

Haugen, P. K., & Krüger, R. (1999). *Din tanke er din skjebne – Sol Seim og hennes forskning [Your thought is your destiny – Sol Seim and her research].* Spydeberg: Akribe.

Heimer, G., Andersson, T., & Lucas, S. (2014). *Våld och hälsa; En befolkningsundersökning om kvinnors och mäns våldsutsatthet samt kopplingen till hälsa [Violence and health; a population survey on women and men exposed to violence and the connection to health].* Uppsala, Sverige: Nationellt centrum för kvinnofrid [National Centre for Knowledge on Men's Violence Against Women], NCK; Uppsala universitet [Uppsala University].

Helsedirektoratet. (2014). *Nasjonal faglig retningslinje for svangerskapsomsorgen – hvordan avdekke vold [National professional guidelines for pregnancy care – how to uncover violence]. Utgitt 1. april 2014*. Oslo: Helsedirektoratet [Norwegian Directorate of Health].

Hjemdal, O. (2014). Vold mot kvinner – definisjoner, forekomst og risikofaktorer [Violence against women – definitions, prevalence and risk factors]. In K. Narud (Ed.), *Vold mot kvinner [Violence against women].* Oslo: Cappelen Damm Akademisk.

Hjemdal, O., & Juklestad, O. (2006). *En privatsak? Eldres oppfatning av vold og overgrep og om å melde fra om vold [A private matter? Elderly peoples perceptions of violence and abuse and about the reporting of violence].* Oslo: Nasjonalt kunnskapssenter om vold og traumatisk stress [Norwegian Centre for Violence and Traumatic Stress Studies].

Hjemdal, O., Sogn, H., & Schau, L. (2012). *Vold, negative livshendelser og helse; En gjennomgang av data fra to regionale helseundersøkelser [Violence, negative life events; A review of data from two regional health surveys].* Oslo: Nasjonalt kunnskapssenter om vold og traumatisk stress [Norwegian Centre for Violence and Traumatic Stress Studies].

Hydle, I., & Johns, S. (1992). *Stengte dører og knyttede never. Når eldre blir utsatt for overgrep i hjemmet [Closed doors and knotted nerves. When the elderly are abused at home].* Oslo: Kommuneforlaget.

Jacobsen, F., Mekki, T., Førland, O., Folkestad, B., Kirkevold, Ø., Skår, R., . . . Øye, C. (2017). A mixed method study of an education intervention to reduce use of restraint and implement person-centered dementia care in nursing homes. *BMC Nursing, 16* (1; published 27.9.2017).

Jonassen, W., & Sandmoe, A. (2012). *Overgrep mot eldre i Norge – erfaringer og løsningsstrategier [Abuse of the elderly in Norway – experiences and solution-based strategies].* Oslo: Nasjonalt kunnskapssenter om vold og traumatisk stress [Norwegian Centre for Violence and Traumatic Stress Studies].

Justis- og beredskapsdepartementet. (2013a). *Et liv uten vold; Handlingsplan mot vold i nære relasjoner [A life witout violence;Action plan against violence in close relationships] 2014–2017*. Oslo: Justis- og beredskapsdepartementet [Norwegian Ministry of Justice and Public Security].

Justis- og beredskapsdepartementet. (2013b). *Melding til Stortinget nr 15 (2012-2013) Forebygging og bekjempelse av vold i nære relasjoner [Report to the Norwegian Parliament No. 15 (2012-2013) The prevention and combatting of violence in close relationships].* Oslo: Justis- og beredskapsdepartementet [Norwegian Ministry of Justice and Public Security].

Kilpatrick, D., Edmunds, C., & Seymur, A. (1992). *Rape in America: A report to the nation.* Arlington: National Victim Center.

Kilpatrick, D., Ruggiero, K., Acierno, R., Saunders, B., Resnick, H., & Best, C. (2003). Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: Results from the national survey of adolescents. *Journal of consulting and clinical psychology, 71*(4), 692-700.

Kristensen, K., & Lindell, L. (2013). *OFREDAD – om våld och övergrepp mot äldre personer [UNPROTECTED – On violence and abuse of elderly people]*. Visby: Region Gotland, socialförvaltningen [The Social Administration].

Krug, E., Dahlberg, L., Mercy, J., Zwi, A., & Lozano, R. (Eds.). (2002). *World report on violence and health*. Geneva: World Health Organization.

Lachs, M., Psaty, I., & Berman, J. (2011). Under the Radar: New York State Elder Abuse Prevalence Study. US: Prepared by: Lifespan of Greater Rochester, Inc., Weill Cornell Medical Center of Cornell University. New York City Department for the Aging.

Lafferty, A., Fealy, G., Downes, C., & Drennan, J. (2014). *Family Carer of Older People: Result of a National Survey of Stress, Conflict and Coping.* Dublin: NCPOP; University College Dublin.

Lithwick, M., Beaulieu, M., Gravel, S., & Straka, S. (1999). The Mistreatment of Older Adults: Perpetrator-Victim Relationships and Interventions. *Journal of Elder Abuse & Neglect, 11*(4), 95-112.

Luoma, M.-L., & Manderbacka, C. (2008). *Breaking the Taboo. Overview of research phase Finland*: Stakes.

Macdonald, A. (1997). ABC of mental health: Mental health in old age. *British Medical Journal, 315*, 413-417.

Malmedal, W. (2013). *Inadequate Care, Abuse and Neglect in Norwegian Nursing Homes*. (Doktorgrad), Norges teknisk-naturvitenskapelige universitet [Norwegian University of Science and Technology] (NTNU) Trondheim.

Martinussen, M. (Ed.) (2010). *Kvantitativ forskningsmetodologi i samfunns- og helsefag [Qunatative research methodology in social- and health sciences*. Bergen: Fagbokforlaget.

Mowlam, A., Tennant, R., Dixon, J., & McCreadie, C. (2007). *UK Study of Abuse and Neglect of Older People: Qualitative Findings.* London, UK: National Centre for Social Research and King's College London, prepared for Comic Relief and the Department of Health.

N.K.S. (2016). Gravide blir ikke spurt om vold [Pregnant women are not asked about violence], Publisert [Published] 08.12.16, lesedato [read date] 07.11.17 Retrieved from https://www.sanitetskvinnene.no/sanitetskvinnene/Gravide+blir+ikke+spurt+om+vold.b7C_wBrGYO.ips

Naughton, C., Drennan, J., Treacy, M., Lafferty, A., Lyons, I., Phelan, A., . . . Delaney, L. (2010). *Abuse and Neglect of Older People in Ireland: Report on the National Study of Elder Abuse and Neglect*. Dublin, Ireland: NCPOP; University College Dublin.

NCK (2014). *Våld och hälsa – En befolkningsundersökning om kvinnors och mäns våldsutsatthet samt kopplingen till hälsa [Violence and health – A population survey of women's and men's exposure to violence and the link to health].* Uppsala: Nationellt centrum för kvinnofrid [National Centre for Knowledge on Men's Violence Against Women].

O'Keeffe, M., Hills, A., Doyle, M., McCreadie, C., Scholes, S., Constantine, R., . . . Erens, B. (2007). *UK Study of Abuse and Neglect of Older People: Prevalence Survey Report.* London, UK: National Centre for Social Research and King's College London, prepared for Comic Relief and the Department of Health.

Optum ™ (2017). SF-8 ™ Health Surveys. US; OptumInsight Life Sciences, Inc.; Access Date: 6 Oct 2016. Retrieved from https://campaign.optum.com/content/optum/en/optum-outcomes/what-we-do/health-surveys.html

Perel-Levin, S. (2008). *Discussing screening for elder abuse at primary health care level.* Geneva: World Health Organization.

Phelan, A. (Ed.) (2013). *International Perspective on Elder Abuse*. London, UK: Routledge.

Piispa, M. (2004). Age and Meaning of Violence: Women's experiences of Partner Violence in Finland. *Journal of Interpersonal Violence, 19* (1), 30-48.

Polit, D., & Beck, C. (2010). *Essentials of nursing research: appraising evidence for nursing practice* (7th ed.). Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins.

Reeves, K., Desmarais, S., Nicholls, T., & Douglas, K. (2007). Intimate Partner Abuse of Older Men: Considerations for the Assessment Risk. *Journal of Elder Abuse & Neglect, 19*(1/2), 7-27.

Reis, M., & Nahmiash, D. (1998). Validation of the Indicators of Abuse (IOA) Screen. *Gerontologist, 38*(4), 471-480.

Saldarriaga-Cantillo, A., & Rivas Nieto, J. (2015). Noah Syndrome: A Variant of Diogenes Syndrome Accompanied by Animal Hoarding Practices. *Journal of Elder Abuse & Neglect, 27*(3), 270-275. doi:10.1080/08946566.2014.978518

Saltzman, L. E., Fanslow, J. L., McMahon, P. M., & Shelley, G. A. (2002). *Intimate partner violence surveillance: uniform definitions and recommended data elements, version 1.0*. Atlanta, Georgia Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Sandmoe, A., & Hauge, S. (2014). When the struggle against dejection becomes a part of everyday life: a qualitative study of coping strategies in older abused people. *Journal of Multidisciplinary Healthcare*(7), 283-291.

Sandmoe, A., Kirkevold, M., & Ballantyne, A. (2011). Challenges in handling elder abuse in community care. An exploratory study among nurses and care coordinators in Norway and Australia. *Journal of Clinical Nursing, 20* (23/24), 3351-3363.

Sethi, D., Wood, S., Mitis, F., Bellis, M., Penhale, B., Marmolejo, I., . . . Kärki, F. (Eds.). (2011). *European report on preventing elder maltreatment.* Copenhagen, Denmark: World Health Organization.

Skjørten, K. (2009). Partnervold blant eldre [Partner violence among the elderly]. *Tidsskrift for Psykisk Helsearbeid, 6*(2), 120-127.

Skretting, A., Vedøy, T., Lund, K., & Bye, E. (Eds.). (2016). R*usmidler i Norge 2016 Alkohol, tobakk, vanedannende legemidler, narkotika, sniffing, doping og tjenestetilbudet [Drugs in Norway in 2016. Alcohol, tobacco, addictive medicines,drugs, sniffing, doping, and the services offered].* Oslo: Folkehelseinstituttet, Område for psykisk og fysisk helse, Avdeling for rusmiddelbruk [Norwegian Institute of Public Health, Area of Mental and Physical Health, Department of Drug Use].

Skårderud, F. (2004). Det sitter i veggene [It sits in the walls]. *Dagbladet, Magasinet; 19. juni.*

Soares, J., Barros, H., Torres-Gonzales, F., Ioannidi-Kapolou, E., Lamura, G., Lindert, J., . . . Mindaugas Stank, M. (2010). *Abuse and Health among Elderly in Europe.* Kaunas: European Commission, Executive Agency for Health and Consumers.

SSB (2017a). Folkemengd, etter kjønn, alder og sivilstand [Population, by sex, age and marital status] 1. januar 2017. Oslo; Statistisk sentralbyrå [Statistics Norway]. Lesedato [Read date]: 30. okt 2017. Retrieved from http://www.ssb.no/300113/folkemengd-etter-kjonn-alder-og-sivilstand.1.januar-2017-sa-60

SSB (2017b). Nøkkeltall for innvandring og innvandrere [Key figures for immigration and immigrants]. Oslo; Statistisk sentralbyrå [Statistics Norway). Lesedato [Read date]: 15. okt 2017. Retrieved from http://www.ssb.no/innvandring-og-innvandrere/nokkeltall/innvandring-og-innvandrere

Stang, G., & Evensen, Å. (1985). Eldremishandling frem i lyset [Spotlight on elderly abuse]. *Tidsskrift for den norske lægeforening, 105*, 2475-2478.

Straffeloven. (2005). *Lov om straff [Law on Punishment]. Sist endret [Last changed]: LOV-2017-06-21-90 fra 01.07.2017*. Oslo: Justis- og beredskapsdepartementet [Norwegian Ministry of Justice and Public Security].

Straus, M., Hamby, S., Boney-Mccoy, S., & Sugarman, D. (1996). The Revised Conflict Tactics Scales (CTS2). *Journal of Family Issues, 17*(3), .283-316

Sørbø, M. (2014). Helsekonsekvenser av vold mot kvinner [Health consequences of violence against women]. In K. Narud (Ed.), *Vold mot kvinner [Violence against women]* (pp. 211-228). Oslo: Cappelen Damm Akademisk.

Thoresen, S., & Hjemdal, O. (Eds.). (2014). *Vold og voldtekt i Norge; En nasjonal forekomststudie av vold i et livsløpsperspektiv [Violence and rape in Norway; A national prevalence study of violence in a life course perspective].* Oslo: Nasjonalt kunnskapssenter om vold og traumatisk stress [Norwegian Centre for Violence and Traumatic Stress Studies].

UN (2013). *Neglect, Abuse and Violence against Older Women.* New York: United Nations, Department of Economic and Social Affairs.

Veenstra, M., & Slagsvold, B. (2009). Helseatferd gjennom livsløpet: Hva betyr utdanning for vår helseatferd? [Health behaviour throughout the life course: what does education mean for our health behaviour?] Samfunnsspeilet, 23(1/2009), 45-51. http://www.ssb.no/sosiale-forhold-og-kriminalitet/ssp/2009-1

Wallace, R., & Bonnie, R. (Eds.). (2003). *Elder Mistreatment: Abuse, Neglect and Exploitation in an Aging America.* Washington: CNSTAT, Division of Behavioral and Social Sciences and Education: National Academies Press.

WHO (2002). *The Toronto Declaration on the Global Prevention of Elder Abuse.* Geneva, Switzerland: World Health Organization.

WHO (2014). *Global status report on violence prevention.* Geneva, Switzerland: World Health Organization; UNOCD; UNDP.

Winterstein, T., & Eisikovits, Z. (2005). The Experience of Loneliness of Battered Old Women. *Journal of Women & Aging, 17*(4), 3-19.

Yon, Y., Mikton, C., Gassoumis, Z., & Wilber, K. (2017). Elder abuse prevalence in community settings: a systematic review and meta-analysis. *Lancet Glob Health, 5*, e147–156.

Appendix 1:
Weighted and unweighted prevalences in total, and for women and men

Weighted and unweighted Prevalences	Total		Women		Men	
	Unweighted	Weighted	Unweighted	Weighted	Unweighted	Weighted
At least one type of abuse after 65	10,0	10,1	10,5	11,0	9,5	9,1
At least one type of abuse in the past year	5,2	5,0	5,0	4,9	5,3	5,0
Physical violence after 65	2,5	2,5	2,5	2,8	2,4	2,5
Sexual abuse after 65	1,4	1,4	1,2	1,4	1,5	1,5
Controlling behaviour or psychological violence after 65	4,5	4,2	5,1	4,9	3,9	3,3
At least one type of abuse from a close relative after 65	5,4	5,2	5,9	6,2	4,9	4,9

Appendix 2: **Statistical Analyses**

This is a technical description of the statistical approaches that were used in addition to those in the section above and the actual report. The description primarily covers matters that are too technical to include in the report, including specifications and explanations of the formulations used therein.

Processing of insufficient data and inconsistencies found in individual questions

The survey was a postal questionnaire sent to the respondents for them to complete and return. This resulted in the receipt of a fair amount of incomplete answers to individual questions, as well as some inconsistent answers. Here there was a difference between questions and question groups, which required the insertion of a cross for a positive answer only. All other questions required the insertion of a cross for negative answers. Questions that only required the insertion of a cross for a positive answer, where counted as a “No” if a cross was not inserted. All other questions with a missing cross where counted as a missing value.

Questions that only required the insertion of a cross for a positive answer includes one question group related to the causes of health problems and one related to perpetrators of less severe violence, but not two question groups related to the actual less severe physical violence.

They also include two question groups on severe physical violence and perpetrators of the violence, and two question groups related to the reasons for not reporting the violence to the police.

Likewise, questions that only required the insertion of a cross for a positive answer include two question groups related to perpetrators of severe sexual abuse, but not three groups on severe sexual abuse. Also included is a question group related to perpetrators of less severe sexual abuse, but not question group related to the abuse.

The approach includes a methodological divergence in that there is a lower percentage of missing data for questions where a cross is only inserted for a positive answer, without it necessarily having any connection with reality. The answer categories “Don’t’ know/do not want to give an answer”, where answer choices are given, are entered as missing data in all instances.

Inconsistencies are handled as follows: For question group related to whom the person lives with, the insertion of a cross for living alone is not counted if a cross has also been inserted for living with someone. For the question groups related to exposure to violence and sexual abuse, it is considered that the actual type of violence and abuse has taken place if the perpetrator is stated to have engaged in the same type of violence and abuse. It is also considered that the actual type of violence and abuse has taken place after the age of 65 years, if it is stated that it took place in the past 12 months. This is connected to the fact that the questionnaire was completed at the age of 66 years at the earliest.

For all types of violence or abuse, a combination of variables is calculated for the actual type of violence or abuse. The combination of variables is calculated in a way that it is counted as a “Yes” if at least one of the questions in each group is answered with a “Yes.” It is only counted as a “No” if all the questions have been answered, and answered with “No”; otherwise they are counted as unanswered. For question groups where a cross is only inserted for a positive answer, it means that there could be a methodological divergence in that the number of “No” answers are systematically lower than the number of “Yes” answers. In some cases, percentages are also reported to be calculated on the basis that all answers that are not classified as “Yes” are set to “No”. The correct percentages will probably lie somewhere in the middle.

The approach that we have chosen to process missing data and inconsistent answers means that there will be a higher or lower percentage of people in the sample that cannot be classified for many of the question groups. In the report, those who can be classified are described as “people whose answers were possible to assess.”

During the past decade, we have acquired more knowledge about violence in close relationships, for example, through national and international prevalence studies. The report of the World Health Organisation "Global Status Report on Violence Prevention" from 2014 highlights Norway's efforts in this area. At the same time, it states that Norway has not conducted any national prevalence studies on violence against elderly people, and does not have any policies, plans of action, support systems or prevention programmes in place that are specially aimed at the elderly age groups. This project is part of NKVTS' research programme on violence in close relationships, which was implemented on behalf of the Norwegian Ministry of Justice and Public Security.

This report describes the results of the first national prevalence survey on personal safety and quality of life among elderly women and men in Norway. The prevalence of violence and abuse after the victim of violence has turned the age of 65 years and in the past year is described. In addition, an account of how many of the respondents stated that they have been exposed to severe physical violence or severe sexual abuse earlier in life is provided.

The report describes many different circumstances connected to exposure to violence and abuse in old age, and a number of health, social and psychological consequences are discussed. A consistent characteristic is that victims of violence rarely tell others about their situation and few victims contact the support services and legal system.

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